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CMS Combines Enrollment Screening With Claims Scrutiny to Fight Fraud

CMS is using the one-two punch of enrollment screening and claims scrutiny to slow the flow of Medicare fraud and abuse, and is developing new methods to profile providers and suppliers.

"CMS is focused on integrating provider enrollment and claims payment strategies," says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. "They're trying to put all the pieces of the puzzle together." The goal is to get better at figuring out who the bad apples are, connect them to patterns suggesting fraudulent claims and respond with administrative action, such as revoking or deactivating the provider's Medicare billing privileges, she says. The target won't always be a phantom durable medical equipment company. Sometimes legitimate providers and suppliers will feel the heat from failing to update enrollment forms when an address or executive has changed or dropping the revalidation ball, she says. All providers and suppliers must revalidate (re-enroll) every five years, except durable medical equipment and prosthetics and orthotics suppliers (DMEPOS), which are required to do it every three years *(RMC 11/7/11, p. 1).*

One sign of more aggressive enrollment and claims screening is CMS's implementation of the National Fraud Prevention Program. It "focuses on two key program integrity gateways: provider enrollment and claims payment," according to *MLN Matters* SE 1211. "By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims." The National Fraud Prevention Program's two main drivers are "automated provider screening" and national site visits.

Two New Contractors Screen Enrollees

CMS hired a new automated provider screening contractor to check out enrollees and report its findings to Medicare administrative contractors (MACs) and the National Supplier Clearinghouse (NSC), according to a Government Accountability Office report issued in April (GAO-12-351). Using various data sources, the contractor will screen enrollees and re-enrollees for the usual stuff (e.g., licenses, accreditation and a valid NPI) as well as for Medicare exclusions and other black marks. Screening will be routinely conducted, with weekly licensure checks, GAO said.

But there's more to this story. "CMS officials said that the automated screening contractor is developing an individual risk score for each provider or supplier. This individual risk score is similar to a credit risk score," GAO said. "The contractor's risk scores may be used eventually as additional risk criteria that determine screening activities for providers and suppliers." The automated screening contractor is also supposed to find more data sources for screening, such as financial, tax and business information, and geospatial data sources, GAO said.

Before the automated screening contractor came along, MACs and the NSC screened providers, GAO said. They are still responsible for enrollment and revalidation and for getting documentation from providers on information flagged by the automated provider screening contractor.

CMS has also hired a site visit contractor to make in-person checks of providers and suppliers (except DMEPOS) designated as moderate or high risk in February 2011 regulations that interpreted the screening and enrollment mandates in the 2010 health reform law. Sec. 1866(j)(2)(B) requires CMS and OIG to screen provider categories according to a hierarchy of enrollment risk. The regulation set forth three risk levels — limited, moderate and high — and assigned provider/supplier types to each.

The screening requirements get stricter as the risk level increases. For example, hospitals are in the limited-risk category and therefore subject to certification of Medicare-specific screening requirements, license verification and assorted other checks.

GAO says the site-visit contractor started in February 2012 and has been reporting back to CMS and its contractors. There are two kinds: routine site visits, during which the contractor verifies physical location and collects data (e.g., photographs of the provider's door); and rapid response site visits, which are performed when the contractor is alerted to potential fraud.

Meanwhile, CMS is partnering with G-men in its push to keep out bad apples and false claims. By

the end of the year, CMS has reported that it plans to contract with FBI-approved entities to do fingerprint checks and criminal background screening of high-risk providers and suppliers, GAO says. Also, this fall CMS is expected to publish a regulation requiring surety bonds for home health, independent diagnostic testing facilities and possibly outpatient rehabilitation facilities.

CMS Reaches Out for New Technology

In perhaps the most surreal aspect of its enrollment crackdown, CMS in May announced the "CMS Provider Screening Innovator Challenge." CMS describes this as "an innovation competition to develop a multi-state, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs," according to a notice in the May 29, *2012 Federal Register.*

In partnership with NASA, CMS is offering a prize estimated at $500,000 to $600,000 to the contestant who designs a system of identity verification for enrollment. It's sort of an ideal because the criteria are ambitious. According to the notice, they include:

◆ "Capability to retain screening and enrollment information and results, and compare against past and future screening results;

◆ "Capability to create a watch list to ensure that providers that are suspected or known to be fraudulent are flagged at the time of screening; and

◆ "Capability to revalidate periodically to ensure that changes in provider profiles are updated on a regular basis."

In light of all the screening, Waltz suggests that providers "do their provider enrollment submissions and updates with great care." Update the 855 forms promptly and pay attention to detail. Mistakes have been known to invite enforcement attention on occasion, she says.

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