Medicare Minute - Targeted Probe and Educate Resumes

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Hello and welcome to another edition of Medicare Minute. I'm Dr. Robert Hoover, medical director at CGS Administrators, the Jurisdictions B and Jurisdiction C DME MAC. Today I'm going to update you on Medical Review activities and talk about the resumption of Targeted Probe and Educate or TPE.

You may recall before the Public Health Emergency that the DME MACs were doing TPE with pre-payment claims. For those of you new to billing Medicare, pre-payment review is a process where, before a claim is paid, medical documentation is requested that supports the claim's payment. This is in contrast to post-payment review, sometimes referred to as "pay and chase", where the DME MAC processes and pays a claim and then at a later date requests the documentation to support the claim.

TPE can be done on a pre-payment or post-payment basis; however, the preferred method is pre-payment review. The DME MACs have been doing limited post-payment review for a while now; however, CMS recently instructed the DME MACs to resume pre-payment TPE.

So what does this mean for suppliers? The basics of TPE pre-payment review are essentially the same as the prepay TPE that the DME MACs were doing prior to the public health emergency.

On your screen now you'll see a flow chart for TPE. Suppliers selected for the TPE process, based on data analysis of claims submitted in Jurisdictions B and C, will receive a letter explaining that they've been selected for TPE. It will describe the process, the reason for selection and the HCPCS code or codes under review. It all starts at the top with a 10 claim probe. Ten (10) claims will initially be selected for review and if the 10 claims are without error and can be paid, no further action is taken. That's why that step is labeled "Pass/Fail".

However, if there are claim errors that result in payment denial, the supplier moves to Round 1 of TPE. A minimum of 20 but up to 40 pre-payment claims will be selected and developed for additional documentation. This documentation will be evaluated by a CGS Medical Review clinician. Depending on the number and type of errors found, the supplier will receive 1-on-1 education from the Medical Review clinician, including helpful material to reduce or eliminate the claim errors noted in the review. If the error rate is low, no further action is taken and the supplier's location is excluded from further TPE review for 12 months for the HCPCS code or codes that were reviewed.

For suppliers with higher error rates in Round 1, claim-specific 1-on-1 education will be provided and at least 45 days will be given to implement any necessary changes to the supplier's processes. At that point, Round 2 of TPE will take place, with review of an additional 20 to 40 pre-payment claims. Similar to the first round of TPE, a Medical Review clinician will again conduct 1-on-1 education.

If high denial rates continue after three rounds of TPE, CGS will consult with CMS for additional action, which may include extrapolation, referral to the ZPIC or UPIC, referral to the RAC, 100% pre-payment review or other additional actions.

It's especially important that you respond to the TPE letter! The letter includes contact information so that you can reach out to the CGS TPE team with any questions you may have.

One question you might be asking is "How will TPE be handled in light of the PHE flexibilities CMS granted to suppliers and providers in the Interim Final Rules with Comment from the spring of 2020?" Recall that these were the two interim regulations that covered a variety of issue and were put in place to protect beneficiaries, suppliers and providers from exposure to the SARS-COV2 virus. I'm going to cover just one aspect of the IFCs here but you can read the entire Joint DME MAC article from June 29, 2020 on the CGS website that describes other flexibilities and waivers as well.

One of the flexibilities CMS implemented with the regulations was to instruct contractors to not enforce certain clinical indications of coverage for various types of devices used to treat beneficiaries with COVID-19. On your screen now you'll see the list of national coverage determinations and local coverage determinations that were included in the Interim Final Rules. For this initial period of TPE, the DME MACs will exclude from TPE the review of claims for items covered under those Interim Final Rule regulations. In other words, claims for those select items with dates of service on or after March 1, 2020 will not be reviewed.

In the TPE process, CGS will use data analysis techniques to target suppliers most likely to be submitting non-compliant claims. The purpose of TPE is to efficiently utilize medical review processes and incorporate comprehensive education, with the option for potential elevated action; all designed to reduce or prevent improper payments and reduce appeals.

If you are selected for TPE, you'll have all of the information you need in the letter you'll receive from CGS. Read it carefully and follow the directions closely. As I mentioned earlier, it is critically important that you respond to the request for records promptly.

That does it for this edition of Medicare Minute. Thank you for watching and have a nice day.

