

Payment Integrity Scorecard

Program or Activity

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

Reporting Period

Q4 2025

FY 2024 Overpayment Amount (\$M)*

\$31,001

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



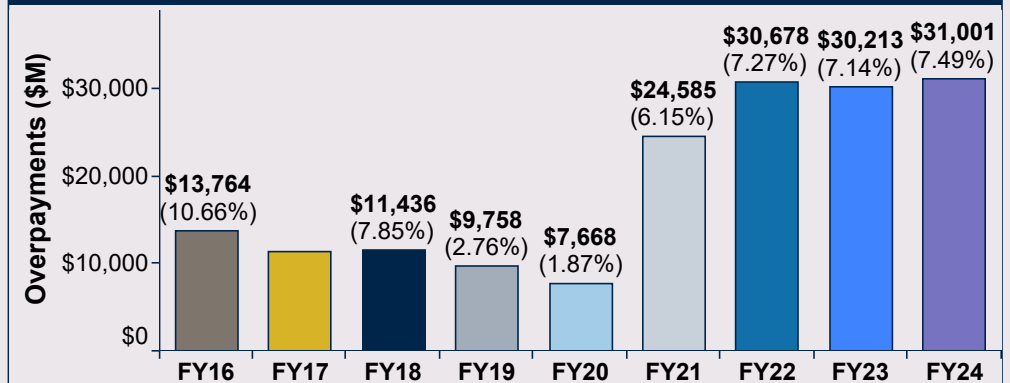
HHS

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 4 of FY 2025, the Centers for Medicare & Medicaid Services (CMS) announced a new demonstration program for Ambulatory Surgical Centers requiring prior authorization for select services. CMS also completed a 2-year skilled nursing facility project that reviewed claims from every facility and provided education on necessary documentation requirements. Lastly, CMS continued providing stakeholders with detailed information about the Review Choice Demonstration for Inpatient Rehabilitation Facility services so that they can understand and learn how the demonstration is performing.

Accomplishments in Reducing Overpayment

Date

1	Concluded a 2-year probe and educate program for every Skilled Nursing Facility (SNF) billing Medicare FFS. This program reviewed claims from every SNF and provided education as needed to help lower the SNF improper payment rate.	Jul-25
2	Published cycle level data for the Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration for Alabama and Pennsylvania allowing stakeholders to understand top denial reasons and trends for the program.	Aug-25
3	Announced an Ambulatory Surgical Center prior authorization demonstration in 10 states for certain codes already reviewed in the Hospital Outpatient Department (HOPD) Prior Authorization (PA) program.	Sep-25

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Goals towards Reducing Overpayments		Status	ECD	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	Expand the hospice notification pilot to additional states. Through this pilot, notification letters are sent to beneficiaries newly enrolled in hospice to ensure the hospice election was accurate and not fraudulent.	On-Track	Mar-26	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	Identify future items for inclusion to the Master List for Required Prior Authorization for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.	On-Track	Mar-26	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 FY2025 findings and the Office of the Inspector General report recommendations.	Assigned the Supplemental Medical Review Contractor with medical reviews based on recommendations from 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.
			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.
			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.