ENGAGE CONSULTING

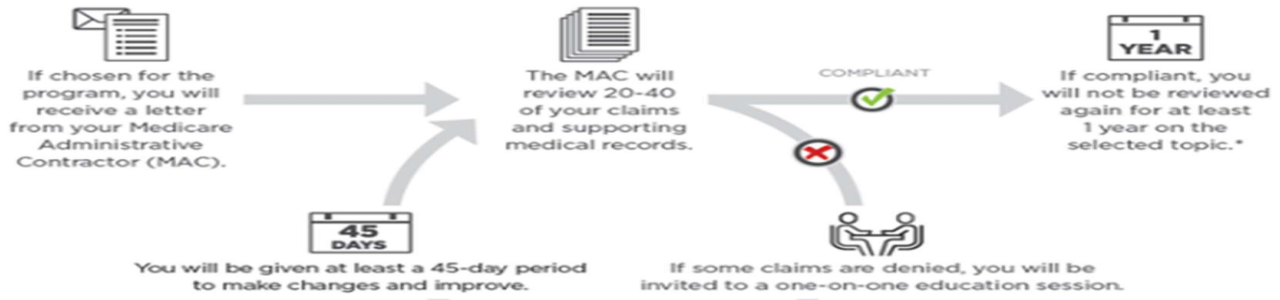
Targeted Probe and Educate Quick Guide

Two types of Target Probe and Educate Reviews
Traditional Targeted Probe and Educate: Designed to help providers and suppliers reduce claim denials and appeals through one on one help. Goal is to help providers quickly improve, and increase accuracy.
SNF 5 Claim Probe and Educate Review: Goal is to lower Skilled Nursing Facility (SNF) improper payment rates and help them avoid future claim denials and adjustments, through target review and education.

Traditional Targeted Probed and Educate Review

Who is selected?
MACs use data analysis to identify:
- Providers and suppliers who have high claim error rates or unusual billing practices
- Items and services that have high national error rates and are a financial risk to Medicare

Not every provider will be chosen for a review.



* Targeted Probe and Educate webpage, www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe

Following the review:
- One on one education will be provided if claims are denied
- Facilities who fail to improve after three rounds of TPE will be referred to CMS for further action, which may include:
  - 100% pre-pay review
  - Extrapolation
  - Referral to a Recovery Auditor (RA)
  - Other action

SNF 5 Claim Probe and Educate Review

Who is selected?
- MACs will review a small number of claims from EVERY Medicare-billing SNF in the country.
- Each facility will undergo only one round of review.
- If a facility is currently undergoing a traditional TPE, they will continue with that program, and will not qualify for a 5-Claim review for one year after being released from the TPE.

Sample Selection
- Reviews will be pre-pay, unless a post-pay review is requested by the provider due to financial burden.
- Five records will be selected.
- Facilities will have 45 days to submit the requested information.
- Claims containing a diagnosis of COVID-19 will be excluded if the dates of service are during the public health emergency.

Following the review:
- The MAC will send a detailed results letter, which will include claim-by-claim denial reasons.
- Facilities will be offered one-on-one telephone education.
  - If the error rate is 20% or less (1/5 claims in error) education will be widespread.
  - If the error rate is over 20%, more individualized training will be provided.

Helpful Links

Medicare Benefit Policy Manual, Chapter 8
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673

MDS 3.0 RAI Manual
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

Medicare General Information, Eligibility and Entitlement Chapter 3 10.4 Benefit Period
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c03.pdf

ENGAGE CONSULTING

Targeted Probe and Educate Quick Guide

Items to be Reviewed

Information which will validate the HIPPS score

PDPM HIPPS Billing Code	
1st Character	PT and OT case-mix group
2nd Character	SLP case-mix group
3rd Character	Nursing case-mix group
4th Character	Non-therapy ancillary case-mix group
5th Character	Assessment indicator code (0 = Interim payment assessment, 1 = 5-Day PPS assessment)

Information to support Medicare Part A technical requirements such as:

- Three-day qualifying hospital stay
- Medicare Secondary Payor (MSP)
- Physician certification and recertifications
- SNF ABN (if applicable)

Best Practices for Information Gathering

- Consider a TPE checklist to ensure all needed material has been gathered
- Consider a cover letter for ease of review which may include:
  - Dates of service
  - Reason the resident required skilled service
  - Where documentation to support each component of the score and each technical requirement can be found
  - Contact name and phone number at the facility

Recommended Information to Provide to the Reviewer

	Documentation to support each component of the HIPPS coded billed. (Include records for date of service and MDS look-back period.)
Physician Records:	
	All physician orders
	Signed physician certification and recertification
	Progress notes from admission through current billing
	SNF H&P performed by the physician. (If signed by an NP or specialist, also submit a statement verifying no direct or indirect employment relationship with the skilled nursing facility.
	Signature logs to indicate the identity and credentials for any hand-written documents
MDS:	
	Copy of Five-Day Assessment, and Interim Payment Assessment (if applicable)
	Transaction report confirming MDS was accepted in the National Repository. Delete identifying information for other residents contained on the report, if applicable. (Item request is MAC specific.)
Hospital Records:	
	Records validating qualifying stay
	Hospital discharge summary or transfer documentation, including therapy discharge summaries
	Any additional hospital records required to validate coding on MDS form (IV fluids, specific diagnoses active in the last 7 days)
Nursing Documentation:	
	Nurses' notes
	Pre-admission/screening documentation
	Admission assessment
	Resident plan of care
	Treatment records
	Medication records and graphic sheets
	ADL sheets, and additional supporting ADL documentation if applicable
Therapy Documentation:	
	Signed therapy orders
	Signed plan of treatment for each discipline
	Initial evaluation of all therapies
	Progress notes from start of care through dates of service billed
	Therapy daily treatment notes
	Therapy service logs
Other:	
	BIMS and PHQ2 to 9 (or appropriate alternate assessment per CMS RAI guidelines)
	Contact name, email, and phone number for questions related to this Additional Documentation Request (ADR)
	SNF ABN, if applicable
Keep an identical copy of the entire packet of information in the facility files.	