DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® — Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Beginning January 1, 2012, eligible professionals and group practices participating under the group practice reporting option (GPRO) that have not successfully met the requirements of the eRx incentive program (or, alternately, qualify for a significant hardship exemption) will be subject to the 2012 Medicare eRx payment adjustment. The adjustment will reduce Medicare payment rates by 1% of the provider's allowable Medicare Part B charges. Individual eligible professionals must submit their hardship exemption requests through the Quality Communications Support Page and group practices participating under the group practice reporting option (GPRO) must submit hardship exemption requests via a letter to CMS. The deadline to submit a hardship exemption request is Tuesday November 1, 2011.

MLN Matters® Number: SE1133

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Predictive Modeling Analysis of Medicare Claims

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who submit Fee-For-Service (FFS) claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment (DME) MACs, and Home Health and Hospice MACs (HH+H MACs)).

What Providers Need to Know

STOP – Impact to You

As of June 30, 2011, the Centers for Medicare & Medicaid Services (CMS), has implemented a predictive analytics system that will analyze all Medicare FFS claims to detect potentially fraudulent activity.

CAUTION – What You Need to Know

The predictive analytics system uses algorithms and models to examine Medicare claims in real time to flag suspicious billing. This article briefly explains the predictive modeling system, its purpose, and how CMS is incorporating the system into its claims payment process.

GO – What You Need to Do

See the Background and Additional Information sections of this article for more information about this change.

Background

Section 4241 of the Small Business Jobs Act of 2010 (SBJA) mandated that the CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity. Signed by the President in Fall 2010, the SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity. This new process is similar to the pre-payment analysis already done by the financial and credit card industries. The entire text of the SBJA is available at http://www.gpo.gov/fdsys/pkg/BILLS-111hr5297enr/pdf/BILLS-111hr5297enr.pdf on the Internet.

Real Time Claims Streaming to Build Profiles and Create Risk Scores

As of June 30, 2011, CMS is streaming all Medicare FFS claims through its predictive modeling technology. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns.

Risk scores enable CMS to quickly identify unusual billing activity and flag claims for more thorough review prior to releasing payment. The system automatically prioritizes claims, providers, beneficiaries, and networks that are generating the most alerts and highest risk scores. CMS is leveraging the benefits of its new high-tech system to complement, not replace, the expertise of its experienced analysts:

- Analysts review prioritized cases by closely reviewing claims histories, conducting interviews, and performing site visits as necessary.
- If an analyst finds only innocuous billing, the outcome is recorded directly into the predictive modeling system and the payment is released as usual. This feedback loop refines the predictive models and algorithms to better target truly fraudulent behavior.

- Analysts who find evidence or indicators of fraud will work with the CMS Center for Program Integrity, MACs, and Zone Program Integrity Contractors to enact targeted payment denials, and in cases of egregious fraud, revoke Medicare billing privileges. Program integrity entities may also, as appropriate, coordinate with law enforcement officials to investigate cases for criminal or civil penalties.

Effect of Risk Scores on Claims Payment

Risk scores alone do not initiate administrative action and serve only to alert CMS to the necessity of more careful review of claims activity. While providers will be unable to appeal risk scores, CMS's new technology will in no way alter a provider or supplier's existing rights to appeal administrative actions or overpayment recovery efforts.

Currently, CMS is not denying claims solely based on the alerts generated by predictive models. CMS is focused on developing and refining models that identify unusual behavior without disrupting its claims processing for Medicare providers.

Working closely with clinical experts across the country and of every provider specialty, CMS is developing and refining algorithms that reflect the complexities of medical treatment and billing. The new technology will ultimately benefit the program's many honest providers and suppliers by enabling the agency to prioritize the highest-risk cases for investigation and review. Prioritizing the alerts will minimize the disruption to providers who may occasionally exhibit unusual but honest billing.

CMS's predictive modeling technology also enables automated cross-checks of provider, beneficiary, and claim information against historical trends and external databases. Automating checks that were previously performed manually will help CMS to more quickly identify and resolve any issues that may delay payment to providers and suppliers. Even as CMS implements a more thorough claims screening process, the Agency remains dedicated to ensuring prompt payment for the providers. Prompt payment of claims is a statutory requirement; only in exceptional and urgent circumstances will CMS leverage its authority to waive prompt payment to conduct further investigation or review.

Additional Information

If you have any questions, please contact your Medicare contractor (carrier, FI, A/B MAC, HH+H MAC, or DME MAC) at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.