CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1049	**Date: February 24, 2012**
	Change Request 7669

SUBJECT: Implement Fraud Prevention Predictive Modeling Prepayment Edits - Analysis and Design Only

I. SUMMARY OF CHANGES: 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 FFS 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 and telecommunication sectors and have applicability to Medicare. The legislation requires the program to be in place by July 1, 2012.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: July 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.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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: 1049	Date: February 24, 2012	Change Request: 7669

SUBJECT: Implement Fraud Prevention Predictive Modeling Prepayment Edits – Analysis and Design Only

Effective Date: **July 1, 2012**

Implementation Date: July 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 via the Fraud Prevention System (FPS) that can 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 FPS 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 will be refined to account for the characteristics of the 20 legitimate targets.

The FPS will become mature in June 2012. With this CR, CPI seeks the ability to use FPS in conjunction with CWF and the shared systems as an additional prepayment check to ensure proper claims payment. This CR requests analysis and design hours toward the implementation of changes to the Common Working File (CWF) and shared systems that will allow the FPS to review claims approved for payment by CWF and make a payment determination that is returned to the shared systems for appropriate action with as minimal impact on the current claims flow as possible. This includes requiring the Common Working File (CWF) and shared systems maintainers and MACs to collaborate with CMS and the FPS contractor in the development of the necessary requirements.

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 FFS 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 and

telecommunication sectors and have applicability to Medicare. The legislation requires the program to be in place by July 1, 2012.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7669.1	The CWF maintainer shall work with CMS to develop a process that shall transmit claims information that each CWF host receives daily to the Fraud Prevention System (FPS) contractor.									X	FPS Contract-or
7669.2	The CWF maintainer shall work with CMS to develop the requirements for reading files in the format specified in attachment 1 or a format mutually agreed to by the CWF maintainer and the FPS Contractor.									X	FPS Contract-or
7669.2.1	The requirements developed to meet Business Requirement (BR) 7669.2 shall specify that FPS receives files daily and that FPS shall send responses to the files daily.									X	FPS Contract-or
7669.2.2	The requirements developed to meet BR 7669.2 shall include a mechanism for informing MACs of claims that should not be paid based on the information provided in the format found in Attachment 1.									X	
7669.3	Shared system maintainers shall develop requirements for a mechanism to deny the claims identified in the format found in Attachment 1.						X	X	X		
7669.3.1	The requirements for BR 7669.3 shall include the use of reason codes for the denial of claims. Reason codes shall be determined based on discussion with maintainers and contractors that BR 7669.5 requires.						X	X	X		
7669.3.2	The requirements for BR 7669.3 shall include development and use of Medicare Summary Notice codes for the denial of claims. MSN codes shall be determined based on discussion with maintainers and contractors that BR 7669.5 requires.						X	X	X		
7669.3.3	The requirements for BR 7669.3 shall include the requirement that claims denied through this process are denied with provider liability.						X	X	X		
7669.3.3.1	The FPS contractor shall provide a non technical description for each denial reason code identified in BR 7669.3.1.										FPS Contract-or
7669.4	The shared system maintainers shall develop						X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	requirements for producing the report specified in attachment 2.										
7669.5	Contractors and shared system maintainers shall participate in calls to discuss this CR.	X	X	X	X	X	X	X	X	X	FPS Contract-or, EDCs, PDAC
7669.5.1	The calls that BR 7669.5 requires shall be held twice a week until requirements for modules to meet the BRs of this CR have been developed.	X	X	X	X	X	X	X	X	X	FPS Contract-or, EDCs, PDAC
7669.5.2	The contractors and shared systems maintainers shall deliver a document that outlines the system requirements that must be met to implement the BRs of this CR on April 1, 2012.						X	X	X	X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Craig Mooney 410-786-1956, William.Mooney@cms.hhs.gov
Maura McHale Allison 410-786-2093 MauraMcHaleAllison@cms.hhs.gov
David Nelson 410-786-5246, David.Nelson@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)*, include the following statement:

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.

Attachments (2)

Attachment 1 – Format of input file

FORMAT OF TRANSMISSION FILE FROM THE FPS SYSTEM						
FIELD #	**Field Description**	**Start Position**	**End Position**	**Length**	**Type**	**Field Definition**
1	Referral Reference Number	1	8	8	CHAR	The number that the FPS assigns to the request (reset to 1 each day).
2	Referral Date	9	16	8	DATE	The date of the referral in DDMMYYYY format.
3	Shared system	17	17	1	CHAR	Shared system that processed the claim (1= FISS, 2=MCS, 3=VMS)
4	Billing Provider NPI	18	27	10	CHAR	The NPI of the billing provider.
5	Billing Provider Number	28	40	13	CHAR	The PIN (left justified) of the billing provider.
6	MAC ID	41	45	5	CHAR	The contractor number where the claims is processed.
7	ICN or DCN	46	68	23	CHAR	The claim ID (left justified) on which the shared system shall act.
8	Line Number	69	71	3	CHAR	Line number of the service to be denied.
9	HCPCS/CPT Code	72	76	5	CHAR	HCPCS/CPT code of the service to be denied.
10	Start Date of Service	77	84	8	DATE	The date on which the service to be denied started in DDMMYYYY format.
11	End Date of Service	85	92	8	DATE	The date on which the service to be denied ended in DDMMYYYY format.

Attachment 2 – Reports to be produced

MAC ID	**NPI/PTAN**	**LINES DENIED**	**DOLLARS DENIED**
CCCCC	CCCCCCCCCCCCCC/CCCCCCCCCCCCCC	NNN,NNN	$NNN,NNN,NNN