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CMS May Expand Fraud Prevention System to MACs, Medical Review

Zone program integrity contractors (ZPICs), which hunt down fraud and abuse for CMS, get most of their leads from the Fraud Prevention System, which generated $210.7 million in Medicare savings in fiscal year 2013, CMS said in a report released June 25. Now the Fraud Prevention System may be coming to a Medicare administrative contractor near you, as CMS contemplates applying "predictive analytics technology" to medical review.

CMS touted the successes of its Fraud Prevention System, which was mandated by the 2010 Small Business Jobs Act. It screens all Medicare Part A and B claims before payment, running every claim against multiple models that address different types of vulnerabilities and schemes.

The Fraud Prevention System taps into the Integrated Data Repository, which includes claims, beneficiary data, and Part D drug information, and uses other resources, including compromised beneficiary Medicare identification numbers.

In its second year of operations, the Fraud Prevention System doubled recoveries, generated leads for 469 new investigations by program integrity contractors and beefed up information for 348 existing investigations (see chart, p. 5), according to CMS, which reported a $5 return for every $1 invested. Leads from the Fraud Prevention System led to administrative actions against 938 providers and suppliers in fiscal year 2013.

The HHS Office of Inspector General certified most of CMS's numbers, but reported only a $1.34 return on every $1 invested in the Fraud Prevention System, according to a report released the same day. Although it's doing what Congress asked it to do, CMS's procedures weren't always adequate to ensure MACs gave reliable data to support the savings attributed to the Fraud Prevention System. MACs need more written instructions in this area, OIG said.

"The number of reported administrative actions is quite low," says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. Maybe that's because, as OIG says, contractors need more guidance on reporting administrative actions stemming from the Fraud Prevention System, she says. "But given what great tools they have to work with — pre-pay edits, billing privileges revocations, referrals to law enforcement, and payment suspensions — I am surprised the numbers are not larger." The number of investigations, however, was more impressive, according to Waltz.

At the moment, the ZPICs are the primary users of the Fraud Prevention System. When they flag suspicious behavior or billing, ZPICs do site visits, beneficiary interviews and medical chart reviews. "Based on the findings, ZPICs may receive CMS approval to implement appropriate administrative actions, such as prepayment review, revocation, or payment suspension. When warranted, ZPICs also refer cases to law enforcement," according to CMS.

MACs may be the next frontier for the Fraud Prevention System, which is being nudged toward overpayments stemming from errors. In fiscal year 2013, CMS finished pilot projects to expand the Fraud Prevention System so it provides leads to MACs for medical review and denying claims not supported by Medicare policy. In the pilot, the Fraud Prevention System identified eight providers in one MAC jurisdiction that appeared to be billing improperly. The MAC reached out to the providers, and if they couldn't explain the billing aberrations or didn't make changes, their claims were put on prepayment review. Within a month, four of the eight providers were in compliance, but will be monitored by the Fraud Prevention System. Two more were told to self-audit, and results are pending. The last two providers dug in their heels; one is on prepayment review and the other is facing a review of past claims to see whether they require further action. "CMS may expand these pilot projects nationally to improve fraud, waste, and abuse prevention and detection," CMS says.

The Government Accountability office also weighed in on the Fraud Prevention System. In a report released June 25, GAO said, "CMS lacks information on the timeliness of ZPICs' actions — such as the time it takes between identifying a suspect provider and taking actions to stop that provider from receiving potentially fraudulent Medicare payments — and would benefit from knowing whether ZPICs could save more money by acting more quickly."

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