E-BRIEF SERIES

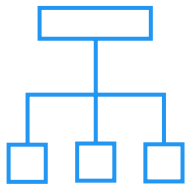
Healthicity

Understanding Medicare's Targeted Probe and Educate (TPE) Program

CJ Wolf MD, CHC, CPC, COC, CCEP, CHPC, CIA

The Centers for Medicare & Medicaid Services' Targeted Probe and Educate (TPE) program is one of the processes that Medicare administrative contractors (MACs) can use when providers are selected by medical review. CMS claims this review process is designed to help providers reduce claim denials and appeals through one-on-one help. Their stated goal is to help providers improve quickly. The MACs should work with providers to identify errors and help providers correct them.

The MACs typically use data analysis to identify potential inaccuracies in the submission of claims. Some of the issues that are identified might be isolated from a single provider with unusual billing practices. Other items and services that have high national error rates and are a financial risk to Medicare might be the focus of a TPE review.



At a high level, the process is supposed to work like this:

1. If a provider is chosen for review (based on data analysis), they will receive a letter from their MAC.
2. The MAC will review 20-40 claims and their supporting medical record. documentation. If compliant, the provider will not be reviewed again for at least one year on the selected topic.
3. If reviewed claims are denied, the provider can receive an education session on how to correct the errors.
4. The provider is given at least 45 days to make changes in their billing and/ or documentations practices and demonstrate improvement.
5. Then the cycle begins again with the MAC selecting another 20-40 claims for review.

If a provider performs poorly on multiple reviews, some MACs will refer the provider and results to CMS. Then, CMS will determine additional actions, which may include additional rounds of review, 100 percent prepayment review, extrapolation, referral to the recovery auditor (RA), referral for revocation, etc.

MACs often publicly release cumulative data results (without identifying specific providers) for certain issues. Coders and auditors should be aware of the TPE issues published by their MAC. Much can be learned about the types of codes and billing practices that the MAC is scrutinizing. This can help the conscientious coder, auditor or compliance program have an opportunity to proactively perform internal reviews.

Below are some issues that multiple MACs across the country have focuses on for their TPE reviews:

WOUND CARE

For the CPT codes 11042-11045, one MAC's round of TPE review found that a lack of medical necessity was a significant reason for denying the claims. That MAC has a published Local Coverage Determination (LCD) which outlines some of their medical necessity and medical documentation expectations. These include:

- Clinical documentation of diagnosis or symptoms to justify services.
- Identification of wound location, size, depth, and stage supported by a drawing or photograph of the wound.
- Current progress notes (including measurable signs of healing as well as causes of delayed wound healing or modification to the treatment plan).
- Documentation of the character of the wound (including dimensions, description of necrotic material present, description of tissue removed, degree of epithelialization, etc.) before and after debridement.
- Operative note or procedure note for the debridement services including description of tissue debrided, instrumentation used, pre and post wound measurements.
- Wound care should employ comprehensive wound management including appropriate control of complicating factors such as unrelieved pressure, infection, vascular and/or uncontrolled metabolic derangement, and/or nutritional deficiency in addition to appropriate debridement. Medicare coverage for professional wound care procedures requires that all applicable adjunctive measures are also employed as part of comprehensive wound management. Wound care in the absence of such measures, when they are indicated, is not considered to be medically reasonable and necessary.
- Debridement will be considered not reasonable and necessary for a wound that is clean and free of necrotic tissue/slough.
- Debridements are considered selective or non-selective unless the medical record supports that a surgical excisional debridement was performed.

VASCULAR STENTING:

For the CPT codes 37227 and 37229, a MAC shared the following reasons for denial as well as requirements from their LCD:

- Documentation that includes evidence of a qualifying medical condition/disease(s) to support Medicare coverage requirements as outlined in LCD.
- Documentation includes evidence of a thorough physical examination to support the condition(s) being treated.
- Relevant medical history (e.g., claudication, critical limb ischemia).
- Vascular physical examination (including measurement of the ankle-brachial index).
- Previous noninvasive diagnostic evaluation(s).
- Detailed summary of the angiography report.
- Detailed summary of the procedure/operative report.
- Documentation that includes a procedure note with a thorough/detailed description of the procedure being performed (beyond simple statements), location of each site treated, and type of anesthesia utilized.

EVALUATION AND MANAGEMENT (E/M) SERVICES:

While most of the issues posted by MACs on their website are audit results, one MAC announced a future audit of E/M codes, by showing a "Coming Soon" message on their website. In this instance, the MAC specifically stated which E/M codes would likely be targeted for reviews. The codes they mentioned were not ranges of codes, but very specific codes within varying E/M categories. These included 99214 (level 4 established patient office/outpatient), 99213 (level 3 office/outpatient), 99233 (level 3 subsequent hospital inpatient), 99232 (level 2 subsequent hospital inpatient), and 99204 (level 4 new patient office/outpatient). Of course, there were no results to share yet as they were announcing a future audit. However, they did provide a checklist of important aspects of the medical documentation they would likely be looking for. These included:

- Documentation supports medically reasonable and necessary E/M service as outlined in CMS IOM, Pub. 100-04, Claims Processing Manual, Chapter 12, Section 30.6.
- If billing service based on medical decision making, all relevant documentation that supports the level of service billed (e.g., office and/or progress notes, physician's orders and intent, emergency room records, consultations/procedure reports, radiology/diagnostic tests, EKG, lab, and pathology results, etc.):
    - Number and complexity of problems addressed.
    - The amount and/or complexity of data to be reviewed and analyzed.
    - Risk of complications and/or morbidity or mortality of patient management
- If billing service based on time, documentation to support time spent performing E/M service.
- Documentation to support any applicable modifiers billed with the E/M service.
- Documentation to support "incident to" guidelines (if applicable), that includes evidence of the billing provider's presence in the office suite and prior, ongoing participation in patient care.
- Any additional documentation to support medical necessity or any applicable policy guidelines for the services billed.

CONCLUSION

CMS' TPE process is alive and well. MACs are performing medical record reviews and finding common errors which they are summarizing and posting on their websites. In some cases, they are even announcing future audits. Either way, the information that can be gathered from a MAC's TPE website posts can assist coders, auditors and compliance professionals when planning and performing their own internal reviews.

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CJ Wolf

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CJ Wolf is a highly regarded healthcare professional with more than 20 years of experience in revenue cycle management, practice management, compliance, coding, billing, auditing, and client services. He is a nationally recognized compliance thought leader who has published numerous articles and resources and has been featured at national conferences and events.

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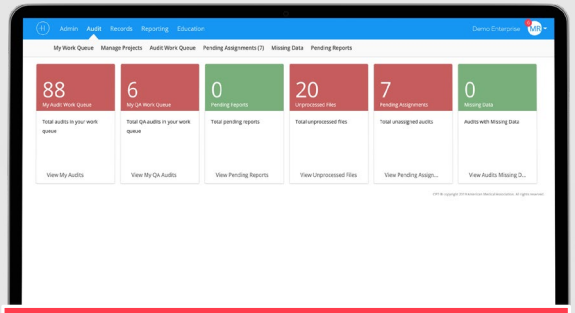
AUDIT MANAGER



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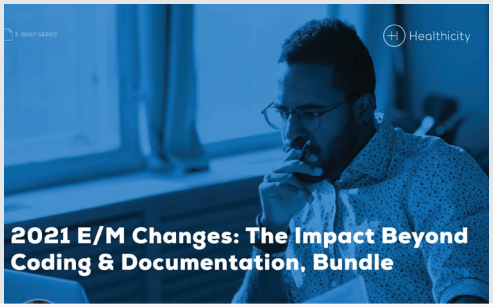

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