CMS Guidance Document	**Department of Health & Human Services (DHHS)**
Pub 100-20 One Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Executive Guidance Number 0287	**Date: February 21, 2008**
Planned Web Site Address http://www.cms.hhs.gov/manuals/	**Release planned: March 6, 2008**

PROGRAM AREA: One Time Notification

SUBJECT: Medicare Fraud Edit Module

APPLIES TO: Physician and Non-Physician Practitioner

I. SUMMARY OF DOCUMENT: The concept for the Fraud Edit Module began as a result of the Infusion Therapy fraud in South Florida. First Coast Service Options (a Medicare Carrier in Florida) developed a series of edits to flag claims with potential improper payments associated with Infusion Therapy for further review and denials. The edits have helped to reduce improper payments in Florida, but with a considerable cost to FCSO operating budget. Data suggested that Infusion Therapy fraud was moving to Michigan and NJ/NY. WPS and NGS developed similar edits to address this same issue. In Michigan, these edits have been able to save close to $6.8 M in improper payments and $3.1M in NJ and NY. Programming these edits, and associated reviews, requires a considerable operating expense for contractors. As the fraud moves from state to state, the need for a low-cost way to share and implement edits on the fly becomes clear. One option is to develop a shared system solution to meet this need.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)
STATUS: R=REVISED, N=NEW, D=DELETED.

Status	**CHAPTER/SECTION/SUBSECTION/TITLE**
N/A	

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Tim Hill/(410) 786-5448/OFM
Agency POC	Lameka Davison/ (410) 786-1189/OFM/PIG/DAE

IV. TYPE (Check appropriate boxes for type of guidance)

	Audit Guide
X	**Change Request**
	HPMS
	Joint Signature Memorandum/Technical Director Letter
	Manual Transmittal/Non-Change Request
	State Medicaid Director Letters
	Other

V. STATUTORY OR REGULATORY AUTHORITY: [include the citation of what statute or regulation is being interpreted. If not applicable, indicate N/A]

Attachment – One-Time Notification

Pub. 100-20	Transmittal:	Date:	Change Request: 5725

SUBJECT (Change Request Title): Medicare Fraud Edit Module

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

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 OFM Program Integrity Group, CMM, OIS 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.

B. Policy:

The Program Integrity Manual (PIM), Pub. 100-08, reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). The primary principle of Program Integrity (PI) is to pay claims correctly. In order to meet that goal, Program Safeguard Contactors (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 (CR) is required by Pub. 100-08, chapter 4.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER		RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5725.1	The MCS shared system maintainer shall develop a shared system capability that allows contractors to produce an electronic report that contains all parameters for an SCF edit.								X			
5725.2	The MCS maintainer shall ensure that the capability developed for requirement 5725.1 allows contractors to (a) monitor and take no action, (b) auto-deny, or (c) auto-suspend claim lines that fail an edit.								X			
5725.3	The maintainers shall ensure that the capability developed for requirement 5725.1 shall have the capacity to create a file that can be downloaded to a server that a personal computer using the server can read.								X			
5725.4	CMS shall distribute edit requirements that CMS, a Medicare contractor, or a PSC require in a CMS change request that specifies a file that may be pulled to the contractor from the CMS data center via NDM.											CMS
5725.4.1	CMS shall provide instructions for contractors concerning what action to take for a claim line that fails an edit on the NDM file (i.e., monitor, auto-deny, or auto-suspend) when CMS provides the NDM file.											CMS
5725.5	CMS shall distribute updates to edit requirements distributed using the method described in requirement 5725.4 using the method described in requirement 5725.4											CMS
5725.6	Medicare contractors may share their edits by sending a CD ROM containing a file that is in the format developed for requirement 5725.1 to the CMS Central Office.	X			X							
5725.7	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 MSN: 21.6 - This item or service is not covered when performed, referred or ordered by this provider.	X			X							

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER		RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	for claim lines that the capability developed for requirement 5725.1 denies.											
5725.8	Contractor data centers and Enterprise Data Centers (EDCs) shall ensure that the capability developed in requirements 5725.1 through 5725.7 is installed in time for carriers to begin operating the capability by the implementation date of this CR.											Contractor Data centers and EDCs
5725.9	Contractors shall ensure that the capability developed in requirements 5725.1 through 5725.7 is installed in time to begin operating the capability by the implementation date of this CR.	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

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

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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

V. CONTACTS

Pre-Implementation Contact(s): Lameka M. Davison, lameka.davison@cms.hhs.gov or John Stewart, john.stewart@cms.hhs.gov.

Post-Implementation Contact(s): Lameka M. Davison, lameka.davison@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 FY 2008 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 Statement of Work (SOW). 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.