IMPROVING THE MEDICARE CLAIMS REVIEW PROCESS

The Targeted Probe and Educate (TPE) program includes one-on-one help to reduce claim errors and denials.

When Medicare claims are submitted accurately, everyone benefits.

Most providers and suppliers will never need TPE. The process is only used with those who have high denial rates or unusual billing practices. If you are chosen for the program, the goal is to help you quickly improve. Often, simple errors – like missing a signature – are to blame. The process is designed to identify common errors in your submissions and help you correct them.

HOW DOES IT WORK?

If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).

The MAC will review 20-40 of your claims and supporting medical records.

COMPLIANT

If compliant, you will not be reviewed again for at least 1 year on the selected topic.*

You will be given at least a 45-day period to make changes and improve.

If some claims are denied, you will be invited to a one-on-one education session.

**MACs may conduct additional review if significant changes in provider billing are detected.*

WHAT IF MY ACCURACY STILL DOESN'T IMPROVE?

This should not be a concern for most providers and suppliers. The majority of those that have participated in the TPE process increased the accuracy of their claims. However, any who fail to improve after 3 rounds of TPE will be referred to CMS for next steps.

WHAT ARE SOME COMMON CLAIM ERRORS?

The signature of the certifying physician was not included

Encounter notes did not support all elements of eligibility

Documentation does not meet medical necessity

Missing or incomplete initial certifications or recertification

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Targeted Probe and Educate

When Medicare Claims are submitted accurately, everyone benefits.

CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.

Most providers will never need TPE.

TPE is intended to increase accuracy in very specific areas.
MACs use data analysis to identify:

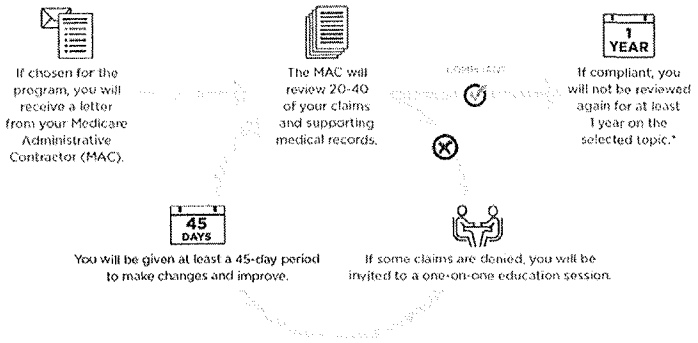
- providers and suppliers who have high claim error rates or unusual billing practices, and
- items and services that have high national error rates and are a financial risk to Medicare.

Providers whose claims are compliant with Medicare policy won't be chosen for TPE.

What are some common claim errors?

- The signature of the certifying physician was not included
- Documentation does not meet medical necessity
- Encounter notes did not support all elements of eligibility
- Missing or incomplete initial certifications or recertification

How does it work?



**MACs may conduct additional review if significant changes in provider billing are detected*

What if my accuracy still doesn't improve?

This should not be a concern for most providers. The majority that have participated in the TPE process increased the accuracy of their claims. However, any problems that fail to improve after 3 rounds of education sessions will be referred to CMS for next steps. These may include 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other action.

Learn More About the TPE Program

View, print or share information on the new TPE program with this simple one-pager (PDF).

For further details and information about the TPE program, check out this list of TPE Q&As (PDF).

Targeted Probe and Educate (TPE) Q & A's

Q1. What is Targeted Probe and Educate?

A1. When performing medical review as part of Targeted Probe and Educate (TPE), Medicare Administrative Contractors (MACs) focus on specific providers/suppliers that bill a particular item or service rather than all providers/suppliers billing a particular item or service. MACs will focus only on providers/suppliers who have been identified through data analysis as being a potential risk to the Medicare trust fund and/or who vary significantly from their peers. TPE typically involves the review of 20-40 claims per provider/supplier, per item or service. This is considered a round, and the provider/supplier has a total of up to three rounds of review. After each round, providers/suppliers are offered individualized education based on the results of their reviews. Providers/suppliers are also offered individualized education during a round when errors that can be easily resolved are identified.

Q2. Why did CMS move to the TPE process for medical review?

A2. The results of previous Probe and Educate (P&E) programs have been well received by the provider/supplier community. Additionally, positive results of the TPE pilot program included a decrease in appeals as well as an increase in provider education which resulted in decreased denial rates for a vast majority of providers as they progressed through the P&E process. These initial P&E programs, however, included all providers/supplier that billed a particular service. In an effort to refine the P&E programs, CMS determined that efforts would be better directed toward those providers/suppliers who, based on data analysis, provide the most risk to the Medicare program, and not to all providers/suppliers billing a particular item/service.

Q3. How will a provider/supplier know if they have been selected for TPE review?

A3. Providers/suppliers who are included in the TPE process will receive a notification letter from their MAC. This letter will outline why the provider/supplier has been selected for review as well as what to expect throughout the review and education process.

Q4. Why are the TPE probe sample sizes generally set at 20-40 claims?

A4. The 20-40 claim sample size is intended to allow the MACs to review enough claims to be representative of provider/supplier behavior. This allows MACs and to assess whether claims generally have the necessary supporting documentation to meet Medicare rules and requirements, while not being overly burdensome.

Q5. What happens if there are errors in the claims reviewed?

A5. At the conclusion of each round of 20-40 reviews, providers/suppliers will be sent a letter detailing the results of the reviews and offering a 1-on-1 education session. MACs will also educate providers/suppliers throughout the TPE review process, when errors that can be easily resolved are identified, helping the provider to avoid additional similar errors later in the process. CMS' experience has shown this educational approach is well received by

providers/suppliers and helps to prevent future errors.

Q6. What should a provider/supplier expect during a 1-on-1 education session?

A6. During a one 1-on-1 education session (usually held via teleconference or webinar), the MAC will educate the provider regarding claims with errors representative of those identified during review. Providers/suppliers will have the opportunity to ask questions regarding their claims and the CMS policies that apply to the item/service that was reviewed.

Q7. What error percentage is considered a "high denial rate" and what other factors are used to determine whether a provider moves on for additional review?

A7. The error percentage that qualifies a provider/supplier as having a high denial rate varies, based on the service/item under review. The Medicare Fee-For-Service improper payment rate for a specific service/item or other data may be used in this determination, and the percentage may vary by MAC. Other factors that determine the need for additional review may include but are not limited to decrease in error rate with each round, as well as participation in and improvement with education.

Q8. Can claims reviewed as part of the TPE process be appealed? If a claim is appealed and overturned, would this impact the provider denial rate?

A8. The appeals process is unchanged under the TPE process. If a claim denial is appealed and overturned, this would be taken into consideration in subsequent TPE rounds. *If the appeals results are not available at the time a provider progresses to a second or third round of TPE, but are available when the provider is referred to CMS, CMS takes these results into consideration when determining the need for additional action. If a provider's adjusted error rate, after appeals, indicates no need for additional review, CMS will make that recommendation, and the provider will be monitored by the MAC as they would be had they passed the TPE process and been released from review.*

Q9. Under the TPE program, do the MACs send a letter to the provider/supplier with details regarding the results of their reviewed claims?

A9. At the conclusion of each round of review, the MAC sends the provider/supplier a letter detailing the results of the 20-40 claims reviewed during that round, including details regarding claim errors. This letter may be sent before or after the final one-on-one educational call.

Q10. Is the education provided after each round provider/supplier-specific or general education given to all providers/suppliers?

A10. The education session after each round is developed based on the review findings from the most recently completed round of reviews and is not the same as that given to other providers/suppliers unless errors found in the reviewed claims are the same. The education will reinforce corrections that should be made for errors that continue to be identified.

Q11. Will previous Probe and Educate (P&E) review results be used to identify providers who will be

included in TPE?

A11: CMS is encouraging MACs to use all available sources of data when selecting providers to include in the TPE process. The results of previous P&E programs is one source of data MACs will use to select providers for review. MACs will also use provider billing and utilization patterns, as well as provider specific error rates.

Q12: Can a provider/supplier be included in multiple TPE probes at the same time?

A12: Yes, if a provider/supplier has multiple National Provider Identifiers (NPIs), each NPI could be subject to TPE review. Additionally, if a provider/supplier submits claims to Medicare for more than one item or service, each item/service could be subject to a separate probe as part of the TPE program. Providers/Suppliers and the specific items and services included in the TPE process are those who have been identified through data analysis as being a potential risk to the Medicare trust fund and/or who vary significantly from their peers.

Q13. When a provider/supplier is moved to an additional round of TPE review, when should the provider expect the additional reviews to start?

A13. MACs can begin sending documentation requests for claims with dates of service no earlier than 45 days after the previous post-probe one-on-one education. This time gives the provider/supplier the opportunity to make changes based on the education received prior to being subjected to additional review. If a provider declines to schedule education within a reasonable time after receiving the offer, subsequent reviews will be for claims with dates of service no earlier than 45 days from the one-on-one post probe education offer.

Q14. How many provider/suppliers were reviewed on TPE in Fiscal Year 2019?

A14. From October 2018 to September 2019 approximately 13,500 providers and suppliers were started on TPE. Of those started, less than 2% of providers and suppliers have failed all three rounds of TPE. *Note, this percentage is based on all providers/suppliers who started round 1 of TPE and those who have completed all three rounds. Providers and Suppliers still on review, are not yet counted.*

Q15. How many claims were reviewed and accepted as billed in the TPE program in Fiscal Year 2019?

A15. Approximately 435,000 claims were reviewed from October 2018 to September 2019 and approximately 60% were accepted as billed.

Q16. How many educational contacts were completed in Fiscal Year 2019?

A16. There were approximately 90,000 intra- and post-probe educational contacts. Educational contacts include, but not limited to: phone calls, face-to-face visits, webinar/e-visits, emails, and letters.

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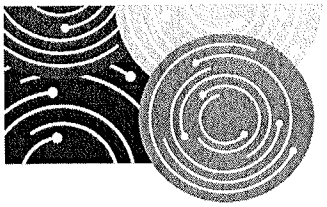

mlnconnects

Official CMS news from the Medicare Learning Network®

Thursday, August 12, 2021

News

COVID-19: Vaccinate Your Patients

Help protect your patients from COVID-19. Medicare covers the COVID-19 vaccine administration. There's no cost to your Medicare patient for the vaccine and its administration.

Find out if your Medicare patient is fully vaccinated:
- Check Medicare eligibility for COVID-19 vaccine administration history from Fee-for-Service claims paid for calendar years 2020 and 2021. This includes Medicare Advantage patients.
- You'll get the CPT or HCPCS codes, date of service, and national provider identifier for who administered the vaccine for each paid vaccine administration claim.
- If you don't see information about Medicare claims, ask your patients about their COVID-19 vaccination history; they may have been vaccinated, and the provider didn't submit a Medicare claim (like if they got vaccinated at a free event).

More Information:
- COVID-19 Provider Toolkit: Enroll with Medicare to administer the vaccine; get information on coding, payment, and billing
- CDC Vaccines & Immunizations webpage: Enroll with the CDC to get the vaccine; get information on training, reporting, and support
- CDC Vaccines and Administration webpage: How to talk to your patients about COVID-19 vaccination

CMS Resumes Targeted Probe & Educate Program

CMS is restarting the Targeted Probe and Educate (TPE) program to help educate providers and reduce future denials and appeals. If your Medicare Administrative Contractor audits you, take advantage of the TPE education, and get up to 3 rounds of educational claim review to help you bill accurately.

Compliance

Cardiac Device Credits: Medicare Billing

A 2018 Office of the Inspector General report found that payments for recalled cardiac medical devices didn't comply with Medicare requirements for reporting manufacturer credits. Hospitals didn't adjust these claims with the right condition codes, value codes, or modifiers to reduce payment, as required. Review the Medicare Billing for Cardiac Device Credits fact sheet to avoid overpayment recoveries.

More Information:

- Medicare Claims Processing Manual, Chapter 3, Section 100.8
- Medicare Claims Processing Manual, Chapter 4, Section 61.3.5

Claims, Pricers, & Codes

Non-Drug & Non-Biological Items and Services: HCPCS Application Summaries & Coding Decisions

CMS published the first bi-annual 2021 HCPCS Application Summaries and Coding Decisions. Visit the HCPCS Level II Coding Decisions webpage for more information.

The October 2021 HCPCS update file will be available soon on the Alpha-Numeric HCPCS webpage.

MLN Matters® Articles

Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)

Skilled Nursing Facilities (SNFs): Learn about changes to clarify existing content.

Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF))

IRFs: Learn about finalized policies.

New Waived Tests

Learn about waived laboratory tests, effective October 1.

Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2022

Learn about this annual update.

Multimedia

SNF Section K: Height, Weight, and Nutritional Approaches Web-Based Training

This web-based training course for Skilled Nursing Facility (SNF) providers covers assessment and coding of K0200: Height and Weight and K0500: Nutritional Approaches.

Visit the SNF Quality Reporting Program Training webpage for more information.

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