CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 265	Date: August 8, 2008
	Change Request 6135

SUBJECT: Medicare Fraud Edit Module Phase 3

I. SUMMARY OF CHANGES: 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. Later, data suggested that Infusion Therapy fraud was beginning to occur in Michigan and New Jersey/New York (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.

NEW / REVISED MATERIAL
EFFECTIVE DATE: APRIL 1, 2009
IMPLEMENTATION DATE: APRIL 6, 2009

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
R	4/4.3/Medical Review for Benefit Integrity Purposes

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

Manual Instruction
Recurring Update Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – Recurring Update Notification

Pub. 100-08	Transmittal: 265	Date: August 8, 2008	Change Request: 6135

SUBJECT: Medicare Fraud Edit Module Phase 3

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

This CR will be split between the January 2009 release (analysis) and the April 2009 release (implementation).

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. Later, data suggested that Infusion Therapy fraud was beginning to occur in Michigan and New Jersey/New York (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 plug and play shared system solution.

The Centers for Medicare & Medicaid (CMS) convened a Fraud Edit Module workgroup consisting of representatives from OFM Program Integrity Group, Centers for Medicare Management, Office of Information Systems and the New York & Los Angeles Satellite Offices to develop requirements for a proactive Fraud Edit Module that would allow Medicare Carrier System (MCS) users to implement on–the-fly edits when potentially fraudulent claims are found locally or nationally. The vision of CMS is that the fraud edit module will provide Medicare contractors with an improved fraud editing capability.

The CR 5725, issued March 7, 2008, will implement the fraud edit module for MCS in July 2008, and CR 6035, issued May 16, 2008, will implement the fraud edit module for VIPS Medicare System (VMS) in October 2008. This instruction (CR 6135) will make the fraud edit capabilities similar to those CR 5725 and Cr 6035 made available in MCS and VMS respectively available to the users of the Fiscal Intermediary Shared System (FISS).

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				OTH-ER
							FISS	MCS	VMS	CWF	
6135.1	The FISS shared system maintainer shall develop a shared system module that shall allow specification of edits based on the following criteria: 1. Dimension – Dimension is the criteria that allow the user to select a specific group of claim lines for further editing. The dimensions are: Procedure code Diagnosis code Beneficiary Provider (both legacy and National Provider Identifier) Dates of service (date range) Dates of submission Type of Bill Provider Type HCPC code 2. Measure – Measures are the criteria that users may set to reject the claim. The measures are: Units of service Days of service Dollars submitted						X				

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTH-ER
							FISS	MCS	VMS	CWF	
	Duplicate services Services submitted Services allowed										
6135.1.1	If the shared system currently has a capability that meets some or all of the requirements of this CR, the shared system may utilize the existing capability in meeting this requirement.						X				
6135.1.2	The shared system maintainer may base the module it develops to meet requirement 6135.1 on the module developed for CR 5644 where the shared system maintainer deems the use of the module for CR 5644 practical.						X				
6135.2	The maintainers should ensure that the module developed for requirement 6135.1 shall allow a contractor to turn an edit on or off at their option.						X				
6135.2.1	If a contractor turns off an edit requested by CMS or a PSC, the contractor shall follow local security procedures and corrective action plans for turning off an edit and shall immediately notify CMS or the PSC.	X		X		X					
6135.3	The maintainers should ensure that the module developed for requirement 6135.1 shall allow contractors to change edit parameters (dimensions and measures) to meet local requirements and conditions.						X				
6135.3.1	If a contractor changes an edit parameter of an edit requested by CMS or a PSC, the contractor shall follow local security procedures and corrective action plans for changing edit parameters and shall immediately notify CMS or the PSC.	X		X		X					
6135.4	The maintainers shall ensure that the module developed for requirement 6135.1 allows contractors the option to (a) monitor and take no action, (b) auto-deny or (c) auto-suspend claim lines that fail an edit.						X				
6135.5	The edits contractors implement for the module the shared system maintainer develops for requirement 6135.1 that are auto-deny edits should take precedence over edits funded with Medicare Integrity Program funds.						X				
6135.6	The maintainers should ensure that the module						X				

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTH-ER
							FISS	MCS	VMS	CWF	
	developed for requirement 6135.1 shall allow contractors to implement the edits that the module produces as Expert Claims Processing System (ECPS) edits or a comparable mechanism that the shared system maintainer chooses.										
6135.7	The maintainers should ensure the module developed for requirement 6135.1 shall allow edits it produces to review up to 27 months of claims data or for the length of time for which claim history is present.						X				
6135.8	The maintainers should ensure that the module developed for requirement 6135.1 shall produce edits that apply to multiple claims, i.e., the edits shall add up measures for claim lines that the dimensions select and test the sum against the measurement criteria.						X				
6135.9	The maintainers should ensure that the module developed for requirement 6135.1 shall produce edits that can compare one claim with other claims in process within the same claims processing batch as well as to claims history.						X				
6135.10	The maintainers should ensure that the module developed for requirement 6135.1 shall allow the contractor to update shared system edit criteria with a file that a personal computer can generate, that can be uploaded to the processing system computer, and that contains user specified dimension and measure values.						X				
6135.10.1	The maintainer should propose the format for the file that the module produces that meets the requirements of requirement 6135.10.						X				
6135.11	The maintainers shall ensure that the module developed for requirement 6135.1 shall have the capability of creating a file that can be downloaded to a server that a personal computer using the server can read, and that contains the dimension and measure values for an edit that the module produces.						X				
6135.12	The maintainers should ensure that the module developed for requirement 6135.1 shall have the capability to exclude results for a specific audit from shared system consideration. For instance, if a shared system audit makes the						X				

Number	Requirement										
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTH-ER
							FISS	MCS	VMS	CWF	
	shared system bypass edits this module creates (for example, because of a modifier included on the claim line), the capability for which this requirement calls shall allow the contractor to turn off that audit causing a bypass using the capability the shared system implements to meet this requirement.										
6135.13	The maintainers should ensure that the module developed for requirement 6135.1 shall allow the contractor to specify "Shared system edit" in the PIMR edit description module if the contractor chooses to implement the edit.						X				PIMR
6135.14	The maintainers should ensure that the module developed for requirement 6135.1 allows the contractor to specify "PSC/CMS required edit" in the PIMR edit description module if the PSC or CMS requires the contractor to implement the edit.						X				PIMR
6135.15	The CMS shall distribute edit requirements that either CMS, a Medicare contractor, or a PSC require in a CMS change request that specifies an ASCII file with comma delimited fields that may be pulled to the contractor from the CMS data center via Network Data Mover (NDM).										CMS
6135.15.1	The 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
6135.16	The CMS shall distribute updates to edit requirements distributed using the method described in requirement 6135.15.										CMS
6135.17	Medicare contractors may share their edits by sending a CD ROM containing a file that is in the format developed for requirement 6135.10.1 to the CMS Central Office.	X		X		X					PSCs
6135.18	In the absence of more specific reason, adjustment, MSN and remarks codes more appropriate to the edit situation (e.g., "the procedure/revenue code is inconsistent with the patient's gender;" "the diagnosis is inconsistent with the procedure," "this (these) diagnosis (diagnoses) (is) are not	X		X		X					

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTH-ER
							FISS	MCS	VMS	CWF	
	covered, missing or are invalid"), 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. for claim lines that the module developed for requirement 6135.1 denies.										
6135.19	Contractors should implement the files described in 6135.10 that either CMS or a PSC requires within 60 days of the date that the contractor receives notification via a CMS CR that the NDM file containing the edit parameters is available.	X		X		X					**CDCs and EDCs**
6135.20	Contractor data centers and enterprise data centers shall ensure that the module developed in requirements 6135.1 through 6135.13 is installed in time for contractors to begin operating the module by the implementation date of this CR.										CDCs and EDCs
6135.21	Contractors shall ensure that the module developed in requirements 6135.1 through 6135.13 is installed in time to begin operating the module by the implementation date of this CR.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section 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
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VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

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

Section B: *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.

4.3 – Medical Review for Benefit Integrity Purposes

(Rev.265, Issued: 08-08-08, Effective: 04-01-09, Implementation: 04-06-09)

As stated in PIM, chapter 1, section 1.1, the CMS' national objectives and goals as they relate to medical review are as follows: 1) Increase the effectiveness of medical review payment safeguard activities; 2) Exercise accurate and defensible decision making on medical review of claims; 3) Place emphasis on reducing the paid claims error rate by notifying the individual billing entities (i.e., providers, suppliers, or other approved clinicians) of medical review findings and making appropriate referrals to provider outreach and education (POE); and 4) Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of potential fraud, waste, and abuse.

The statutory authority for the MR program includes sections 1812, 1816, 1832, 1833(e), 1842, 1842(a)(2)(B), 1861, 1862(a), 1862(a)(1), 1861, and 1874 of the Social Security Act (the Act). In addition, the regulatory authority for the MR program rests in 42 CFR 421.100 for intermediaries and 42 CFR 421.200 for carriers. Refer to PIM, chapter 3, for detailed information about the statutory and regulatory authorities.

The focus of MR units is to reduce the error rate through medical review and provider notification and feedback, whereas medical review for BI purposes focuses on addressing situations of potential fraud, waste and abuse.

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis may include simple identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims that might suggest improper billing or payment. The contractor's ability to make use of available data and apply innovative analytical methodologies is critical to the success of both MR and MR for BI purposes. See PIM, chapter 2, in its entirety for MR and BI data analysis requirements.

The PSC BI units and DME PSC, AC, and A/B MAC MR units shall have ongoing discussions and close working relationships regarding situations identified that may be signs of potential fraud. Intermediaries and A/B MACs shall also include the cost report audit unit in the ongoing discussions. AC and A/B MAC medical review (MR) staff shall coordinate and communicate with their associated PSC BI units to ensure coordination of efforts, to prevent inappropriate duplication of review activities, and to assure contacts made by the AC or MAC are not in conflict with benefit integrity related activities.

A. Referrals from the Medical Review Unit to the Benefit Integrity Unit

If a provider appears to have knowingly and intentionally furnished services that are not covered, or filed claims for services not furnished as billed, or made any false statement on the claim or supporting documentation to receive payment, the DME PSC, AC, or MAC MR unit personnel shall discuss this with the PSC BI unit. If the PSC BI unit

agrees that there is potential fraud, the MR unit shall then make a referral to the PSC BI unit for investigation. Provider documentation that shows a pattern of repeated misconduct or conduct that is clearly abusive or potentially fraudulent despite provider education and direct contact with the provider to explain identified errors shall be referred to the PSC BI unit.

B. Referrals from the Benefit Integrity Unit to the Medical Review Unit and Other Units

The PSC BI units are also responsible for preventing and minimizing the opportunity for fraud. The PSC BI units shall identify procedures that may make Medicare vulnerable to potential fraud and take appropriate action.

The PSC BI unit may request the AC or A/B MAC to install a prepayment edit or auto-denial edit.

The CMS has implemented recurring edit module*s* in *all claims* processing system*s* to allow PSCs and/or CMS to monitor specific beneficiary and/or provider numbers *and other claims criteria* when PSCs or CMS have discovered problems *that the claims criteria detect*. The ACs/MACs and PSCs shall comply with requests from PSCs and/or CMS to implement those edits. The ACs/MACs shall implement parameters for those edits/audits within 30 days of when the file containing the parameters becomes available *to the contractor*.

The PSC shall work with its own nurses to perform MR for BI reviews.

C. Benefit Integrity/Medical Review Determinations

When MR staff is reviewing a medical record for MR purposes, their focus is on making a coverage and/or coding determination. However, when PSC staff are performing BI-directed medical review, their focus may be different (e.g., looking for possible falsification). The PIM, chapter 3, §§3.4-3.4.3 outlines the procedures to be followed by both MR and MR for BI staff to make coverage and coding determinations.

1. The PSC shall maintain current references to support medical review determinations, including but not limited to:

- Code of Federal Regulations;
- CMS Internet Only Manuals (IOMs);
- Local coverage determinations (LCDs) and/or local medical review policies (LMRPs) from the affiliated contractor (AC) or MAC;
- Internal review guidelines (sometimes defined as desktop procedures); and
- The review staff shall be familiar with the above references and able to track requirements in the internal review guidelines back to the statute or manual.

2. The PSC shall have specific review parameters and guidelines established for the identified claims. Each claim shall be evaluated using the same review guidelines. The claim and the medical record shall be linked by identification of patient name, HIC number, diagnosis, ICN, and procedure. The PSC shall have access to provider tracking systems from medical review. The information on the tracking systems should be used for comparison to PSC findings. The PSC shall also consider that the medical review department may have established internal guidelines. (See PIM chapter 3, §3.4.4.)

3. The PSC shall evaluate if the provider specialty is reasonable for the procedure(s) being reviewed. As examples, one would not expect to see chiropractors billing for cardiac care, podiatrists for dermatological procedures, and ophthalmologists for foot care.

4. The PSC shall evaluate\determine if there is evidence in the medical record that the service submitted was actually provided and if so, if the service was medically reasonable and necessary. The PSC shall also verify diagnosis and match to age, gender, and procedure.

5. The PSC shall determine if patterns and/or trends exist in the medical record which may indicate potential fraud, waste or abuse. Examples include, but are not limited to:

- The medical records tend to have obvious or nearly identical documentation
- In reviews that cover a sequence of codes (evaluation & management codes, therapies, radiology, etc.), there may be evidence of a trend to use the high ends codes more frequently than would be expected
- In a provider review, there may be a pattern of billing more hours of care than would normally be expected on a given workday

6. The PSC shall evaluate the medical record for evidence of alterations including, but not limited to: obliterated sections, missing pages, inserted pages, white out, and excessive late entries.

7. The PSC shall document errors found and communicate these to the provider in a written format when the provider review does not find evidence of potential fraud. A referral may be made to the POE staff at the AC or MAC for additional provider education and follow-up, if appropriate.

8. The PSC shall downcode or deny, in part or in whole, depending upon the service under review when medical records do not support services billed by the provider.

9. The PSC shall thoroughly document the rationale utilized to make the medical review decision.

D. Quality Assurance

Quality assurance activities shall ensure that each element is being performed consistently and accurately throughout the PSC's MR for BI program. In addition, the PSC shall have in place procedures for continuous quality improvement. Quality improvement builds on quality assurance in that it allows the contractor to analyze the outcomes from their program and continually improve the effectiveness of their processes.

1. The PSC shall assess the need for internal training on changes or new instructions (through minutes, agendas, sign-in sheets, etc.) and confirm with staff that they have participated in training as appropriate. The PSC staff shall have the ability to request training on specific issues.

2. The PSC shall evaluate internal mechanisms used to determine whether staff members have correctly interpreted the training (training evaluation forms, staff assessments) and demonstrated the ability to implement the instruction (internal quality assessment processes).

3. The PSC shall have an objective process to assign staff to review projects, ensuring that the correct level of expertise is available. For example, situations dealing with therapy issues may include review by an appropriate therapist or use of a therapist as a consultant to develop internal guidelines. Situations with complicated or questionable medical issues, or where no policy exists, may require a physician consultant (medical director or outside consultant).

4. The PSC shall develop a system to address how it will monitor and maintain accuracy in decision-making (inter-reviewer reliability) as referenced in PIM, chapter 1, §1.2.3.4.

5. When the PSC evaluation results identify the need for prepayment edit placement at the AC or A/B MAC, the PSC shall have a system in place to evaluate the effectiveness of those edits on an ongoing basis as development continues.