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Fiscal Year 2022 Improper Payments Fact Sheet | CMS

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What You Need to Know:

Improper payments represent payments that do not meet program requirements.

The vast majority of improper payments occur in situations where there was an unintentional payment error or a reviewer cannot determine if a payment was proper due to insufficient payment documentation from a state, provider, or the Exchange.

Improper payments do not necessarily represent expenditures that should not have occurred and can include both overpayments and underpayments where there is insufficient documentation to determine if a payment is proper in accordance with program payment requirements.

While fraud and abuse are improper payments, not all improper payments represent fraud. Improper payment estimates are not fraud rate estimates.

Improper Payments Do Not Necessarily Indicate Fraud. Most improper payments are caused by improper or inadequate documentation. Improper payments also do not necessarily represent expenditures that should not have occurred.

Improper payments can result from a variety of circumstances, including:

1) items or services provided with no documentation,
2) items or services provided with insufficient documentation, or
3) no record of the required verification of an individual's eligibility, such as income, specifically for Medicaid, CHIP, and the Federally-facilitated Exchange.

- **Post payment Review**: A reviewer makes a claim determination after the claim has been paid. Post payment review results in either no change to the initial determination or a 'revised determination' indicating that an overpayment or underpayment has occurred.

- **Service Specific Review**: A review that is performed when the same or similar problematic process is noted to be widespread and affecting a particular type of service. When data analysis confirms that an improper payment can be prevented through service specific complex review, the Medicare Administrative Contractor (MAC) and the Railroad Retirement Board Specialty Medicare Administrative Contractor (RRB SMAC) will install claim edits that target the specific service identified.
- **Provider Specific Review**: A review that is performed when data analysis indicates a potential error exists with a specific provider or providers that cannot be confirmed without requesting and reviewing documentation associated with the claim.

- **Service Specific Post-Payment Reviews** - All post-payment reviews will be closed. Post-payment reviews occur when a reviewer makes a claim determination after the claim has been paid. Post-payment reviews result in either no change to the initial determination or a "revised determination" indicating that an overpayment or underpayment has occurred.

DDSN operates a review program to detect, prevent and correct fraud, waste, and abuse and to facilitate accurate claim payments. To further this program, DDSN conducts reviews on a post-payment basis.

DDSN (or its designee) conducts post-payment reviews of the providers' records related to services rendered to participants of DDSN Operated Home and Community-Based Waiver Services. During such reviews, the provider is asked to allow DDSN access to the service records and billing documents that support the claims billed.

For additional reference:

- *The Treatment, Payment and Health Care Operations (TPO) exception under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (45 CFR 164.506) allows the release of medical records containing protected health information between covered entities without an additional authorization for the purpose of payment and review of healthcare claims. Providers who believe that an additional release authorization for this review is necessary should obtain from DDSN participants their authorization for release of the medical records to DDSN, along with the provider's service agreement, or the requirement will be waived if permitted by law.*
- *DDSN utilizes, but is not limited to, the resources below to conduct its reviews. These are widely acknowledged national guidelines for billing practices. An authorization must be present to support all claims, along with documentation to support the services or supplies that were billed.*
- *DDSN Directives and Individual Service Standards*
- *DHHS Manuals for Individual Services*
- *DHHS Medicaid Bulletins*
- *Centers for Medicare & Medicaid Services (CMS) guidelines*
- *Food and Drug Administration guidance*
- *Department of Health and Human Services final rules, regulations and instructions published in the Federal Register*