

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 746	Date: August 6, 2010
	Change Request 7067

SUBJECT: Changes to the Medicare Fraud Edit Modules

I. SUMMARY OF CHANGES: This Change Request updates Transmittal 326, dated March 7, 2008, (CR 5725 for MCS); Transmittal 342, dated May 16, 2008 (CR 6035 for VMS); and Transmittal 265, dated August 8, 2008 (CR 6135 for FISS). It provides further instructions to contractors regarding MSN messages and provider appeal rights.

EFFECTIVE DATE: September 6, 2010

IMPLEMENTATION DATE: September 6, 2010

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

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: 746	Date: August 6, 2010	Change Request: 7067
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SUBJECT: Changes to the Medicare Fraud Edit Modules

Effective Date: September 6, 2010

Implementation Date: September 6, 2010

I. GENERAL INFORMATION

A. Background: The concept for the Fraud Edit Module is based on the Infusion Therapy fraud project in South Florida. First Coast Service Options (FCSO - the Medicare Carrier for Florida) developed a series of edits to deny claims with potentially improper payments associated with Infusion Therapy. The edits have helped to reduce improper payments in Florida but with a considerable cost to the FCSO operating budget. Recently, data suggested that Infusion Therapy fraud was beginning to occur in Michigan and NJ/NY. The carriers for those states, Wisconsin Physician Services, and National Government Services, developed similar edits to address this same issue. These edits saved close to \$6.8 million in improper payments in Michigan and \$3.1 million (combined) in NJ and NY.

Programming these edits and associated reviews requires a considerable operating expense for contractors. As a fraud moves from state to state, the need for a low-cost way to share and implement edits on the fly became clear. One option to reduce the cost of developing these edits is to develop a shared system solution using existing shared system capabilities such as SCF.

CMS convened a Fraud Edit Module workgroup consisting of representatives from Center for Program Integrity Medicare Program Integrity Group, Center for Medicare, Medicare Contractor Management, Office of Information Systems and the NY & LA Satellite Offices to develop requirements for a proactive Fraud Edit Module that allows Medicare Carrier System (MCS) users to implement on-the-fly edits when potentially fraudulent claims are found locally or nationally. The fraud edit module will provide Medicare contractors with an improved fraud editing capability.

This CR updates Transmittal 326, dated March 7, 2008, (CR 5725 for MCS); Transmittal 342, dated May 16, 2008 (CR 6035 for VMS); and Transmittal 265, dated August 8, 2008 (CR 6135 for FISS). The updates are:

- Instructing contractors to use their discretion when choosing the appropriate MSN message based on the circumstances of the denial;
- Not including a default MSN in the CR;
- Requiring that providers have appeal rights if services are denied; and
- Instructing contractors to work individually with providers if the providers contact the contractor regarding denials made without appeal rights.

There are no other changes.

B. Policy: Pub. 100-08, Medicare Program Integrity Manual, reflects the principles, values, and priorities for the Medicare Integrity Program. The primary principle of program integrity is to pay claims correctly. In order to meet that goal, Program Safeguard Contractors (PSCs), Affiliated Contractors (ACs) and Medicare

Administrative Contractors (MACs) must ensure that they pay the right amount for covered and correctly coded services that legitimate providers render to eligible beneficiaries. The CMS follows four parallel strategies in meeting this goal: 1) preventing fraud through detection, effective enrollment, and education of providers and beneficiaries, 2) early detection through medical review and data analysis, 3) close coordination with partners, including PSCs, ACs/MACs, and law enforcement agencies, and 4) fair and firm enforcement policies. Use of the edits specified in this change request is required by Pub. 100-08, chapter 4.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	A / B M A C	D M A C	F I E R	C A R I E R	R H I	Shared-System Maintainers				OTH ER
							F I S S	M C S	V M S	C W F	
7067.1	For claim lines that the developed modules deny, contractors shall use Reason Code: M79: Missing/incomplete/ invalid charge. Note: (Modified 2/28/03) Claim Adjustment Reason Code: A1: Claim/service denied. Remark code: CO: Provider Responsibility for claim lines that the capability developed for requirement 7067.1 denies.	X	X	X	X	X					
7067.1.1	For claim lines that the modules developed for requirement 5725.1, 6035.1, or 6135.1 deny, contractors shall use their discretion to choose the most appropriate MSN message based on the circumstances of the denial.	X	X	X	X	X					
7067.2	If, after the effective date of CR 7067, the modules developed for requirements 5725.1, 6035.1, or 6135.1 deny a claim line, contractors shall give providers appeal rights.	X	X	X	X	X					
7067.3	Contractors shall work individually with a provider if a provider contacts the contractor regarding denials that the shared systems modules developed to meet the requirements of 5725.1, 6035.1, or 6135.1 made without appeal rights.	X	X	X	X	X					
7067.3.1	Contractor action for 7067.3 may include clerical error reopenings and other types of reopenings.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information: Crosswalk to CR 5725, 6035, and 6135 requirements
7067.1	Requirements 5725.7, 6035.18, and 6135.18 with the default MSN removed
7067.1.1	New requirement for CRs 5725, 6035, and 6135
7067.2	New requirement for CRs 5725, 6035, and 6135
7067.3	New requirement for CRs 5725, 6035, and 6135

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

V. CONTACTS

Pre-Implementation Contact(s): John Stewart, john.stewart@cms.hhs.gov.

Post-Implementation Contact(s): John Stewart, john.stewart@cms.hhs.gov.

VI. FUNDING

A. For Fiscal Intermediaries (FIs) and Carriers:

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

B. For Medicare Administrative Contractors (MAC):

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.