

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-20 One-Time Notification</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1004</b>	<b>Date: December 2, 2011</b>
	<b>Change Request 7645</b>

**SUBJECT: Requirement to Report Medicare Fee for Service Rendering Provider Place of Service Address Information to the Common Working File**

**I. SUMMARY OF CHANGES:** Recently, the National Fraud Prevention Program (NFPP) has discovered that the billing address of providers in the Integrated Data Repository (IDR) is not the address at which services were delivered; it is the address of the entity that submitted the bill. One of the models that the NFPP applies to claims requires the assessment of the distance between where a service is provided and where the beneficiary lives. Since the billing address may be a long distance from where the service is provided, a high number of false positives is being produced by the model. The address where a service is delivered is available in the shared systems. This change request (CR) requires that the address where the service is delivered be included in the Common Working File (CWF) file and that it be carried through processing to the IDR.

**EFFECTIVE DATE: April 1, 2012**

**IMPLEMENTATION DATE: April 2, 2012**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
N/A	N/A

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements

**IV. ATTACHMENTS:**  
**One-Time Notification**

*\*Unless otherwise specified, the effective date is the date of service.*

## Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1004	Date: December 2, 2011	Change Request: 7645
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**SUBJECT: Requirement to Report Medicare Fee for Service Rendering Provider Place of Service Address Information to the Common Working File**

**EFFECTIVE DATE:** April 1, 2012

**IMPLEMENTATION DATE:** April 2, 2012

### **I. GENERAL INFORMATION**

#### **A. Background:**

The loss of taxpayer dollars through waste, fraud, and abuse drives up health care costs. CMS is pursuing an aggressive program integrity strategy that will prevent fraudulent transactions from occurring, rather than simply tracking down fraudulent providers and pursuing fake claims. CMS' program integrity mission also encompasses the operations and oversight necessary to ensure that CMS makes accurate payments to legitimate providers and suppliers for appropriate, reasonable, and necessary services and supplies for eligible Medicare beneficiaries. Reversing the traditional pay-and-chase approach to program integrity is the main goal of the National Fraud Prevention Program (NFPP), a long-term, sustainable approach that incorporates innovative technologies in integrated solutions. The NFPP is being implemented by the Center for Program Integrity (CPI), the CMS component that is accountable for the prevention and detection of fraud, waste, abuse and other improper payments under the Medicare and Medicaid programs.

The vision of the NFPP is to implement proven predictive modeling tools into the claims processing system to stop payment on high risk claims. However, before applying the tools on claims prepayment or taking action on providers, it is essential that the algorithms are rigorously tested to: 1) avoid a high rate of false positives to ensure that claims are paid for legitimate providers without disruption or additional costs to honest providers; 2) in no way degrade access to care for legitimate beneficiaries; and 3) identify the most efficient analytics in order to appropriate target resources to the highest risk claims or providers. As the system is implemented, it is also imperative that the models and analytics are "retrained" and "learn" from how the investigations conclude. For example, if the models identified 100 targets, and 20 were investigated and found to be legitimate, the models should be refined to account for the characteristics of the 20 legitimate targets.

Recently, the NFPP has discovered that the billing address of providers in the Integrated Data Repository is not the address at which services were delivered; it is the address of the entity that submitted the bill. One of the models that the NFPP applies to claims requires the assessment of the distance between where a service is provided and where the beneficiary lives. Since the billing address may be a long distance from where the service is provided, a high number of false positives is being produced by the model. The ZIP code of the address where a service is delivered is available in an existing field of the Multi-Carrier System (MCS) shared system, i.e., DTL-PRV-ZIPCODE. This CR requires that the address where the service is delivered be included in the MCS transmit file and the Common Working File (CWF) file, and that it be carried through processing to the Integrated Data Repository (IDR).

#### **B. Policy:**

Section 4241 of the Small Business Jobs Act of 2010 (Public Law 111-240) mandates the use of predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse in the Medicare Fee for Service program. The system implemented through this legislation has significant potential to improve CMS' ability to prevent payment of fraudulent claims. These tools have been used successfully in the financial



Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R I E R	R H H I	Shared-System Maintainers				OTHER
		M A C	M A C				I S S	M C S	V M S	C W F	
	Medicare Beneficiary Database (MBD).										

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R I E R	R H H I	Shared-System Maintainers				OTHER
		M A C	M A C				I S S	M C S	V M S	C W F	
	None.										

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

X-Ref Requirement Number	Recommendations or other supporting information:
7645.1	Details of DTL-PRV-ZIPCODE can be found in the MCS documentation in the Screen documentation for HI-Detail History screen Page 3 of the HI screen - Page 44 of the documentation word file from the October 2011 documentation on MCS.
7645.1	CWF will get the zip code of the doctor's office if the place of service code is Office; it should get the beneficiaries home zip if the place of service is Home; and it should get the zip of the skilled nursing facility if that is where the service was rendered.

**Section B: For all other recommendations and supporting information, use this space: N/A**

### V. CONTACTS

**Pre-Implementation Contact(s):** John Stewart 410-786-1189 John.Stewart@CMS.HHS.GOV  
 Anthony Hodge 410-786-6645 Anthony.Hodge2@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

## **VI. FUNDING**

### **Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

### **Section B: For *Medicare Administrative Contractors (MACs)*:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements