Targeted Probe and Educate

NGS Answers Your Questions

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Today's Presenter

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  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- To provide information about the Targeted Probe and Educate Medical Review Activities
- To learn how to respond efficiently and accurately to an Additional Development Request (ADR) to support payment of the Home Health Claim
- To further the understanding of the documentation that supports home health certification and recertification
- To share our efforts in providing consistent reviews

Agenda

- Medical Review - Objectives, History, and Changes
- Targeted Probe and Educate
  - Intra-probe Education
  - Same RN who reviewed the claim does 1:1 education
  - Job Aid
- Responding to an Additional Development Request (ADR)
- 5 Home Health Eligibility Requirements
  - Incorporation Regulation
- NGS Internal Education – Ensuring Consistency and Compliance

Objective for Medical Review Activities

- Objectives of any medical review is to:
  - Identify and prevent inappropriate payment
  - Identify potential risk to the Medicare trust fund
  - Educate providers
  - Appropriately pay for covered services
- Medical review meets these objectives through medical review activities

Medical Review Process Change

- The medical review process moved from a Progressive Corrective Action (PCA) process to a Targeted Probe and Educate (TPE)
  - Effective date of change was October 1, 2017
  - All lines of business
- TPE
  - History
    - Demonstration projects for inpatient services and home health
    - Proved successful in lowering providers payment error rates
    - New model changed some of the process but not affect policy and procedures

TPE – Purpose and Goal

- 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 and identify errors and help you correct them.

TPE

- Most providers will never need TPE
- 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.

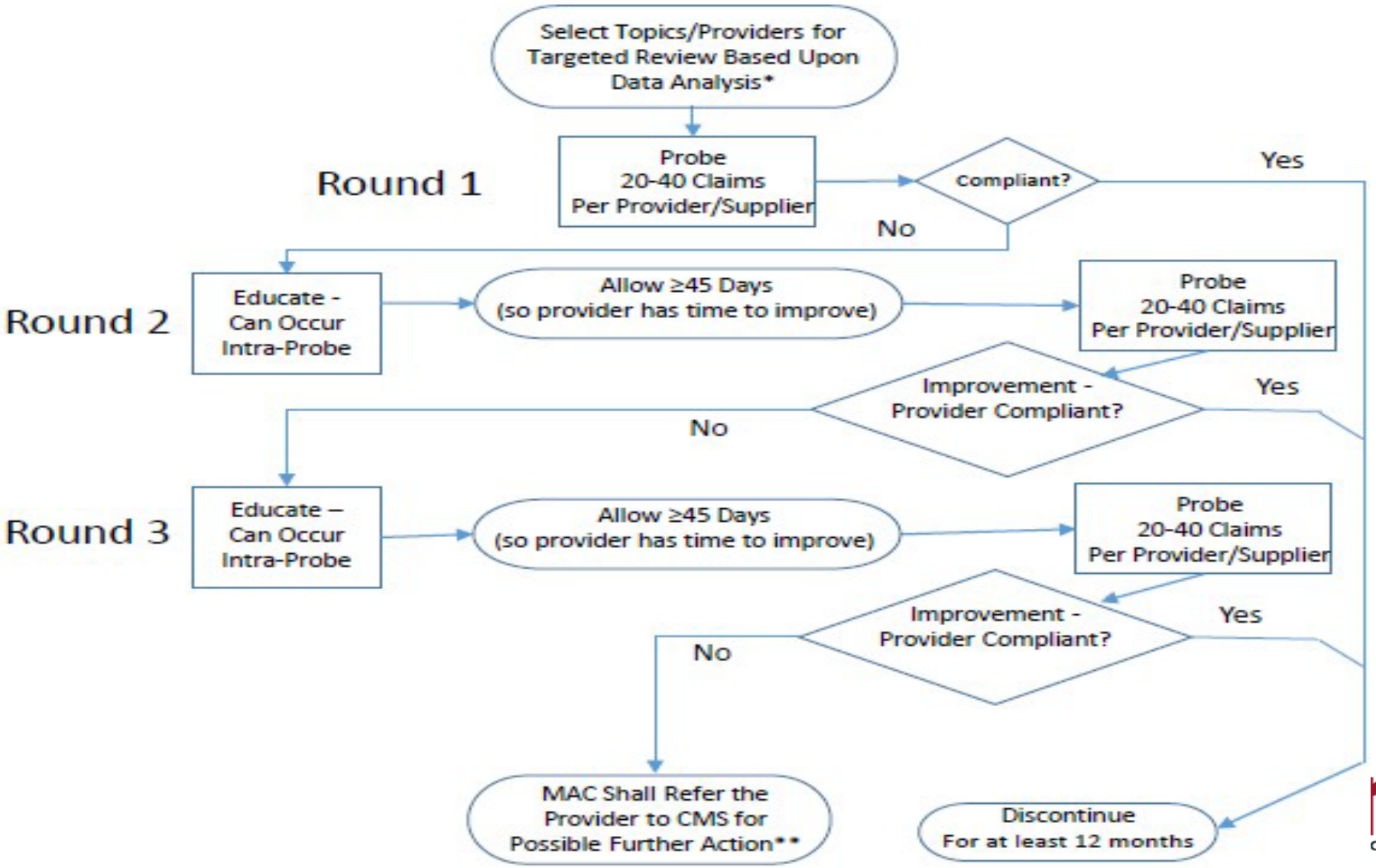
Moving from a Demonstration Project to TPE

- Differences between the demonstration projects for HH and inpatient services and the TPE
  - MACs will select the area of review based on existing data analysis procedures
    - CMS selected the area of review during the demonstration projects (HHTPE)
  - MACs can target the providers based on data rather than perform a 100% review of all providers
    - All providers were subject to review during the demonstration project
  - MACs will provide education between each round of review
  - Education also occurring during the review process – intensive area of education
  - 20-40 claims for probes and each additional round of review

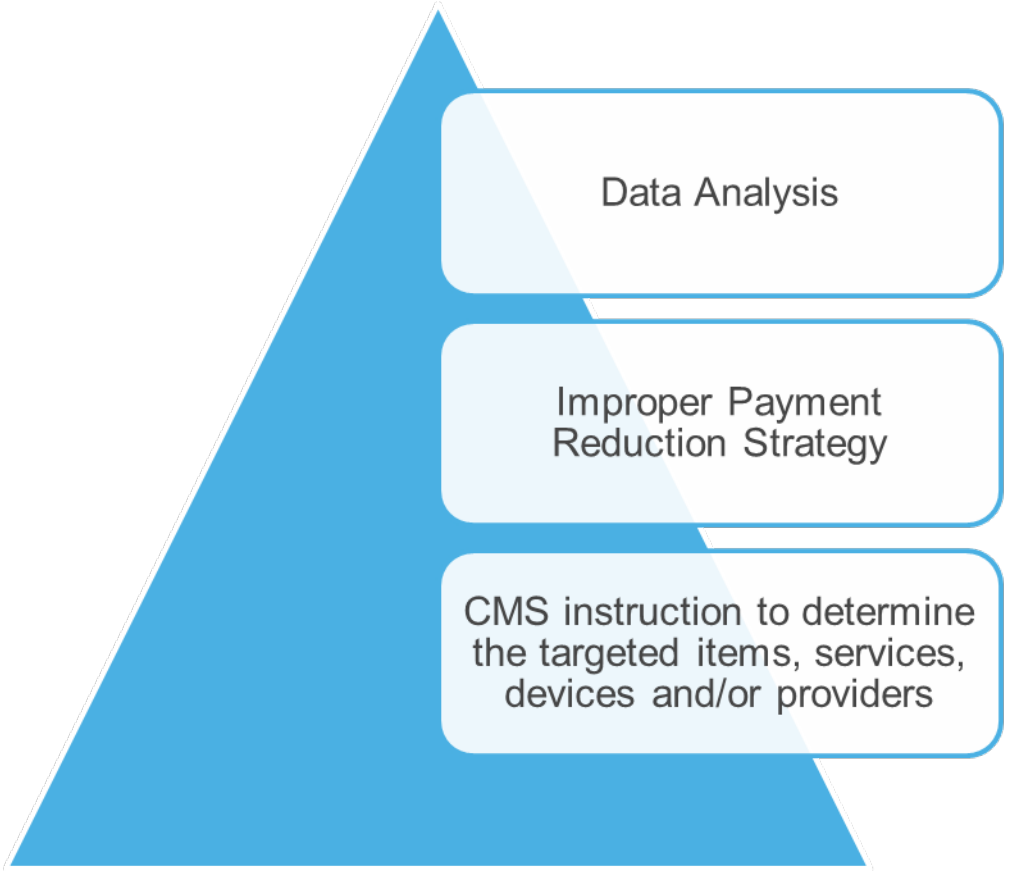
Changes in the Medical Review Process – PCA vs TPE

- Process for selecting and conducting medical review has changed
  - Specific number of claims to be reviewed during each round
    - PCA allowed advancement of review activity based on percentages of all claims submitted
    - PCA reviews and ADR requests quarterly
  - 1:1 Education between each round
    - Providers will have 45-56 days after the education before the next round of records will be requested
  - Intra-probe education – unique to TPE
    - If the reviewer identifies something that can easily be corrected during the review phase, they will reach out to provider prior to rendering decision

Targeted Probe & Educate



How Will Review Areas Be Selected?



TPE Process

Initial Probe

- Provider notification
- ADR request
- Validation
- Calculation
- Results letter
- Education

Round 2

- 45-56 days after education – ADRs
- Validation
- Calculation
- Results letter
- 1:1 education

Round 3

- 45-56 days after education – ADRs
- Validation
- Calculation
- Result letter
- Referral (if applicable)

CMS Corrective Actions

- Extrapolation
- Referral to ZPIC, UPIC or RAC
- 100% prepay review
- *list not all inclusive

Initial Probe

- During the initial probe providers can expect:
  - Provider Notification Letter
    - Expect ADRs for TPE
    - Reason for review
    - Specific number noted in letter, between 20-40 claims
  - ADRs will be generated via the usual process
    - Medical review within 30 days of receipt
    - Provider results letter will offer 1:1 education
      - Follow directions provided in the letter to request education

Rounds of Review

- TPE consists of three rounds if the provider continues to have a high payment error rate above 15%
  - Initial probe
  - Round 2
  - Round 3
- Education will occur prior to the 2nd and 3rd round of review
  - 1:1 education with medical review after each round of review
  - Heavy emphasis on “Intra-round education” if the reviewer identifies missing documentation, sometimes several phone calls to provider (*not an appeals means to be used later if provider disagrees, opportunity to send missing info during review*)
  - ADR approximately 45-56 days after the education is complete
  - Detailed results letter

CMS Referral

- After three rounds of review and continued Payment Error Rate above 15%, possibilities include:
  - Referral to the Zone Program Integrity Contractor or Unified Program Integrity Contractor
  - Referral to the Recovery Audit Contractor
  - Extrapolation of payments based on
  - 100% prepay review

Validation Phase

- Medical review of records for:
  - Physician orders
  - Medicare coverage guidelines
  - Documentation to support eligibility
  - Medical necessity of services
  - Physician certification of beneficiary eligibility
  - Documentation supports the services billed

Calculations

Payment Error Rate

- Payment / payment denied
- 1,000 /500 = 50% PER

Claims Error Rate

- # of claims/ claims in error
- 10 claims/ 5 claims denied = 50% CER

Calculations

- Payment Error Rate (PER) - Dollars that are at risk to the Medicare trust fund. The payment error rate will determine if a provider is released from medical review.
- The PER is calculated by taking the dollars that Medicare would have paid you vs the dollars medical review denied to obtain a percentage. For example if Medicare would have paid you a thousand dollars and Medical review denied 500 dollars, your payment error rate would be 50% (example in previous slide). The PER is reported on your detailed provider specific results letter.
- A Claims Error Rate looks at the number of claims reviewed by the number of claims that were denied. This was the calculation used in the HH Probe & Educate. For example if medical review looks at 10 claims and denied 5 claims you have a 50% claims error rate.

Detailed Provider Results Letter

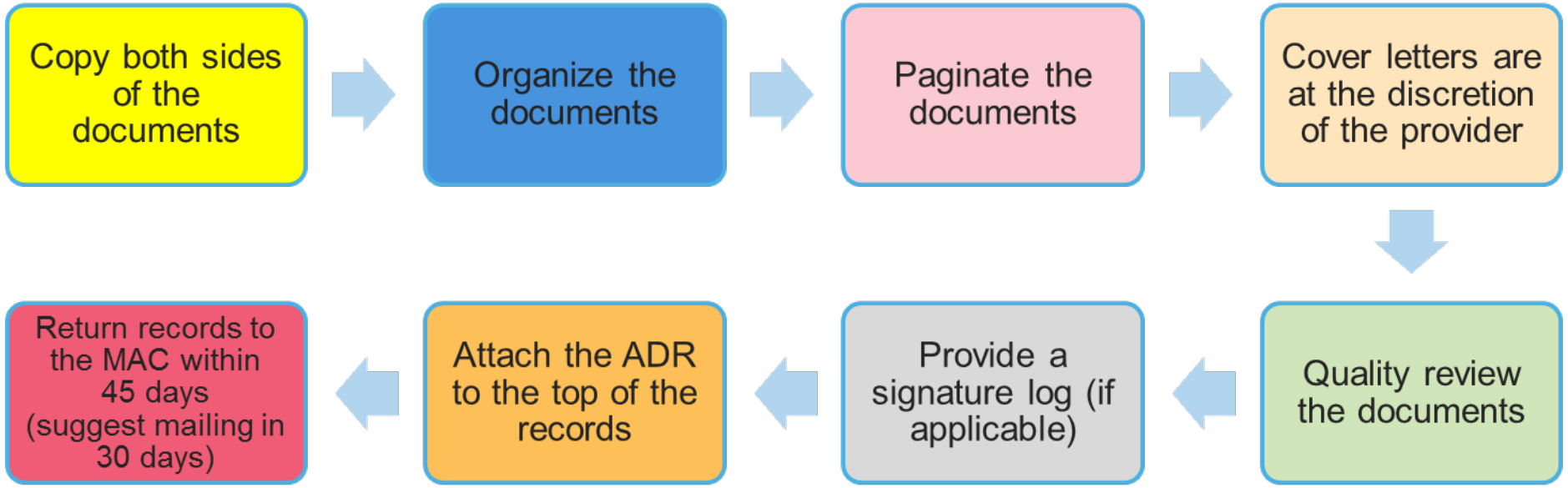
- Detailed results letter at the conclusion of each round will include:
  - Outline again the Targeted Probe & Educate process
  - Reason for denials including reference to the CMS regulations
  - Denial rates (PER)
  - Release or retention from medical review
    - PER of 15% or below in order to be released from additional rounds of review
  - 1:1 education information
- Read the letter in its entirety for important information regarding additional rounds of review

Record Preparation

Additional Documentation Request

System issues an ADR	• Claims suspends to status location SB 6001 • ADR is sent to provider • Provider has 45 days to return records to the MAC
Records are **NOT** received by day 45	• On day 46 the system will deny the claim moving it to a status location of DB 9997 • Reason code 56900
Wait one week and recheck status location	• If the records were received the claim will move to status location SM 5REC • If denial code appears, recheck, all customer care for assistance if necessary

Preparing Your Documentation



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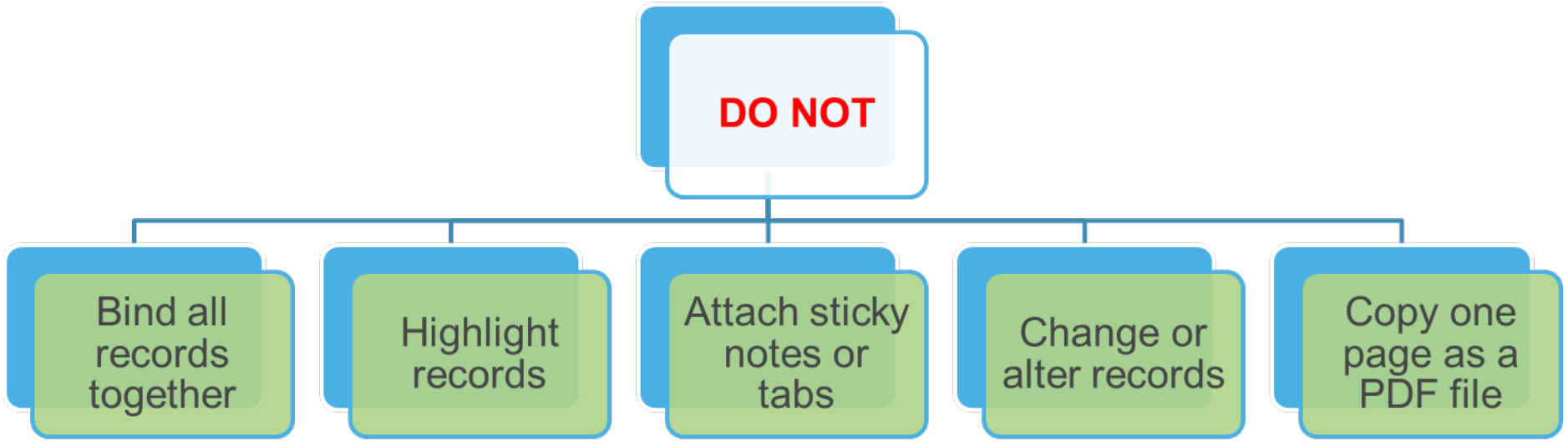


Home Health Regulations

Accepting a Home Health Referral

Questions to consider:

- What is your intake process?
- Do you use a checklist for the 5 eligibility requirements?
- What if some are missing?
- Who in your agency is most familiar with these requirements?
- Who else needs to know?

The Role of the Physician

- As of 1/1/2015, documentation in the certifying physician's medical records and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined

The Role of the Physician

- Home health agencies require as much documentation from the certifying physicians' medical records and/or the acute/post-acute care facility's medical records as necessary to assure that the patient eligibility criteria have been met and must be able to provide it to CMS and its review entities upon request

The Role of the Physician

Ordering home health services

- Is the beneficiary *eligible* for home health (HH) services?
  - Homebound?
  - Skilled need?
  - F2F encounter?
- Is it *documented* prior to the point of referral by the physician?
- Is the documentation being *shared* with the HHA with the referral?

Eligibility Requirements

- Medicare Part A and/or Part B and Section 1814(a)(2)(C) and section 1835(a)(2)(A) state that when the physician refers a patient to HH, the patient must
  - Be confined to the home
  - Need skilled services
  - Be under the care of a physician
  - Receive services under POC established and reviewed by a physician
  - Have had a FTF encounter for their current diagnosis with a physician or allowed NPP – PA, NP, CNM, CNS

Eligibility Requirements: Homebound Status

Criteria One One Standard Must Be Met
Because of Illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.
OR
Have a condition such that leaving his or her is medically contraindicated.

Criteria Two Both Standards Must Be Met
There must exist a normal inability to leave home.
AND
Leaving home must require a considerable and taxing effort.

Eligibility Requirements: Homebound Status

- Longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort
  - Patient's diagnosis
  - Duration of the patient's condition
  - Clinical course (worsening or improvement)
  - Prognosis
  - Nature and extent of functional limitations
  - Other therapeutic interventions and results, etc.

Eligibility Requirements: Homebound Status

- Criteria two
- Explain the patient's normal inability to leave home and define the taxing effort – this must be patient specific
  - Pain meds?
  - Rest periods?
  - Oxygen?
  - Continence issues?
  - Confusion?
  - Safety concerns?
  - Other accommodation?

Eligibility Requirements: Need for Skilled Services

- Documenting the need for any/all skilled services requested (including skilled nurse [SN], PT/OT/SLP, social work [SW])
  - Distinguish exactly what services are going to be provided by the skilled professional in the patients home
  - Explain why a skilled professional is required to provide the HH care services requested
  - Disclose clinical information (beyond a list of recent diagnoses, injury or procedure) that is individual and specific to the patient
  - The findings from the FTF encounter support the primary reason for home health services being provided

Eligibility Requirements: Need for Skilled Services

- Skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge and skills of a registered nurse are necessary
- To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel

Eligibility Requirements:
Plan of Care, Under the Care of a Physician

- The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care in accordance with *42 Code of Federal Regulations* (CFR) 424.22
- It is expected that in most instances, the physician who certifies the patient's eligibility
  for Medicare home health services will be the same physician who establishes and signs the plan of care

Eligibility Requirements: Plan of Care, Under the Care of a Physician

- Certifying home health services
- As the certifying physician, you are attesting that the beneficiary is eligible for home health services because all ***five*** eligibility requirements have been met. This statement can be signed at the point of referral by the ordering physician or by a community physician prior to submission of the home health agency claim.
  - This may or may not be the same physician who ordered home health services

Eligibility Requirements: Face-to-Face Encounter

- For episodes with starts of care beginning 1/1/2011 and later, in accordance with Section 30.5.1.1 a face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by an allowed provider type

Eligibility Requirements: Face-to-Face Encounter

- A FTF encounter with the patient must be performed by either
  - the certifying physician
  - a physician that cared for the patient in the acute or post-acute care facility
  - or an allowed nonphysician practitioner: nurse practitioner, certified nurse midwife, certified nurse specialist or a physician's assistant

Eligibility Requirements: Face-to-Face Encounter

- 2014
  - FTF Encounter Form
    - Narrative mandatory regarding
      - Need for skilled services, and
      - Homebound status

- 2015
  - FTF Encounter
    - Documentation from the patient's medical record providing proof that a visit occurred (example: discharge summary or office progress note)
    - Narrative required when
      - Skilled oversight of unskilled care is ordered

Certification

The certifying physician must attest

1. The patient is confined to the home (that is, homebound)
2. The patient needs intermittent SN care, PT and/or SLP services
3. A plan of care has been established and will be periodically reviewed by a physician
4. Services will be furnished while the individual was or is under the care of a physician
5. A face-to-face encounter occurred and the date it occurred

Certification

- Physicians or nonphysician practitioners are required to have face-to-face encounters with beneficiaries before they certify eligibility for the home health benefit
- One aspect of the certification is for the certifying physician to certify (attest) that the face-to-face encounter occurred and document the date of the encounter

Certification

- Certifying physician must be enrolled in the Medicare Program and be a doctor of medicine, a doctor of osteopathy; or a doctor of podiatric medicine
- Certifying physician cannot have financial relationship with HHA unless it meets one of exceptions in 42 CFR 411.355–42 CFR 411.357

Certification:
Example of a Complete Certification Statement

I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I further certify this patient had a face-to-face encounter that was performed on xx/xx/xxxx by a physician or Medicare allowed nonphysician practitioner that was related to the primary reason the patient requires home health services.

Recertification

- Recertification is required at least every 60 days
- Medicare does not limit the number of continuous episode recertifications for patients who continue to be eligible for the HH benefit
- The physician recertifying the patients eligibility is the physician that has been monitoring the POC and providing oversight of HH services
- Include an estimate of how much longer the skilled services will be required

Recertification: Example of a Complete Recertification Statement

Suggested Statement:

I recertify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care, and will periodically review the plan. I estimate these services to be required for **XX** more weeks/months/years. (circle one)

Documentation Collaboration

- Examples of documentation to share at the point of referral
  - Order for HH services
  - Documentation (anywhere in the medical record) supporting the need for skilled services and homebound status
  - FTF encounter documentation
    Example: Discharge summary or interoffice progress note documenting the one-on-one physician visit

Documentation Collaboration

- As per CR 9189
  - The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services
  - It is the patient's medical record held by the certifying physician and/or the acute/post-acute care facility that must support the patient's eligibility for home health services

Documentation Collaboration

- Incorporating HH documentation into the physician's record
  - Information from the HHA can be incorporated into the certifying physician's medical record for the patient
  - The certifying physician must review and sign any documentation used to support the certification of eligibility criteria
  - If this documentation is to be used for verification of the eligibility criteria, it must be dated prior to submission of the claim

Physician Billing for Certification and Recertification

HCPCS G0180 Certification and G0179 Recertification

- The descriptions of these two codes indicate that they are used to bill for certification or recertification of patient eligibility “for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with the HHA and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period”
  - *Medicare Benefit Policy Manual*, Chapter 7: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

These claims will not be covered if the HHA claim itself was noncovered if there was insufficient documentation to support that the patient was eligible

Ensuring Consistency

- Inter-reviewer Reliability
  - NGS Meetings between Med Review, Appeals, POE
  - Departmental Meetings
  - All MAC Meetings
- Reviewers attend POE education
- Peer Reviews and Consultation
- Frequent Dialogue between MR-Appeals-POE
  - Areas of top denials
  - Creating Educational Tools
  - Provider Feedback

Educational Opportunities

- Ongoing Free Webinars:
  - Home Health Eligibility: Clinical Documentation Requirements
  - Targeted Probe and Educate Webinar for the HH Audience
  - 30 Minute Webinars:
    - HH Documentation & the Additional Development Request (ADR)
    - HH Certification & Recertification
    - HH Qualifying Criteria
    - HH Homebound Status & the Need for Skilled Services
    - HH Face-to-Face Encounter and the Plan of Care

Educational Opportunities

NGS YouTube Channel

- Home Health Eligibility Criteria Part 1
- Home Health Eligibility Criteria Part 2
- Documenting Homebound Status
- Documenting the Need for Skilled Services
- Physician Oversight of the Plan of Care
- Face-to-Face Encounter Documentation
- Referral, Certification and Oversight of Home Health Services Parts 1, 2 & 3

References and Resources: Computer-Based Training Sessions

- Medicare University clinical education: home health CBTs
  - RHH-C-0019: Home Health: Qualifying Eligibility Criteria
  - RHH-C-0020: Home Health: Face-to-Face Encounters & the Plan of Care
  - RHH-C-0022: Home Health: Homebound Status and the Need for Skilled Services
  - RHH-C-0021: Home Health: Certification and Recertification of Eligibility Criteria
  - RHH-C-0023: Home Health: Documentation and the Home Health Additional Development Request

Educational Opportunities – Annual NGS Medicare Summit 9/19-9/20 Las Vegas

The Orleans Hotel and Casino
400 W. Tropicana Ave. Las Vegas, Nevada 89103 (702-365-7111)
Use Summit Code A8MSC09 for special rate

Day 1: A general session for all HHH providers on disaster preparedness and maintaining and developing a disaster preparedness plan to meet CMS requirements.

Day 2: Individual break-out sessions to address specific HHH billing and clinical documentation.

Cost: $149 per person

National Government Services

References and Resources:
2015 Federal Register Reference

- Federal Register Vol. 79, No. 215
- Released: Thursday, 11/6/2014
- Page 66117
  - http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf

References and Resources: CMS MLN Article SE 9119

- "Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services"
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf
  - In accordance with its references to Transmittal 92 and 208 in the CMS IOM Publications 100-01, *Medicare General Information, Eligibility and Entitlement Manual* and 100-02, *Medicare Benefit Policy Manual*

References and Resources: Change Request 9189

- The purpose of this Change Request (CR) is to manualize policies in the calendar year 2015 Home Health Prospective Payment System Final Rule published on 11/6/2014, in which the CMS finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R602PI.pdf

Resources – Home Health Regulations

CMS IOM Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 7

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 10

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf

CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 6

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf

Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services"

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9119.pdf

  In accordance with its references to Transmittal 92 & 208 in the CMS IOM Publications 100-01 and 100-02

References and Resources

- HH PPS web page
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html
- Medicare HHA website
  - https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- Medicare Learning Network® publication, “Home Health Prospective Payment System”
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-PPS-Fact-Sheet-ICN006816.pdf

CMS Resources - TPE

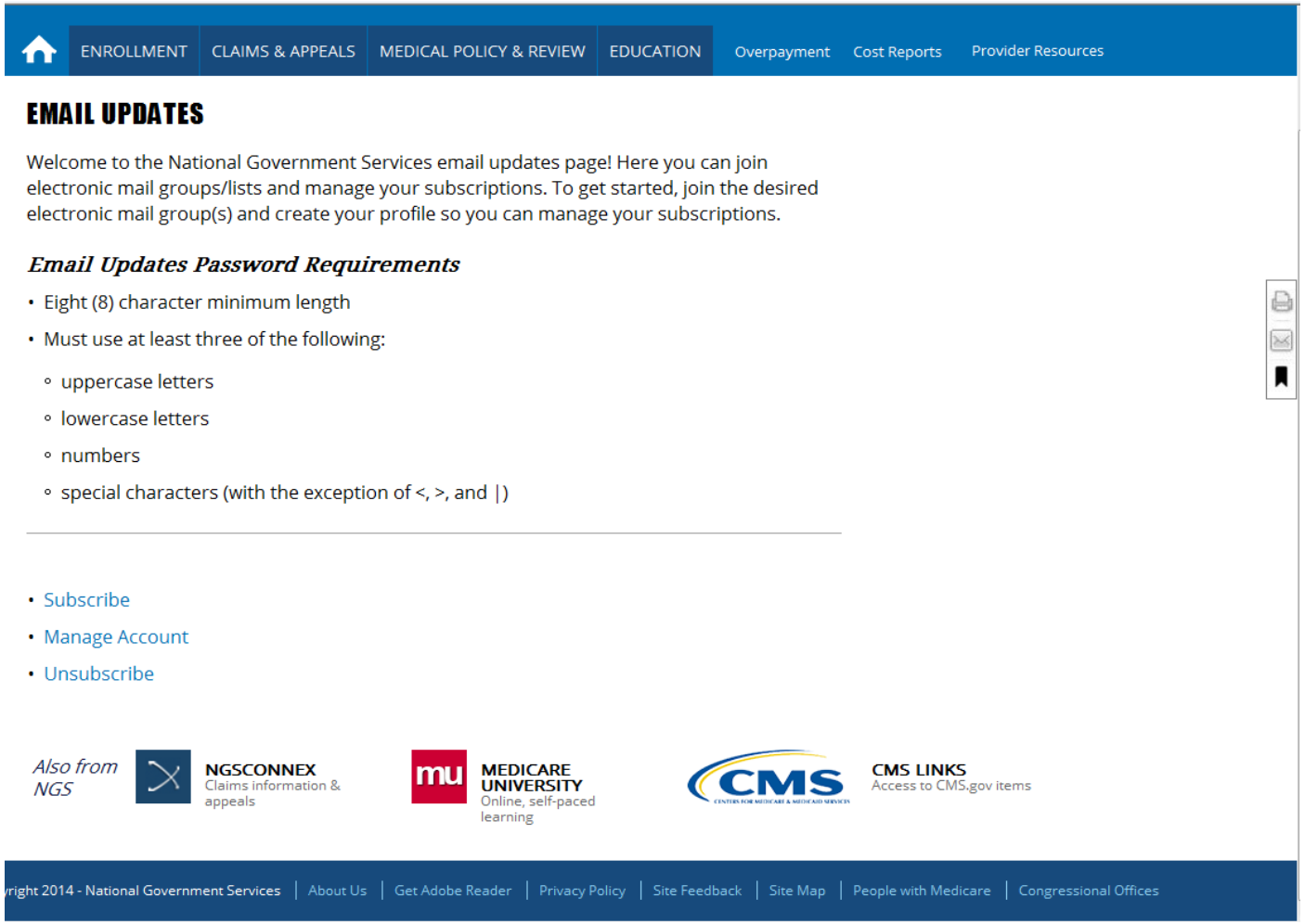
- CMS website
  - Change Request 10249, Transmittal 1919 “Targeted Probe and Educate”, effective 10/1/2017
  - CMS TPE Flow Chart
  - Home Health Medical Review
  - Reducing Provider Burden
  - Targeted Probe and Educate (TPE)

NGS Resources - TPE

- NGS website: https://www.NGSMedicare.com
  - Choose contract, then Medical Policy & Review tab > Medical Review > Targeted Probe and Educate
  - Choose contract, then News and Alerts > Home Health Medical Review and CMS Suggested Documentation Tools

Email Updates

- Subscribe to receive the latest Medicare information.



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