Payment Integrity Scorecard

Program or Activity	Reporting Period	FY 2025 Overpayment Amount ($M)*	$27,870
Centers for Medicare & Medicaid Services (CMS) - Medicare Fee-for-Service (FFS)	Q4 2026		

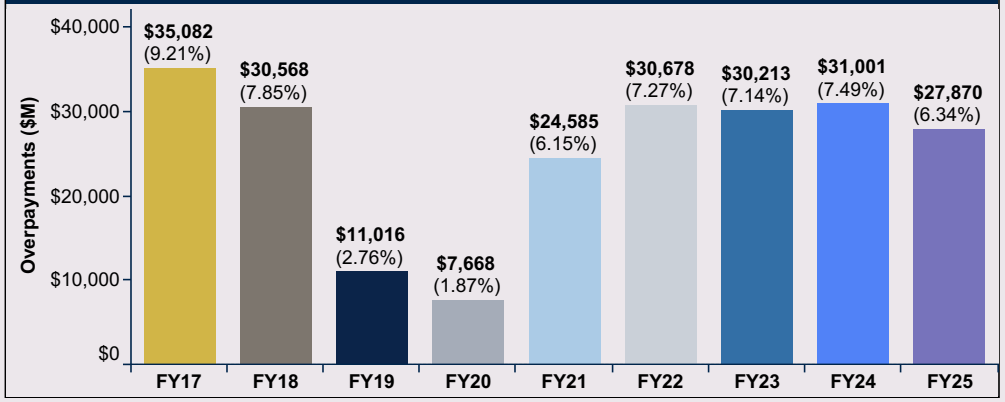
*Estimate based a sampling time frame starting 7/2023 and ending 6/2024

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

The Centers for Medicare & Medicaid Services (CMS) announced the Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, and Supplies (DMEPOS) Probationary Prior Authorization process. This process will require prior authorization for certain highly vulnerable services, items, and supplies for newly enrolled DMEPOS suppliers and those undergoing certain changes of ownership. This process is nationwide and is aimed at ensuring newly enrolled suppliers or suppliers with potentially new ownership are billing accurately. CMS also announced the most recent iteration of the Master List for DMEPOS as well as the Required Face to Face/Written Order Prior to Delivery list and the Required Prior Authorization list. Lastly, CMS held a successful National Provider Compliance Conference which helped bring together providers, the Medicare Administrative Contractors and CMS to discuss provider compliance issues impacting improper payment identification.

	Accomplishments in Reducing Overpayment	Date
1	Announced the DMEPOS Probationary Prior Authorization process for newly enrolled DMEPOS suppliers and those undergoing certain changes of ownership. This process will require prior authorization for these suppliers for highly vulnerable items.	Sep-26
2	Announced the next iteration of the DMEPOS Master List and the Required Prior Authorization list. This update added 8 additional codes including certain orthoses, pressure reducing support surfaces, and a manual wheelchair base to the Required Prior Authorization list.	Jul-26
3	Held an in-person National Provider Compliance Conference in Charlotte, North Carolina. This conference brought together providers, CMS, and the Medicare Administrative Contractors to discuss how to bill and document claims correctly.	Aug-26

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

Reporting Period
Q4 2026

	Goals towards Reducing Overpayments	Status	ECD
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	Dec-26
2	Identify future items for inclusion to the Master List for Required Prior Authorization for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.	Completed	Aug-26

	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 FY2025 findings and the Office of the Inspector General report recommendatio..	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
$27,870M	Overpayments 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.