

October 3, 2017



CMS Announces Targeted Probe and Educate

Introduction

The Centers for Medicare and Medicaid Services (CMS) has once again improved the audit strategy by shifting the previous broad Probe and Educate to a Targeted Probe and Educate (TPE), which is also meant to release some of the burden that providers endured from previous audit processes. The focus is “on specific providers/suppliers within the service rather than all provider/suppliers billing a particular service.” The Medicare Administrative Contractors (MACs) will review 20-40 claims per provider, per item or service, per round. The MAC will allow three rounds of education before proceeding with a more stringent disciplinary action, such as 100% prepay review, extrapolation, and referral to a Recovery Audit Contractor (RAC) or other.¹

CMS developed this process as a pilot in June 2016 and expanded the jurisdictions to include three additional MACs in July 2017. The pilot has been increasingly successful, therefore, CMS has launched the pilot to include all MACs effective October 1, 2017.

Executive Summary

Due to the successful and positive results of the pilot program, CMS has moved full throttle with all MACs performing TPE audits. The MACs have been given the autonomy to select claims that pose a greater risk based on previous data analysis to determine targeted topics and will audit providers based on non-compliance. There will be three rounds of audits for providers with continuous high error rates, after which the MAC will refer the provider to CMS for additional action. The audit will consist of 20 – 40 claims; the amount of claims chosen is dependent upon the focus of the review.

Providers have 45 days to respond to additional documentation requests (ADR). If the provider does not respond within 45 days, the claim will be denied due to lack of documentation. Should a provider fail the first audit round, he/she will have 45-56 days between each education intervention to implement and execute an action plan before the second audit round begins.² However, if the provider passes the first round, the audit process will discontinue for at least 12 months.

There was a significant deletion of psychiatric codes in 2013 thus forcing psychiatric providers to use evaluation and management (E/M) codes which may very well set the providers and service type up for an audit. Psychiatric services also include other modalities such as psychotherapy. Psychotherapy is billed based on time, however, when a provider administers medication management during the same episode of care, he/she is also performing an E/M service. E/Ms may become outliers as providers continuously perform medical management with psychotherapy due to the appropriateness of the service.

E/Ms can be coded based on time as long as the time is noted (either duration of the visit or start/stop times), however, when performed with psychotherapy, the rule does not apply. The provider should be cognizant that his/her documentation must reflect the 4 documentation components needed to support the service rendered: (1)chief complaint, (2)history, (3)physical examination and (4)medical decision making.

Facilities need to be aware of the potential targeted audits they may experience.

Background

CMS has utilized the MACs to conduct audits for several years, however, CMS chose the topic for review. The MACs objective was to review every provider that submitted claims on a chosen topic and to identify improper payments through insufficient clinical documentation. CMS performed data analysis capturing low hanging fruit, such as, billing patterns and improper payments related to one service type.

In 2014, CMS changed the process and incorporated education to help reduce errors and titled the audit Probe and Educate. This process proved successful with a decrease in the number of claim errors following provider education.

Key Elements

- What are the current processes, policies and procedures your facility has in place to handle ADRs and ensure required turnaround times are met?
- What processes have been implemented to ensure provider documentation meets coding and documentation guidelines and that all submitted claims are supported by appropriate documentation?
- Does the facility conduct internal reviews capturing:
 - Appropriate documentation that requires either start and stop times OR total time of the face-to-face interaction with the patient (E/M code or psychotherapy add-on code).
 - Proper documentation supporting the codes submitted to the payor.
- Does the facility have a designated educator/trainer for providers regarding coding and billing guidelines to ensure successful audit results on the first round?

Timing

Effective October 1, 2017

Additional Information

¹<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html>

²<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1919OTN.pdf>

²Example ADR letters

²Audit process diagram

MAC Header Here

EXAMPLE LETTER

PROVIDER NAME
PROVIDER ADDRESS
CITY ST ZIP

Mail Date (ex. December 14, 2014)

Case Number: Case #
Provider NPI Number: Provider NPI

RE: Notice of Review - Targeted Probe and Education

Dear Medicare Provider or Supplier

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), <Select>, your Jurisdiction <Select> Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized Jurisdiction <Select> to conduct the Targeted Probe and Educate (TPE) Pilot review process. The TPE review process includes three rounds of a prepayment probe review with education. If there are continued high denials after three rounds, <Select> will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Note, discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason of Review

Your facility was selected for review based on <Select>. A prepayment review has been initiated to probe a sample of your claims billed with the following <Select> code(s):

- Procedure Code/HCPCS Code - Short Description

The previous medical review resulted in an error rate of XX%. A small sample of randomly selected claims are chosen to determine if a provider is billing and coding according to Medicare guidelines and to ensure services are reasonable and medically necessary.

Additional Documentation Requests

MAC Footer May Be Included Here

MAC Header Here

Please do not send any documentation at this time. Your facility will be notified with an Additional Documentation Request (ADR) letter on each claim selected for review. This letter will include a list of specific elements needed to support the service on review. Please ensure the process for routing these documents to the person(s) responsible for submission is timely and effective. Inform your staff responsible for receiving the ADR letters and submitting the required documentation for this review. Authorization for the release of this information is included in Federal Law regulations reference 42 CFR 411.24(a), 424.5(a)(6) and 44 USC 3101.

If the requested documentation is not returned within 45 days, the claim will be denied due to lack of documentation which will contribute to your error rate. It is your responsibility as a provider to provide the requested documentation within the allotted time frame. Additionally, if providers/suppliers do not respond to the ADR request, MACs have the option to refer to the RAC or ZPIC/UPIC as a result. <Select> will review your claim within 30 days. After all claims selected for the probe are reviewed, you will receive a letter that includes specific findings of our review.

Education

Upon completion of the claim sample, the nurse reviewer will contact you to schedule a 1:1 educational session regarding any errors noted during the claim review. <Select> offers webinars, which are web-based presentations using internet technology. If your office does not have internet capabilities, a traditional teleconference will be offered. We can offer other methods of direct communication if these methods are not convenient. Medical Review will also provide you written notification at the end of the review to include your results. This letter will include the number of claims reviewed, the number of claims allowed in full, the number of claims denied in full or in part and limited education on the results.

In Closing

Thank you for your participation with this review. Please email <Email for contact person(s)> referencing the case number above upon receipt of this letter to provide the name of a contact person, if not already communicated, or with any questions regarding the information in this letter.

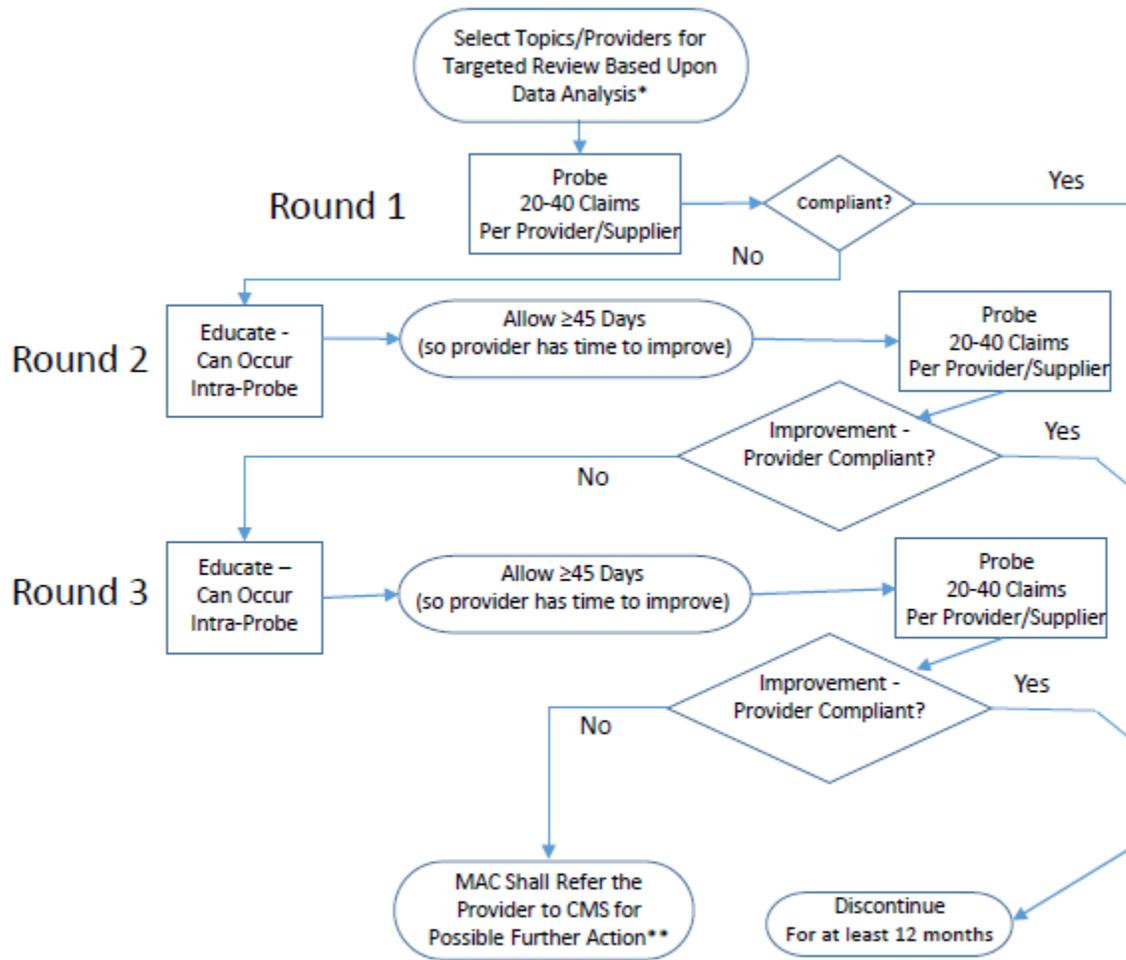
Sincerely,

<Select> MAC Jurisdiction <Select> Medical Review

cc: <CMD and Titles>
Contractor Medical Director
enc: TPE Process Flowchart
Dear Ordering/Referring Physician Letter
Comprehensive Error Rate Testing (CERT)

MAC Footer May Be Included Here

Targeted Probe & Educate



*Data Analysis definition per [PUB 100-08.52.2](#)

**Further Action May Include Extrapolation, Referral To ZPIC/UPIC, etc.