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Advanced Provider Screening

APS

PROACTIVELY IDENTIFY BAD ACTORS

The APS is an early detection screening, monitoring, and alerting tool which identifies bad actors before they can engage in fraud, waste, and abuse. This includes preventing ineligible providers from enrolling in Medicare, and determining which currently enrolled providers are ineligible so that CMS can take appropriate administrative action.

The APS develops complex algorithms to proactively identify bad actors and prevent ineligible healthcare providers from participating in Medicare. As a centralized record, the APS allows CMS, MACs, and other stakeholders to receive up-to-date information from multiple data sources on individuals and institutions enrolled in—or affiliated with—Medicare.

CMS, States, Medicare Administrators (MACs), and other stakeholders use the APS to:

- Prevent ineligible healthcare providers from enrolling in Medicare and Medicaid
- Investigate and, when necessary, remove ineligible providers who have already enrolled in Medicare and/or Medicaid

- Identify currently enrolled providers who are no longer eligible to participate in government-sponsored health care programs

How it Works

The APS receives up-to-date information from multiple data sources including Provider Enrollment Chain and Ownership (PECOS), the National Plan & Provider Enumeration System (NPPES), the Medicare Exclusion Database (MED), and Medicaid to:

- **Verify a provider's identity**
- **View a provider's licensure history Determine whether a provider has any actionable criminal history that would preclude the provider from participating in Medicare**

The APS uses complex algorithms to process this data, and generates alerts when fraudulent activity is likely or suspected. When the APS receives criminal alerts, those alerts are then sent to Medicare Administrative Contractors (MACs) for corroboration.

If a MAC confirms that an alert is valid, the MAC then submits a request for a court docket. When the docket is received, the MAC refers it to the Center for Program Integrity (CPI). CPI then decide if any action should be taken, such as license revocation or suspension, or removing the provider from Medicare.

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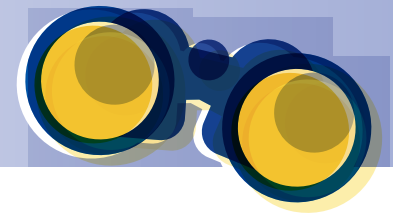
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Features

Criminal Continuous Monitoring (CCM) Report

Identifies health care providers with actionable criminal histories that would preclude them from participating in government-sponsored health care programs.

Do Not Pay (DNP) Report

Identifies health care providers with exclusions who are currently ineligible to receive payments from the Department of Health and Human Services.

Licensure Continuous Monitoring (LCM) Report

Identifies health care providers who have negative dispositions on their medical licenses.

National Licensure Monitoring (NLM) Report

Identifies health care providers whose medical licenses are suspended or revoked in states other than states where they're currently enrolled.

The CCM, DNP, LCM, and NLM reports allow CMS and MACs to review leads, identify, and remove providers from the Medicare program according to policy.

GOALS AND FUTURE STATE
The APS is constantly evolving to meet the National Fraud Prevention Program's key objective of improving screening mechanisms to improve fraud risk management. As part of this continual process, the APS will include:

- UI deployment for additional CMS stakeholders, who would use the APS to gather more supportive documentation for cases

- Addition of newer and better data sources (from criminal screenings, licensure boards, and the government) for greater coverage

- Expansion of web and data services for enhanced application integration with existing data sources such as PECOS, NPPES, the Fraud Prevention System (FPS), One Program Integrity (One PI), and the Unified Case Management (UCM) system

- More custom reporting options for better analytics and modeling capabilities