Targeted Probe and Educate Audits 2025

Is Your Coding and Documentation Bullet Proof?

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CORE VALUES
Elevate Medical Solutions has five core values: Integrity, Humility, Knowledgeable, Solutions Focused, and Team Player. Our focus from day one has been on our people. While everyone's walk of life is unique, we see a common theme in the professional journey of our people. Everyone on our team has a passion for what they do. They care about it, they get excited about it, and they love to watch their skills tackle the challenges their team is setting out to resolve.

Webinar Goals

- What is a Targeted Probe and Educate Audit?
- Who is the target of these audits?
- What are the most common claims errors ?
- What is the impact to the provider if audited?
- Can the provider appeal the audit?
- Strategies for staying off the radar

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Scope of Targeted Probe and Educate Audits

- Combines claim review with post review education
- Each CMS Medicare Administrative Contractor (MAC) has the latitude to determine the scope of and types of claims they review.
- Each MAC's targets are independent of the other MACs.

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Targeted Probe and Educate Audits

- The audit can be performed as either a pre-payment or post-payment review of a sample of twenty to forty claims.
- Intended to increase claims accuracy
- Intended to decrease appeals.
- Scope of review covers all Medicare services and items.

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When Did This Begin

- Initial TPE notification letters were mailed back in October 2017, there was a hiatus for COVID from 2019-2022.
- As new providers and topics are identified, additional notifications are mailed
- TPE probes and rounds are specific to each provider and each provider is treated independently

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Who are the Reviewers?

- Registered Nurses
- Certified Coders
- Physical Therapists

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Financial Impact

- No direct financial impact
- Goal is Audit and Educate
- Potential financial impact if failure to correct the problem, results in denial
- Failure to answer request for additional documentation will result in denial.
- The biggest upfront expense can be documentation copying and mailing

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TPE Error Rates

- Identified by a Charge Denial Rate (CDR) and Claim Line Denial Rate (CLDR)
- An Error rate of 20% or more can result in an initial or subsequent TPE audit.
- Denied Charges divided by Total Charges = CDR
- Number of denied claims divided by Total claims = CLDR

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Physicians Targeted for TPE

- Based on the MACs' error rate calculation.
- MACs focus only on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers (outliers).
- Providers can also be chosen for reasons unrelated to their own billing practices if they bill for services that have a high error rate nationally.

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Improper Payment Rates

- Each MAC independently identifies the risks that render its jurisdiction vulnerable to a higher rate of improper payments.
- Rates are calculated by MAC, service, and provider type.

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Improper Payment Rates

- There is no requirement that the 12 Part A/B MACs be consistent in their method of calculating improper payment rates.
- The sources of data the MACs use to calculate the error rate and the weight they give the data source are not subject to any standard.

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Improper Payment Rates

- Recover Audit Contractors (RACs) and Unified Program Integrity Contractors (UPICs) are required to use strict random statistical sampling methodology as part of their post-payment claims review to ensure that the sample selected is appropriate.

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Improper Payment Rates

- In TPE audits, the claims designated for a pre-payment review are the result of a data-driven selection process, with the attributes of the audit selected by risk.
- Though the probe itself includes a medical review of sample claims, it is intended to validate the data-driven findings.

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No CMS Oversight

- The MAC sets the percentage rate decrease required, and in Chapter 7 of the Medicare Program Integrity Manual, CMS admits that it does not establish or set improvement rate goals.

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Medicare Program Integrity Manual the Blueprint

- Chapter 3 - Verifying Potential Errors and Taking Corrective Actions
- (Rev. 12772; Issued: 08-09-24)
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

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Targeted Probe and Educate Audits

- The MAC will conduct up to three rounds of TPE audits.
- Each providers' billing performance is evaluated to determine whether their error rate has been reduced to meet the benchmark set by the MAC after each round of reviews.

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Targeted Probe and Educate Audits

- Education will take place on an individual basis after errors are identified on each review.
- An increase in the error rate above the MAC-determined acceptable rate will result in further reviews.
- After three reviews providers who are not compliant are referred to CMS for further action.

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TPE Targets Providers and Suppliers with…

- High rate of claim denials,
- Unusual billing practices compared to their peers
- Billing with greater frequency those services or supplies that CMS has determined are more likely to be improperly billed.
- High volume of services
- High-cost items or services
- Dramatic change in frequency of use
- High risk problem-prone areas

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TPE Targets

- MACs shall also initiate targeted, provider specific, pre-payment or post payment review upon referral from the following entities when directed by CMS
  - Recovery Auditor Contractor (RAC),
  - Comprehensive Error Rate Testing (CERT),
  - Unified Program Integrity Contractor (UPIC),
  - Office of Inspector General (OIG), or
  - Government Accountability Office (GAO)

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Part A First Coast TPE List

Part A TPE topics for review

Topic and education	Related CPT/HCPCS	Review status	Documentation checklist	Results
Rehabilitation Services (Outpatient) • L33413 Therapy and Rehabilitation Services (Retired 03/31/2023)	97110, 97112, 97116 and 97140	Active	Checklist Therapy and Rehabilitation Services	Rehabilitation Services Results
Inpatient Rehabilitation Facility (IRF) Services	N/A	Active	Checklist Inpatient Rehabilitation Facility (IRF)	IRF Results
End-Stage Renal Disease (ESRD) Services • L37564 Frequency of Hemodialysis	90999	Active	Checklist End-Stage Renal Disease (ESRD)	ESRD Results
L37166 Wound Care	11042 and11045	Active	Checklist Wound Debridement	Wound Care Results
Skilled Nursing Facility (SNF)	N/A	Active	Checklist Skilled Nursing Facility (SNF)	SNF Results
Diagnositc-Related Group (DRG) Endovascular Cardiac Valve Replacement and Supplement Procedures (DRG 266 and 267)	N/A	Active	Checklist Endovascular cardiac valve replacement and supplement procedures	DRG 226 and 267 Results Coming Soon
Diagnositc-Related Group (DRG) Aftercare, Musculoskeletal Systems and Connective Tissue (DRG 559, 560 and 561)	N/A	Active	Checklist Aftercare, musculoskeletal system and connective tissue	DRG 559, 560, and 561 Results Coming Soon
Diagnositc-Related Group (DRG) Major Hip and Knee Replacement (DRG 469 and 470)	N/A	Active	Checklist Major hip and knee joint replacement or reattachment of lower extremity	DRG 469 and 470 Results Coming Soon

Rehab Checklist First Coast

Check	Documentation description
	Documentation is for the correct beneficiary and date of service.
	Documentation is complete, legible, signed and dated by the physician or clinician.
	Pre-admission screening/note
	Signed and dated overall plan of care, including short- and long-term goals with updates to the plan of care
	Physician and nonphysician practitioners, nurse and ancillary progress notes to support the medical necessity for the IRF: • Physician orders • Required face to face visits • Treatment records • Medication Administration Record (MAR)/Infusion Flowsheet
	Completed admission/discharge IRF PAI (Patient Assessment Instrument) and supporting documentation (i.e., clinical records from preceding acute care stay, transfer sheets, discharge summary, social service, history & physical)
	Records for physical therapy, occupational therapy and/or speech therapy: • Initial evaluation • Plan of care • Treatment record (verifying treatment plan, goals, minutes) • Decubitus records, if applicable
	Documentation to support Health Insurance Prospective Payment System (HIPPS) code
	Itemized bill
	Advanced Beneficiary Notice (ABN), if applicable

Reserved

Part B First Coast TPE

Topic and education	Related CPT/HCPCS	Review status	Documentation checklist	Results
Rehabilitation Services (Outpatient) • L33413 Therapy and Rehabilitation Services (Retired 03/31/2023)	97110, 97112, 97116, 97124, 97140 and 97530	Active	Checklist Therapy and Rehabilitation Services	• Rehabilitation Services Results • Rehabilitation Services with KX Modifier Results
Ambulance Services • L3767 Emergency and Non-Emergency Ground Ambulance Services (Retired 02/09/2023)	A0428 and A0425	Active	Checklist Ambulance Services	Ambulance Services Results
Psychotherapy Services • L33252 Psychiatric Diagnostic Evaluation and Psychotherapy Services	90832, 90834 and 90837	Active	Checklist Psychotherapy Services	Psychotherapy Services Results
End-Stage Renal Disease (ESRD) Services • L37564 Frequency of Hemodialysis	90960	Active	Checklist End-Stage Renal Disease (ESRD)	ESRD Results
Evaluation & Management (E/M)	99214, 99213, 99233, 99232, 99204 and 99281-99285	Active	Checklist Evaluation & Management (E/M)	Evaluation and Management Results
L36393 Laboratory Services	87150, G0480, G0481, G0482, G0483 and G0659	Active	Checklist Laboratory Services	Laboratory Services Results
L33674 Diagnostic Radiology	93975-93976 and 93978-93979	Active	Checklist Diagnostic Radiology	Diagnostic Radiology Results
Annual Wellness Visit (AWV)	G0438 and G0439	Active	Checklist Annual Wellness Visit	AWV Results Coming Soon

Evaluation and Management First Coast

Check	Documentation description
	Documentation is for the correct beneficiary.
	Documentation is for the correct date(s) of service.
	Documentation contains a valid and legible signature, which follows CMS Signature Guidelines for Medical Review Purposes PDF.
	Documentation supports that a face-to-face visit occurred.
	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 (if applicable), 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.
	Documentation includes an advanced beneficiary notice of non-coverage was provided (if applicable and required).
	Any additional documentation to support medical necessity or any applicable policy guidelines for the services billed.

Surgical Services First Coast TPE

Surgical Services

Topic and education	Related CPT/HCPCS	Review status	Documentation checklist	Results
L33763 Vascular Stenting of Lower Extremity Arteries (Retired 05/05/2023)	37227 and 37229	Active	Checklist Vascular Stenting Lower Extremities and Endovascular Revascularization	Vascular Stenting Results
Cataract Extraction • L38926 Cataract Extraction (including Complex Cataract Surgery)	66982, 66983 and 66984	Active	Checklist Cataract Extraction	Cataract Extraction Results
Nail Cutting/Pairing and Debridement • L33941 Routine Foot Care	11055, 11056, 11057, 11719, 11720, 11721 and G0127	Active	Checklist Nail Cutting/Paring and Debridement	Routine Foot Care Results
L33689 Mohs Micrographic Surgery (MMS)	17311, 17312, 17313, 17314 and 17315	Active	Checklist Mohs Micrographic Surgery	Mohs Micrographic Surgery Results
L37166 Wound Care	11042 and 11045	Active	Checklist Wound Debridement	Wound Care Results
L33818 – Excision of Malignant Skin Lesions	11102-11103,11200-11201, 11300-11303, 11305-11308, 11310-11313, 11400-1104, 11406,11420-11424, 11426, 11440-11444, 11446, 11600-11604, 11606, 11620-11624, 11626, 11640-11644 and 11646	Active	Checklist Skin Lesion Removal	Skin Lesion Removal Results

Drugs and Biologicals First Coast TPE

Drugs and Biologicals

Topic and education	Related CPT/HCPCS	Review status	Documentation checklist	Results
L34007 Intravenous Immune Globulin (IVIG)	J1569	Active	Checklist Drugs and Biologicals	IVIG Results
L32270 Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications (Retired 12/14/2023)	J0897	Active	Checklist Drugs and Biologicals	Bisphosphonates Injections with associated administration codes Results
L33274 Botulinum Toxins	J0585	Active	Checklist Drugs and Biologicals	Botulinum Toxin Injection Results
L33767 Viscosupplementation Therapy for Knee (Retired 04/06/2023)	J7318, J7320-J7329 and J7331-J7332	Active	Checklist Drugs and Biologicals	Hyaluronan Acid Therapy Injections with associated administration and placement codes Results
L36377 Application of Skin Substitute Grafts for Treatment of DFU and VLU of Lower Extremities	15271, 15272, 15273, 15274, 15275, 15276, 15277 and 15278	Active	Checklist Application of Skin Substitutes	Coming Soon

Targeted probe and educate (TPE) topics and schedule of review

Novitas Target List

End stage renal disease (ESRD) services (CPT 90960-90961)	Inactive	ESRD checklist	ESRD results
Rehabilitation services: Outpatient physical and occupational therapy (CPT 97530)	Inactive	Therapy checklist	Therapy results
Surgical services: Cataract extraction (CPT 66982-66984)	Active	Cataract checklist	Cataract results
Drugs and biologicals: Drug injections - (Hyaluronan Acid Therapies) with associated administration and placement codes)	Active	Drug injection checklist	Drug Injection results
Psychiatric services: Psychotherapy (CPT 90832, 90834, and 90837)	Active	Psychotherapy checklist	Psychotherapy results
Mohs micrographic surgery (MMS) (CPT 17311-17315)	Inactive	MMS checklist	MMS results
Nail cutting/Paring and debridement (CPT 11719-11721, 11055-11057, HCPCS G0127)	Inactive	Foot care checklist	Foot care results
Anesthesia services: Anesthesia for diagnostic or therapeutic injections; prone position (CPT 01992)	Inactive	Anesthesia checklist	Anesthesia results
Trigger point injections (CPT 20552-20553)	Inactive	Trigger point injection checklist	Trigger point injection results
Paravertebral facet joint injections (CPT 64490-64491)	Inactive	Facet joint injection checklist	Facet joint injection results
Epidural steroid injections for pain management (CPT 62323)	Inactive	Epidural steroid injection checklist	Epidural steroid injection results
Rehabilitation services: Outpatient physical, occupational and speech therapy services billed with KX modifier	Active	Therapy checklist	Therapy KX results

Novita's Target List

Removal of benign skin lesions (CPT 11102-11103, 11200-11201, 11300-11303, 11305-11313 and 11401-11406, 11421-11424, 11426, 11440-11446)	Active	Skin lesion removal checklist	Removal of benign lesions results
Laboratory services: Definitive drug testing (HCPCS: G0480, G0481, G0482, G0483)	Inactive	Laboratory services checklist	Laboratory results
Acupuncture (CPT 97810-97811; 97813-97814)	Inactive	Acupuncture checklist	Acupuncture results
Evaluation & management (E/M) services: Established office/outpatient visits (CPT 99215, 99214, 99213), Subsequent hospital inpatient or observation care (CPT 99232)	Active	E/M checklist	Evaluation & Management results
Annual Wellness Visits (G0438, G0439)	Active	AWV checklist	Coming soon

Targeted Probe and Educate Topics and Schedule of Review

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TPE Results Cataract Surgery

- Palmetto, the MAC in region JJ has published the results of its initial TPE regarding cataract surgery.
- The denial rate of between 20 to 40 cataract cases was 26.67%.
  - 82.26% did not document all the items on the cataract surgery checklist that demonstrated the medical necessity for the surgery
  - 7.53% of claims filed did not include all that was asked for in the ADR.

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TPE Results Cataract Surgery

- Palmetto, the MAC in region JJ has published the results of its initial TPE regarding cataract surgery.
  - 5.38% of the physician's signature was missing or unidentifiable.
  - 2.69% were submitted in error. Perhaps the patient canceled surgery at the last minute, but the surgery was submitted for payment anyway.
  - 1.08% were automatically denied because records were not submitted within the 45-day window. **These physicians will be referred to RAC or UPIC for further action.**

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Novitas Checklist Cataract Extraction

Check	Documentation description
	Documentation is for the correct beneficiary.
	Documentation contains a valid and legible signature.
	Documentation includes procedure notes or operative report of the cataract extraction performed for the date of service under review.
	Documentation includes evidence that the patient has a cataract.
	Documentation includes evidence that the patient has impairment of visual function due to the cataract(s) impacting ability to carry out activities of daily living.
	Documentation includes evidence that the patient has been provided informed consent.
	Documentation of any other pre-operative ophthalmologic studies/work-up completed.
	If applicable and required, submitted documentation should include a beneficiary waiver of liability.

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Novitas Psychotherapy Services

Check	Documentation description
	Documentation is for the correct beneficiary.
	Documentation contains a valid and legible signature.
	Documentation clearly identifies the person performing the service (including title, education background, credentials).
	Documentation clearly demonstrates session start and stop times and/or total time spent providing psychotherapy services to the beneficiary.
	Documentation demonstrates the telehealth method utilized during the service (i.e., audio/video), if applicable.
	Documentation demonstrates the type of service being provided (including the therapeutic techniques and approaches including modalities and frequencies of treatment furnished).
	Documentation supports the medical necessity for psychotherapy treatment as evidenced by: • The maladaptive behavior that supports the need for ongoing psychotherapy treatment. • Results of clinical tests performed. • Medication prescription and monitoring (if applicable). • Summary of the diagnosis/symptoms, functional status, and treatment plan. • Frequency of treatment furnished, prognosis, and progress.
	Documentation to support "incident to" guidelines (if applicable), that includes evidence of billing provider's presence in the office suite and ongoing participation in patient care.
	For services that include an E/M component, the E/M services should be documented.
	If applicable and required, submitted documentation should include a beneficiary waiver of liability.

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Novitas Checklist
Benign Skin Lesion Removal

Check	Documentation description
	Documentation is for the correct beneficiary.
	Documentation is for the correct date(s) of service.
	Documentation contains a valid and legible signature for the provider performing the service(s), which follows CMS Signature Guidelines for Medical Review Purposes .
	Documentation supports the selected ICD-10-CM code(s) billed for the service(s).
	Documentation supports a medically reasonable and necessary service(s) that includes relevant pre-procedure documentation (i.e., history and physical examination, progress notes, pre-operative examination, beneficiary consent/treatment option discussion, laboratory/diagnostic testing results, etc.). Documentation includes applicable operative/procedure note for the service(s) performed.
	Documentation includes an advanced beneficiary notice of non-coverage was provided (if applicable and required).
	Any additional documentation to support medical necessity or any applicable policy guidelines for the service(s) billed.

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Novitas E & M Documentation

Check	Documentation requirements
	Documentation is for the correct beneficiary.
	Documentation is for the correct date(s) of service.
	Documentation contains a valid and legible signature, which follows CMS Signature Guidelines for Medical Review Purposes .
	Documentation supports that a face-to-face visit occurred.
	Documentation supports a medically reasonable and necessary E/M service as outlined in CMS Internet Only Manual, Publication 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 (i.e., 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.
	Documentation includes an advanced beneficiary notice of non-coverage was provided (if applicable and required).
	Any additional documentation to support medical necessity or any applicable policy guidelines for the services billed.

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Laboratory TPE

Results for the WPS Region were published in January 2024, showing more than 50% of the claims reviewed for CPTs 80307 and G0483 failed to include proper documentation or physician orders. [CMS Targeting Errors on Drug Testing Claims Following TPE Review]

Service	Error Rate
Group Psychotherapy – 90853	77%
Paravertebral Facet Joint Injection: 64490-64495	57%
Physical Therapy (PT) Re-evaluation – 97164	54%
Presumptive Drug Test – 80307	53%
Drug Testing – G0483	51%
Wound Care Services – CPT 11042	43%
Intravenous Infusion for Therapy, Prophylaxis, Diagnosis – CPT 96365	32%
Transportation of Portable X-Ray Equipment – R0070	27%
Percutaneous Implantation of Neurostimulator Electrode – 63650	23%
Ambulance Service - Advanced Life Support (ALS) – A0427	14%
Nail Debridement – CPT 11721	4%

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CGS TPE Topics

Edit Code	Description	Review Type	Status	Documentation Requirements Checklist
5MMP4	Review of HCPCS code 70450 for CT of head	Targeted Probe and Educate Postpayment Review	Inactive	CT of Head ADR Checklist
5NPSN	Review of SNF PDPM New Provider	Targeted Probe and Educate Prepayment Review	Active	PDPM ADR Checklist
5PE12	Review of HCPCS code 93798 for Cardiac Rehabilitation with continuous ECG Monitoring	Targeted Probe and Educate Prepayment Review	Active	Cardiac Rehab with Continuous ECG Monitoring ADR Checklist
5PE16	Review of Outpatient Claims for Pulmonary Rehabilitation HCPCS 94625 and 94626	Targeted Probe and Educate Prepayment Review	Active	Pulmonary Rehab ADR Checklist
5PE23	Review of Outpatient Hip Replacement CPT 27130	Targeted Probe and Educate Prepayment Review	Active	Hip Replacement ADR Checklist
5PE24	Review of Outpatient Knee Replacement CPT 27447	Targeted Probe and Educate Prepayment Review	Active	Knee Replacement ADR Checklist
5PE40	Review of IRF CMGs 0103, 0106, 0502, 0604, 0704, 2003	Targeted Probe and Educate Prepayment Review	Active	IRF ADR Checklist
5PE41	Review of SNF PDPM	Targeted Probe and Educate Prepayment Review	Active	PDPM ADR Checklist
5PE42	Review of Outpatient Therapy REV Codes 042X, 043X and 044X	Targeted Probe and Educate Prepayment Review	Active	Outpatient Therapy REV Codes ADR Checklist
5PE43	Review of HCPCS code G0277 for services related to Hyperbaric Oxygen Therapy (HBOT)	Targeted Probe and Educate Prepayment Review	Active	HBOT ADR Checklist
5PE44	Review of Inpatient Septicemia (DRG 871)	Targeted Probe and Educate Prepayment Review	On Hold	Inpatient Septicemia ADR Checklist
5PE47	Review of Outpatient Therapy REV Codes 042X, 043X and 044X with the KX Modifier	Targeted Probe and Educate Prepayment Review	Active	Outpatient Therapy REV Codes ADR Checklis

To

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CGS Targeted Review Findings

- Home Health
  - Initial Certification invalid
  - Skilled Nursing not medically necessary
  - Face To Face document missing/incomplete/untimely
  - Documentation does not support homebound
  - Therapy visits not medically necessary

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CGS TPE September 2021 – August 2022

- FINDINGS = Home Health
  - **Initial certification invalid** accounted for 26.31% of the total TPE denials.
  - **Skilled nursing not medically necessary** accounted for 25.86% of the total TPE denials.
  - FTF documentation denials accounted for 19.62% of the total TPE denials
  - **Documentation does not support homebound** accounted for 6.69% of the total TPE denials.

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CGS Targeted Review Findings

- Hospice Denials
  - Terminal Prognosis not supported
  - Notice of Election invalid
  - Physician Narrative missing/invalid
  - MD services not medically necessary
  - Face to Face Encounter invalid

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CGS TPE September 2021 – August 2022

- FINDINGS =Hospice
  - **Terminal prognosis not supported** accounted for 50.50% of the total TPE denials.
  - **Notice of Election invalid** accounted for 13.37% of the total TPE denials.
  - **Physician services not medically necessary** accounted for 7.43% of the total TPE denials
  - **Face-to-Face Encounter invalid** accounted for approximately 7.43% of the total TPE denials.

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Noridian TPE Audits

Review Criteria	Current Error Rate	Review Results
Therapeutic, Prophylactic, or Diagnostic Intravenous (IV) Injection, CPT® 96374	18.68%	• View Results
Skilled Nursing Facility PPS	7.28%	• View Results
Transthoracic Echocardiograph, CPT® 93306	22.68%	• View Results

Therapeutic, Prophylactic, or Diagnostic Intravenous Injection Targeted Probe and Educate Review Results - JE Part A – Noridian

Medical Record Review Results - JE Part A - Noridian

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Therapeutic, Prophylactic, or Diagnostic Intravenous Injection TPE Noridian

- 96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.
- The findings of the claims reviewed from July 1, 2024 through September 30, 2024 are as follows:
  - 135 claims were reviewed with 18.68% error rate
  - Therapeutic Administration Billing Integral to a Procedure
  - Documentation Requirements of Therapeutic, Prophylactic or Diagnostic Injection, Intravenous Push, Single or Initial Substance/Drug
  - Billing/Coding of Therapeutic, Prophylactic or Diagnostic Injection, Intravenous Push, Single or Initial Substance/Drug

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Noridian Findings

Therapeutic Administration Billing Integral to a Procedure

- Per Current Procedural Terminology (CPT®) manual, IV pushes or IV infusions integral to a procedure, such as contrast material for imaging, should not be billed. This would include CPT® codes 96365-96379.

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Noridian Findings

Documentation Requirements of Therapeutic, Prophylactic or Diagnostic Injection, Intravenous Push, Single or Initial Substance/Drug

- The CPT® manual includes descriptors and guidelines when billing codes for hydration, chemotherapy, infusion, or injections.

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Noridian Findings

- In order to evaluate the actual time of a hydration or infusion/injection services, it is important that the medical record include either documentation of the total infusion time OR both the start time, when the infusion starts dripping, and the stop time, when the infusion stops dripping, to support the services billed.

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Noridian Findings

- Billing/Coding of Therapeutic, Prophylactic or Diagnostic Injection, Intravenous Push, Single or Initial Substance/Drug
- Per the Current Procedural Terminology (CPT®) manual, therapeutic infusions should be billed for infusions lasting 16 minutes up to one hour with CPT® 96365.

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Noridian Findings

- Report 96366 for infusion intervals of greater than 30 minutes beyond 1-hour increments.
- CPT® 96374 should be billed for an intravenous push, single or initial substance/drug, infusions for durations of 15 minutes or less.

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Physical Therapy and TPE Errors

- CMS highlights the most common claim errors:
  - Missing signatures from the certifying physician;
  - Encounter notes not supporting elements of eligibility;
  - Not documenting medical necessity; and
  - Missing or incomplete certifications or recertifications
- Common Reasons for PT Claims Denials | WebPT

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CMS Common Claims Errors

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

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Additional Documentation Requests (ADR)

- An ADR is an additional documentation request (ADR) is generated when documentation is necessary to support a Medicare claim.
- This request is for medical record documentation to support payment of an item(s) or service(s) reported on the claim to ensure compliance with Medicare's coverage, coding, payment and billing policies.
- The ADR is sent to a provider's practice address on file with Medicare.
- 45 Days to respond!
- Additional Documentation Request | CMS

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ADR Best Practices per CMS

- When preparing your documentation, it is best practice to **attach a copy of the ADR letter** as the first page to ensure the documentation is matched to the appropriate patient and claim.

- Providers/Suppliers should submit the necessary documentation to support the services for the billing period being reviewed.

  – This may include documentation that is prior to the review period.

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ADR Best Practices per CMS

- Documentation may be received by your MAC either via
  - US Mail,
  - esMD,
  - your MAC designated provider portal,
  - Fax,
  - on compact disc (CD),
  - digital video disc (DVD),
  - universal serial bus (USB).

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ADR Submitted After 45 Days

- For MACs, SMRC, and RACs reviews, the contractor may accept documentation received after 45-calendar days **for good cause.**
- Good cause means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause in accepting the documentation.

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ADR Failure to Respond

- As outlined in 42 CFR § 405.930 Failure to respond to additional documentation request, if a contractor gives a provider or supplier notice and time to respond to an additional documentation request and the provider or supplier does not provide the additional documentation in a timely manner, **the contractor has authority to deny the claim.**

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Palmetto GBA
Missing Documentation Examples

- **Part A Outpatient Therapy**
- Missing certification
- Missing progress notes
- Missing initial evaluation
- Missing plan of care • Missing total therapy minutes •

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Palmetto GBA
Missing Documentation Examples

- Part A Denosumab (Prolia)
  - Missing Physician's Orders
- Part A DRG 885 Psychoses
  - Missing valid certification
  - Missing initial psychiatric evaluation
  - Missing valid recertification
- Evaluation and Management
  - Missing documentation, including no documentation, partial documentation or incorrect DOS or type of documentation received

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Notification Letter

- The MACs are required to send a notification letter to providers/suppliers being targeted for review that includes the following:
  - Outlines the targeted probe & educate process,
  - Explains the process by which providers/suppliers will be able to receive one on-one education and the types of education that will be available,
  - Notifies providers/suppliers that MACs shall have the option to refer providers/suppliers to the RAC or UPIC due to non-response to Additional Development Requests (ADRs),

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Notification Letter

- Shall include the following language to remind providers of 42 CFR §424.535 “In addition, we remind you that the regulation at **42 CFR §424.535 authorizes us to revoke Medicare billing privileges under certain conditions.**
- Per 42 CFR §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider or supplier’s Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.”

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One-On-One Education

- One-On-One Education For the TPE process, one-on-one education is defined as:
  - Teleconference calls,
  - Face-to face visits,
  - Electronic visits using webinar technology, or
  - Other similar technologies that enable direct communication between the MAC educator and the provider/supplier.
- MACs shall record these activities in monthly reporting to CMS as well as document and maintain the results of the education, and/or attempts for education, for data analysis and possible future reporting.

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Post Probe Education

- The post-probe one-on-one education should be individualized,
- The education should be claim-specific, and conducted in a format that is interactive,
- Training should allow the provider/supplier to ask questions as needed.
- The MAC shall provide a minimum of **45 days** after each post-probe educational session, before selecting new claims for review, to allow time for the provider/supplier to cure identified errors.

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Post Probe Final Results Letter - Passed

- The MAC shall send the provider/supplier a letter detailing the results of the claims reviewed at the conclusion of each round of review.
- The MAC shall include details regarding the provider's/supplier's specific claim errors.

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Post Probe Final Results Letter - Passed

- For providers/suppliers who will be released from review due to meeting the established error rate goal, results letters shall indicate that the provider is being released from review **for one year**, with the caveat that additional review may occur at any time should the MAC identified changes in billing pattern.

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Providers and Suppliers who continue to have high error rates after three rounds of TPE review

- Results letters shall indicate that they have not met the established goal error rate and will be referred to CMS for additional action, which may include:
- Additional rounds of TPE review,
- 100% prepayment review, extrapolation,
- Referral to a Recovery Auditor,
- Referral for revocation.

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TPE Appeals Process

- TPE reviews and TPE audit overpayment determinations may be appealed through the Medicare Appeals Process.
- The first stage of appeal will be to request redetermination of the overpayment by the MAC.
- If the redetermination decision is unfavorable, Medicare providers and suppliers may request an independent review by filing a request for reconsideration with the Qualified Independent Contractor (QIC).

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TPE Appeals Process

- If the reconsideration decision is unfavorable, Medicare providers and supplier are granted the opportunity to present their case in a hearing before an Administrative Law Judge (ALJ).
- While providers or suppliers who disagree with an ALJ decision may appeal to the Medicare Appeals Council and then seek judicial review in federal district court, it is crucial to obtain experienced healthcare counsel to overturn the overpayment determination during the first three (3) levels of appeal

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Wound Care High Target Arena

- Wound care has repeatedly been identified by CMS, the Office of Inspector General (OIG), and Medicare contractors as an area potentially subject to fraud and abuse. In its 2005 to 2007 and 2017 Work Plans, the OIG expressed concern that claims submitted by wound care centers for debridement were not medically necessary.

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Wound Care High Target Arena

- In a 2018 OIG HHS audit, the HHS Office of Audit Services reviewed 120 claims for hyperbaric oxygen therapy services paid by a Medicare Administrative Contractor (Wisconsin Physician Services) over a 2-year period.
- The OIG estimated fraudulent payments totaling $42.3 million had been made to wound care centers, after extrapolating the fraudulent claims to the entire universe of claims. Of the 120 claims reviewed, the government concluded that 85% had not been eligible for payment.

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Documentation

- Adequate documentation is at the heart of commercial payer and Medicare medical necessity requirements. Patient charts must:
- Demonstrate that standard conservative therapy has failed.
- Comply with the requirements of LCD/NCD and payer policies. These policies set the minimum requirements for meeting the medical necessity standard.

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Documentation

- Document the thought processes of the provider.
- All treatment plans should specify
  - Why a particular therapeutic modality was chosen,
  - What treatment options were considered,
  - Weighing of the benefits of those therapeutic modalities.

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Documentation

- The number and complexity of the problem or problems addressed at each encounter
- The risk of complications and/or morbidities or mortality of patient management decisions made at each visit.

- This level of detail is required to support the treatment plan put in place.

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Documentation

- Identify the type of wound, such as chronic wound (diabetic ulcer, arteriosclerotic ulcer, venous ulcer) or traumatic wound (disruption of surgical wound), surgical complication of graft and flaps (delayed healing, failed or compromised graft or flap), or complication with amputations.

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Documentation

- Provide the measurements of the wound both at the time of assessment and at reassessment as well as descriptions of the wound (e.g., consistency and quantity of drainage, color, odor), the condition and appearance of the periwound skin, and the presence or absence of infection.

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Diagnostic Testing

- Record all diagnostic testing performed (e.g., review hemoglobin, A1C testing, duplex scans, ankle brachial index, MRI scans, computed tomography scans, laboratory tests), and counseling performed (nutrition, tobacco cessation) and the documented results.
- The inclusion of all diagnostic testing results provides evidence-based support for the continuation of a specific therapy.

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Failed Response To Wound Care

- It is **not sufficient to state** that a wound is nonhealing and record the duration of time it has been present.
- Medicare defines a **“failed response”** as a wound that has increased in size or depth, shown no change in baseline size or depth, or shown no signs of improvement or indication that improvement is likely (e.g., granulation, epithelialization, or progress toward closing) despite conservative therapy efforts and patient counseling.
- Reimbursement depends on documentation meeting the threshold requirement that conservative therapy efforts have failed after being performed over a specific period.

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Medical Necessity for Wound Care

- The patient assessment and treatment plan must clearly define all diagnoses the provider is managing during a visit.
- For an established diagnosis, include whether the patient's condition is stable, improving, or worsening;
- Timing and ordering diagnostic tests and performing specific therapeutic treatments, require the rationale be included.

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Medical Necessity for Wound Care

- Commercial payer and Medicare LCD/NCD requirements are an overlay based on established evidence-based clinical practice guidance.
- Know the policy for each therapeutic modality for wound care specific to Medicare or commercial payers that establishes medical necessity.
  - Differences exist among various payer policies, so the specific payer requirements must be assessed for each type of wound care treatment.

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Assign ICD 10 CM Codes Based on Wound Type

- The treatment of an uncomplicated surgical wound, is coded as aftercare following surgery.
  - If the condition is still present, that should be coded as well.
- If the wound is a complication of a surgical wound identify
  - Dehiscence relating to a surgical wound,
  - An infected postoperative wound,
  - Drainage quantity and quality
  - Failure of a flap or graft.
- Culture results are reported if performed

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Pressure Ulcers L89

Types of pressure ulcers

- bed sore
- decubitus ulcer
- plaster ulcer
- pressure area
- pressure sore

•

Code first any associated gangrene (I96) (I96)

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Pressure Ulcers L89

Excludes 2

- decubitus (trophic) ulcer of cervix (uteri) (N86) (N86)
- diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622) (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622)
- non-pressure chronic ulcer of skin (L97.-) (L97-L97.929)
- skin infections (L00-L08) (L00-L08.9)
- varicose ulcer (I83.0, I83.2) (I83.0-I83.029, I83.2-I83.229,)

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Non- Pressure Chronic Ulcer L97

Includes

- chronic ulcer of skin of lower limb NOS
- non-healing ulcer of skin
- non-infected sinus of skin
- trophic ulcer NOS
- tropical ulcer NOS
- ulcer of skin of lower limb NOS

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Non- Pressure Chronic Ulcer L97

Code first any associated underlying condition, such as:

- any associated gangrene (I96) (I96)
- atherosclerosis of the lower extremities (I70.23-, I70.24-, I70.33-, I70.34-, I70.43-, I70.44-, I70.53-, I70.54-, I70.63-, I70.64-, I70.73-, I70.74-) (I70.23-I70.239, I70.24-I70.249, I70.33-I70.339, I70.34-I70.349, I70.43-I70.439, I70.44-I70.449, I70.53-I70.539, I70.54-I70.549,)
- chronic venous hypertension (I87.31-, I87.33-) (I87.31-I87.319, I87.33-I87.339,)
- diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622) (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622)
- postphlebitic syndrome (I87.01-, I87.03-) (I87.01-I87.019, I87.03-I87.039,)
- postthrombotic syndrome (I87.01-, I87.03-) (I87.01-I87.019, I87.03-I87.039,)

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Non- Pressure Chronic Ulcer L97

Excludes 2

- pressure ulcer (pressure area) (L89.-) (L89-L89.95)
- skin infections (L00-L08) (L00-L08.9)
- specific infections classified to A00-B99 (A00-B99.9)

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Diabetic Ulcers

- Diabetes with peripheral vascular disease and peripheral arterial disease should be coded as diabetic peripheral angiopathy.
- The coding is further refined by whether the diabetic ulcer is a venous stasis ulcer or a neuropathic ulcer.
- Comorbidities associated with diabetic and other ulcers should be identified and coded

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Multiple Wounds

- All wounds must be coded.
- Wounds at multiple sites, the provider must
  - select the diagnosis code that identifies each wound,
  - the anatomic location,
  - and laterality.
  - Document and code to depth of wound
  - Size of Wound for procedures

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Quality Measures Provided by the US Wound & Podiatry Registries - US Wound & Podiatry Registries

2024 WOUND-RELEVANT QUALITY MEASURES FROM THE US WOUND REGISTRY, APPROVED BY CMS

Measure Number	Title	Specification
USWR22	Nutritional Assessment and Intervention Plan in patients with Wounds and Ulcers	
USWR30	Non-Invasive Arterial Assessment of Patients with Lower Extremity Wounds or Ulcers for Determination of Healing Potential	
USWR32	Adequate Compression at Each Visit for Patients with Venous Leg Ulcers (VLUs) Appropriate to Arterial Supply	
USWR33	Diabetic Foot Ulcer (DFU) Healing or Closure	
USWR34	Venous Leg Ulcer (VLU) Healing or Closure	
USWR35	Adequate Off-loading of Diabetic Foot Ulcers (DFUs) Performed at Each Visit, Appropriate to Location of Ulcer	
USWR36	Pressure Ulcer* (PU) Healing or Closure (not on the lower extremity)	

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Documentation Requirements:

- Extensive documentation requirements:
  - Photo documentation with wound measurements (size, depth) at baseline and follow-ups.
  - Justification for wasted materials, including serial numbers and reason for excess usage.
  - Justification of any repeat application, including whether the current treatment plan has resulted in wound healing and expectation that the wound will continue to heal with this plan. Estimated time for extended treatment, number of additional applications anticipated and plan of care if healing is not achieved as planned.
  - Graphic or photographic evidence of wounds before and after treatment.

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SNF 5 Claim Review

- The Comprehensive Error Rate Testing (CERT) program projected an improper payment rate of 15.1 percent for SNF services in 2022, up from 7.79% in 2021.
- SNF service errors were determined to be the top driver of the overall Medicare Fee-for-Service improper payment rate.
- Part of the reason for the significant increase in the improper payment rate may be misunderstanding by SNFs about how to bill appropriately given the change from the Resource Utilization Group (RUG) IV to the PDPM (patient driven payment model) for claims with dates of service on or after October 1, 2019.
- The goal of the SNF 5 Claim Probe & Educate program is to assist SNFs in understanding how to bill appropriately under this new payment model and decrease the improper payment rate.

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SNF 5 Claim Review

- MACs will review 5 claims from each SNF.
- MACs will complete one (1) round of probe and educate for each SNF, not the potential three (3) rounds that may occur in the traditional TPE program.

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SNF 5 Claim Review

- Education offered will be individualized based on the claim review errors identified in the probe. Review results letters will detail the denial rationales for each claim, as appropriate.
- The SNF 5-Claim reviews commenced on June 5th, 2023, and will affect claims for services furnished after October 1st, 2019. Claims containing the COVID-19 diagnosis will be excluded from the review.

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Flying Under the TPE Radar

- Monitor Denials
- Provide internal audits for trends in denials
  - If you have denials of 10% or more on a specific item nip it in the bud.
- Provide Coder and Provider education as appropriate.
- Assign someone to monitor the mail
- Assign someone responsible to answer ADRs in a timely manner.
- Monitor your local MAC for target lists

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Oops You Hit the TPE Radar

- Make sure the responsible party (ies) attend training.
  - Coder, provider, coding educator, and compliance representative
- Failed review for MAC issues
  - Appeal
  - Attend Medicare Advisory Committee Meetings
  - Write a letter to Medical Director of Local MAC
    - CC AMA, your specialty organization and congressional representative
- Appeal!

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Questions

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- Jurisdiction M Part A - Targeted Probe and Educate
- MR_TPE_Hot_Topic_Call.pdf
- Targeted Probe and Educate Update: September 2021 – August 2022
- 2367_0223_rev_tpe_2023_508.pdf
- New Novitas Process Set to Impact Pathology and Laboratory Claims - Lighthouse Lab Services
- Understanding and Challenging Targeted Probe and Educate Reviews
- Targeted Probe and Educate | CMS
- TPE QAs December 16 2019.pdf
- MR_TPE_Hot_Topic_Call.pdf
- 3_ Hot Topics in Compliance.pdf
- Targeted Probe and Educate Update: September 2021 – August 2022
- Targeted probe and educate (TPE) topics and schedule of review

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