Payment Integrity Scorecard

Program or Activity	Reporting Period
Centers for Medicare & Medicaid Services (CMS) - Medicare Fee-for-Service (FFS)	Q1 2025

FY 2024 Overpayment Amount ($M)* **$31,001**

*Estimate based a sampling time frame starting 7/2022 and ending 6/2023

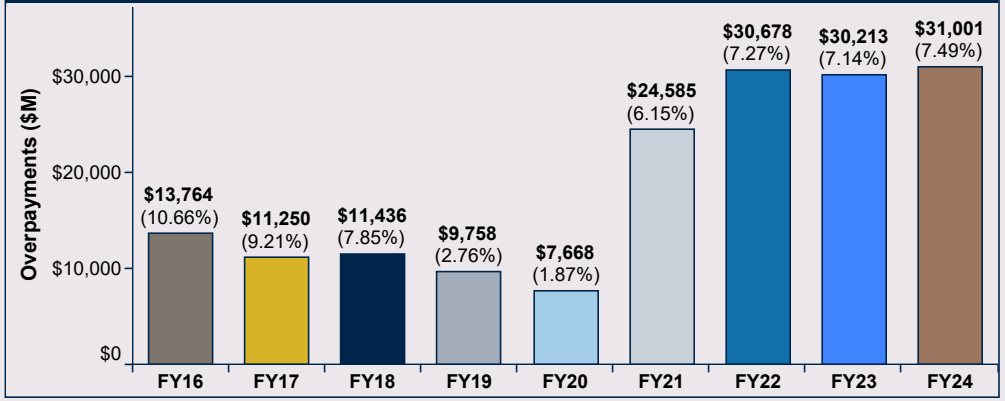
Health and Human Services

Centers for Medicare & Medicaid Services (CMS) - Medicare Fee-for-Service (FFS)

Brief Program Description & summary of overpayment causes and barriers to prevention:

Medicare Fee-for-Service (FFS) is a federal health insurance program that provides hospital insurance (Part A) and supplementary medical insurance (Part B) to eligible citizens. The primary causes of overpayments continue to be insufficient documentation and medical necessity errors for skilled nursing facilities, hospital outpatient, hospice, and home health claims. A known barrier to preventing improper payments is that providers' and suppliers' compliance with requirements is outside of the agency's control.

Historical Payment Rate and Amount ($M)
(Overpayment as Percentage of Total Outlays)



Discussion of Actions Taken in the Preceding Quarter and Actions Planned in the Following Quarter to Prevent Overpayments

In Quarter 1 of FY 2025, CMS finalized regulations to reduce the review and decision timeframes for the Hospital Outpatient Department Prior Authorization Program. These regulations bring the program into compliance with the requirements in the Interoperability Rule. These requirements began in January 2025, a full year earlier than the Interoperability Rule required. In FY 2025, CMS will continue to bring other prior authorization and pre-claim review programs and demonstrations into compliance with the Interoperability Rule. CMS also implemented a high-risk review of hospice providers in 4 states.

	Accomplishments in Reducing Overpayment	Date
1	Implemented a medical review effort for high-risk hospices in Nevada, California, Arizona, and Texas aimed at identifying probable hospice fraud causing possible beneficiary harm.	Oct-24
2	Finalized regulations to reduce the timeframes for review/decision in a prior authorization request for the Hospital Outpatient Department Prior Authorization Program. This final regulation brings the program into compliance with the Interoperability Rule requirements.	Nov-24
3	Highlighted accurate billing and documentation practices in the Medicare Learning Network weekly newsletter for enteral nutrition, hip and knee replacement, immunosuppressive drugs, and infusion pumps.	Dec-24

Payment Integrity Scorecard

Program or Activity
Centers for Medicare & Medicaid Services (CMS) - Medicare Fee-for-Service (FFS)

Reporting Period
Q1 2025

	Goals towards Reducing Overpayments	Status	ECD
1	Begin the Low Biller program which is a modified version of Targeted Probe and Educate program which will allow the program to include more providers who may not bill enough claims of a particular service type to be included in the traditional program.	On-Track	May-25
2	Explore new ways to pilot to determine if increased interoperability using fast healthcare interoperability resources will allow for better documentation to be shared with suppliers from ordering physicians. The receipt of better documentation without significantly increasing physician burden should reduce denials and improper payments that are denied because of lack of documentation from ordering physicians.	On-Track	May-25

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Audit**	Medicare Administrative Contractors and Recovery Audit Contractors will complete post payment review and Targeted Probe and Educate based on improper payment findings.	Medicare Administrative Contractors and Recovery Audit Contractors review claims, identify and collect improper payments, and provide education to providers.
2	**Recovery Activity**	Assign review projects to the Supplemental Medical Review Contractor based on improper payment findings. The contractor will complete reviews to identify improper payments for collection based on FY2024 findings and the Office of the Inspector General report recommendations.	Assigned the Supplemental Medical Review Contractor with medical reviews based on recommendations form the Office of the Inspector General. Claims are reviewed to identify improper payments for collection.
3	**Recovery Activity**	Use a comprehensive approach to prevent overpayments through proactive measures. National prior authorization programs are considered part of the overall recovery strategy, reducing or eliminating the need for recovery activities.	Used the Targeted Probe and Educate medical review process to review and correct overpayments and educate providers to prevent future errors.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$31,001M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	The primary causes of Medicare Fee-for-Service overpayments continue to be insufficient documentation and medical necessity errors for hospital outpatient, skilled nursing facility, home health, and hospice claims.	Change Process altering or updating a process or policy to prevent or correct error.	CMS prevents overpayments through prior authorization programs. Under prior authorization, the provider submits a prior authorization request to CMS and receives the decision regarding whether CMS will pay for a service before any services are rendered.
			Audit - process for assuring an organization's objectives of operational effectiveness, efficiency, reliable financial reporting, and compliance with laws, regulations, and policies.	The Supplemental Medical Review Contractor performed medical reviews of hospice, skilled nursing facility, inpatient rehabilitation facility, and durable medical equipment claims to identify improper payments for collection.
			Training teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Training and education will reduce errors made when billing claims and documenting medical records. System edits, integrated medical review approaches, improved policy, and expanded provider education are used to identify and provide necessary training.