TPE TARGETED PROBE & EDUCATE AUDITS

STRATEGIES & SOLUTIONS FOR A SUCCESSFUL OUTCOME

By: Barbara Blatt, PT
Director of Appeals Management

WHAT IS TARGETED PROBE AND EDUCATE?

In 2014, CMS initiated a program to review clinical documentation, combining a sample of claims with education, to reduce errors in the claim's submission process. They called this medical review strategy Probe and Educate. Believing the results to be successful, CMS expanded into all MAC jurisdictions, and refined their data mining and analysis process to identify potential Medicare fraud and improper payments. The focus shifted to claims that carried the greatest risk to the Medicare fund, and/or providers who had the highest claim error rates and irregular billing practices as compared to their peers. As such, TPE claim selection is provider specific.

WHAT ARE THE CURRENT TARGET AREAS?

The most recent focus has been on the following HIPPS codes: KAGD1, KDGD1, KAGE1, KAXE1, KDE1X These HIPPS are comprised of the most common Case-Mix groups (CMGs) captured, as well as CMGs that do not qualify for presumption of coverage.

HOW DOES THE TPE PROCESS WORK?

Providers selected for TPE review will receive a notification letter from their MAC. The MAC will review 20-40 claims and supporting medical records to assess whether the record provided meets Medicare rules and regulations. There can be up to three rounds. If compliant after the first round, you will not be reviewed for at least one year, if at all. If your claim denial rate is more than 15%, you will have to participate in a one-on-one educational session. Providers with a moderate to high error rate will continue onto a second or pre-pay round of 20 to 40 claims, and a third round if the error rate is still consistently high.

Therefore, billing accuracy and adherence to Medicare claim regulations is crucial. Providers are susceptible to audits when MACs determine there are changes in billing practices or they see consistent "high performance".

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DO NOT IGNORE COMMON CLAIM ERRORS!

RED FLAGS

Avoid a TPE audit through the development of initiative-taking procedures is the best way to prevent claim arbitration and to reduce potential loss of revenue. However, if you are selected, you can still effectively and successfully manage the ADR process.

- Short qualifying hospital stays
- Weak primary medical diagnosis coding
- Lack of documentation to support diagnosis coding
- Signature of certifying physician not included
- Missing or incomplete initial physician cert/recert
- Information provided does not support all elements of eligibility
- Documentation does not support medical necessity or the need for daily skilled nursing and/or therapy services
- Documentation does not support PDPM/HIPPS codes
- Therapy frequency falls short of the required minimum

When sticking to an action plan through diligence and commitment, which are essential models that will yield findings that will eventually provide positive solutions.

To learn more about developing a custom ADR and/or appeal program, contact Barbara Blatt, PT, Director of Appeals Management at bblatt@preftherapy.com or 860.578.5235

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SOLUTIONS TO AVERT A TPE AUDIT!

- Leave no stone unturned
- Structure weekly Medicare meetings with action plans
- Strengthen communication among your interdisciplinary team
- Specialized education for your staff, documentation training, and provision of resources will improve compliance with regulatory statutes and payer requirements
- Particular attention to medical coding and supportive documentation will increase the likelihood of an approved claim
- Properly document on the patient's condition(s)
- Consistency in checking data and analytics will help discover and pinpoint at risk areas to prevent denied claims
- Do not document more, simply better, and accurate!
  - » Be more descriptive and thorough in your documentation
  - » Make sure the information provided strongly demonstrates medical necessity and on-going skill for the entire plan of care
  - » Auditors are looking to make sure that the documentation clearly supports the need for daily skilled nursing facility care as well as the HIPPS codes you are seeking reimbursement for
- Gather and review all components of the patient's record prior to submission to ensure your medical record corroborates the level of skilled services rendered
- Complete an in-depth review of the clinical documentation and billing compliance to assess your financial risk post-claim submission

ABOUT PREFERRED THERAPY SOLUTIONS

Preferred Therapy Solutions is a full-service rehabilitation management organization dedicated to providing state-of-the-art clinical, management, billing, and information technology solutions to the post-acute and long-term care industry. Preferred Therapy Solutions is able to assist in developing a strategic road map designed to increase SNFs market share by identifying potential referral targets and providing useful information on competitor's performance. Preferred Therapy Solutions abilities significantly enhance the quality, productivity, scope, and efficiency of any facility's rehabilitation department while maintaining a focus on achieving high levels of patient satisfaction and providing excellent customer service.