NARA Fall Conference 2022

Targeted Probe and Educate (TPE):

Why You Can't Afford to Not be Experienced

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NARA The National Association of Rehabilitation Providers and Agencies

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Learner Outcomes

- Explain the TPE process including notification expectations, steps associated with each round, and criteria for favorable completion.
- Apply understanding of TPE elements including discipline(s) under review, part A/B, pre-pay/post-pay to compile and organize ADR packets that will provide all necessary medical records to MAC for review.
- Develop strategies for risk assessment, ADR management, claim tracking, and appeals management (if needed).

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Starter Terminology

ADR: Additional Documentation Request

- Request for medical records for manual review to determine if the claim should be paid as billed.
- NOTE: An ADR is NOT a denial. But if the documentation doesn't adequately support what was billed on the claim, a denial will be issued.

MAC: Medicare Administrative Contractor

- A MAC is a private healthcare company that has been awarded a geographic jurisdiction to process Medicare claims.
- MACs include CGS, First Coast, NGS, Noridian, Novitas, Palmetto and WPS

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Starter Terminology

ALJ: Administrative Law Judge

- An ALJ hearing is the third (and usually final) level of appeal for Medicare denials
- The appeal argument is presented to a Medicare judge

TPE: Targeted Probe and Educate

- Audit process used by MACs to target outlier billing behavior and complete medical reviews of claims with those outlier metrics.

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Targeted Probe and Educate (TPE) According to CMS

"When Medicare Claims are submitted accurately, everyone benefits."

"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. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected."

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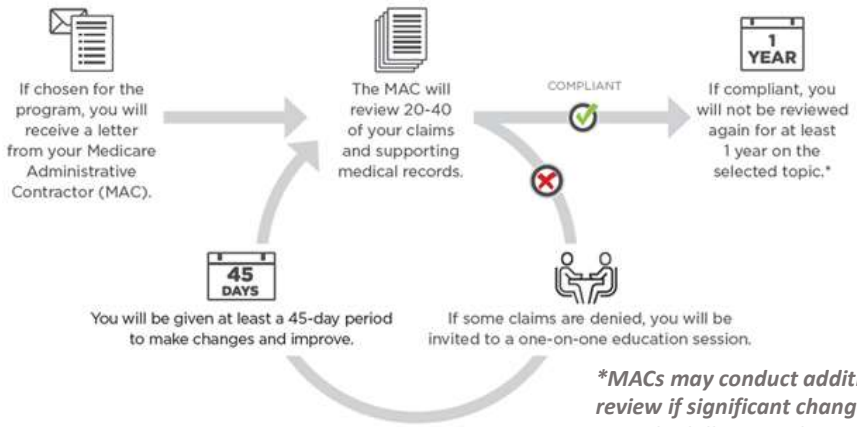
How the TPE Process Works



MACs may conduct additional review if significant changes in provider billing are detected

Source: CMS.gov

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TPE—Things To Remember

- TPEs are initiated to assess outlier billing practices, but being an outlier isn't necessarily a bad thing and doesn't mean you've done anything wrong.
- Medicare Administrative Contractors are only auditing through the TPE process. This means that if you receive an ADR from the MAC, you should automatically suspect you're under a TPE and take immediate action.
- Other CMS reviewing entities (SMRC, RAC, UPIC, CERT) are still doing individual ADRs. TPEs are something that only the MACs are doing.
- We have had facility partners clear their TPE after the first round with no denials. It can be done!
- Facilities/agencies should include their rehab staff and interdisciplinary team in their TPE process and let them assist. It's too big of a task to do alone.

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TPE Timeline Example—Growth of a Snowball

May	Receive TPE notification. 15 claims selected for Round 1 ADR.
June	Organize 15 Round 1 ADR packets. 10 more claims selected for Round 1 ADR.
July	Organize 10 Round 1 ADR packets. Receive 7 Round 1 ADR denials. Start writing Round 1/Level 1 appeal letters.
Aug	Receive 3 more denials and don't pass round 1. Receive education. Increase doc auditing and education efforts in order to pass Round 2. Send some Round 1/Level 1 appeal letters, still writing more.
Sept	Finish up the remainder of the appeal letters needed (10 sent in total). Receive 2 Unfavorable Round 1/Level 1 appeal decisions. Continue doc audits and other education efforts.
Oct	Start writing 2 Round 1/Level 2 appeal letters. Receive 12 Round 2 ADRs. Start gathering records. Receive 2 more unfavorable Round 1/Level 1 appeal decisions (4 total).
Nov	Finish organizing previous 12 ADR packets. Receive 13 more Round 2 ADRs. Start gathering records. Finish writing Round 1/Level 2 appeal letters. Receive 5 Round 2 ADR denials. Start writing Round 2/Level 1 appeal letters.
Dec	Receive 2 more Round 2 ADR denial and don't pass Round 2. Receive education. Modify education efforts to prepare for Round 3 (LAST ROUND). Continue writing Round 2/Level 1 appeals. Receive 2 Unfavorable Round1/Level 2 appeal decisions. Submit these for ALJ hearings (anticipate 3-4 year wait for hearing). Write ALJ appeal arguments now while details are familiar.

And on, AND ON… Even when the TPE is over, appeals continue until resolved.

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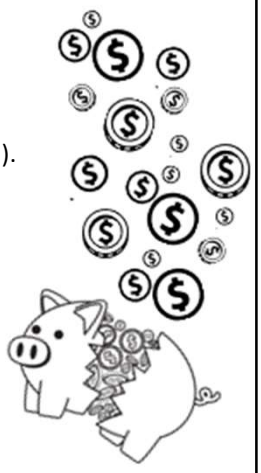
How Much Does a TPE Cost?

Poor TPE outcomes can have expensive consequences. Consider:

- Labor cost associated with managing the steps of up to three unsuccessful ADR rounds (20-40 ADRs each round).
- Labor cost of tracking, drafting and submitting/presenting up to three unique and compelling appeal arguments for every denial received.
- Trickle down consequences of lost focus on key performance metrics while focusing instead on TPE ADRs, appeals and education.
- Potential lost revenue associated with unsuccessful appeals.
- Labor cost and potential lost revenue associated with further CMS sanctions if the TPE isn't passed on or before the third round.



All available data supports investing time and effort early to pass TPEs in the first round.

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Which MACs are Doing TPE Auditing?

MAC	Posted/Known TPE Topics Related to Therapy
CGS	97110—pre and post-pay; SNF Part A (PDPM—anticipated but not yet initiated; HH (new providers and med necessity)
FCSO	SNF part B including 97110, 97112, 97140; IRF (CMG); OP (including 97110, 97112, 97116, 97124, 97140, and 97530)
NGS	CPT codes for PT Re-eval (97164), W/C Mgmt (97542), and Wound Debridement (97597/97598); SNF; IRF; HH (med necessity, HIPPS review, increased reimbursement), OP (PT/OT/ST billed with KX modifier)
Novitas	"Therapy" (97530 and 97110--could also include other CPTs); IRF
Noridian	None posted, but our customers have received TPEs related to increase in PT utilization by 35% and related to increase in OT utilization by 26%
Palmetto	SNF (97110, 97112, and 97140 billed with and without KX modifier); SNF Part A (HIPPS ID, IE, JD, KA, KD, KE); HH (general); OP (97110, 97112, 97140, and 97530)
WPS	IRF, inpatient SNF, and outpatient group therapy anticipated to start over the next several months; SNF part B

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TPE Variations

- Setting: SNF (Part A or Part B), HH, and outpatient
- Payment status: pre-pay or post-pay
- Triggers: Note that these are outlier triggers we've seen so far, but it may not be an exhaustive list of outliers targeted.
  - Discipline utilization: PT, OT and/or ST
  - LOS
  - CPT utilization (compared to similar provider or same provider/different time period)
  - HIPPS utilization
  - Use of KX modifier with a specific CPT
  - New provider billing
- Number of audits per round: 20-40

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TPE Notification Letters

- If a TPE is only discovered when ADRs are received, providers can contact their MAC and request a copy of the notification letter.
- Notification letters will be sent by the MAC to providers via USPS.
- You will want to know if a notification has been mailed to your facility. Facility staff education may be needed.
  - Who opens the mail?
  - Will they know what to do/who to notify if they open a notification letter?
- Recommend that facilities/agencies share all notification letters with their rehab manager right away. The letter will likely provide important details about the TPE and may dictate some of the next steps.

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TPE Notification Letter Examples

First Coast is tasked with preventing inappropriate Medicare payments which is accomplished through provider education, training, and the medical record review of claims. First Coast performs data analysis on a regular basis on all providers that it services to assure compliance with the Medicare Program requirements.
Based on routine data analysis, First Coast has identified a potential aberrancy with your facility in regard to the billing of 97110-Therapeutic exercises to develop strength.

For 97110, between the paid dates of 02/01/2021 and 01/31/2022, your facility had an average payment per beneficiary of $[redacted] which is 22.50% above the average jurisdiction payment per beneficiary of $[redacted]. Also, our data indicates that your facility had an average occurrence per beneficiary of 35 which is 52.58% above the average jurisdiction payment per beneficiary of 23.

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TPE Notification Letter Examples

Reason for Review

A prepayment review has been initiated to probe a sample of your claims billed with the following code(s):

- Outpatient Occupational Therapy services
  - Review also includes any incidental services or add-on codes related to this service billed on the claim

Your facility was selected for review based on a six month to six-month comparative billing reports concerning of Occupational Therapy services. It indicates that your facility increased utilization of this service by 33% compared to your previous utilization data.

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TPE Notification Letter Examples

Reason of Review

Your facility was selected for review based on data analysis. A prepayment review has been initiated to probe a sample of 20-40 claims billed with the following CPT code(s):

- CPT 97110: – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.

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TPE Notification Letter Examples

Reason for Review

Your organization was selected for review based on Internal Data Analytics. A review has been initiated to probe a sample of your claims billed for the following:

- JJ - SNF (HIPPS Codes ID, IE, JD, KA)

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Pre-Pay vs Post-Pay Significance

- Pre-pay TPEs may require several months to pull enough claims to complete the 20-40 claim sample size. Use the time between waves of ADRs wisely. Keep educating and monitoring documentation. If a patient's claim is selected one month and the patient is still on caseload the following month, there is a high likelihood the same patient will be selected for the subsequent month in the next wave of ADRs.
- If the TPE facility/agency is behind on their billing, pre-pay could still represent older claims. If you know your TPE is pre-pay, consider what month of service was most recently billed to Medicare. Note that there is no advantage to holding claims. It will only delay the overall process.

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Pre-Pay vs Post-Pay Significance

- Post-pay TPEs may involve older claims, but only for the first round. If a second round is needed, the claims selected for round two *should* be claims billed after the education was provided and the after the TPE is officially resumed with the initiation of Round 2. Documentation auditing and subsequent education efforts should be initiated immediately after TPE notification just in case a second round is needed.

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Possible Part A ADR Decisions

- Approve payment of claim as billed
- Approve payment at an adjusted rate by downcoding the HIPPS code based on:
  - Change in GG scoring, which may change PT/OT clinical category and nursing clinical category
  - Change in I0020B, which may change PT/OT clinical category and/or SLP clinical category
  - Change in SLP clinical category due to lack of support for section K0100A-D MDS entries, for speech comorbidity diagnoses, or mechanically altered diet
  - Change in nursing clinical category due to lack of support for corresponding diagnoses, conditions and/or interventions
  - Change in NTA clinical category due to lack of support for corresponding diagnoses, conditions and/or interventions

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Possible Part A ADR Decisions

- Deny payment for all or a portion of the dates in question due to criteria for (skilled) part A stay not being met
- Deny payment for all or a portion of the dates in question due to lack of medical necessity
- Deny payment due to invalid part A (facility) certification and/or recertifications

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Part A ADR Components

ADR packet should include (legible copied/printed) medical records that support:

- The HIPPS code captured by the MDS—the MDS coordinator should deconstruct the HIPPS code, identify what components contributed to the HIPPS code and ensure that supporting documentation for every component of each clinical category is included.
- The need for 24-hour skilled level of care in a SNF for the dates in question—ideally there will be support in nursing and rehab (if provided) documentation
- Skilled therapy services (if provided)—documentation should indicate that the services required the expertise of licensed rehab professionals
- The resident's need for these specific services at this point in time (medical necessity)

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Part A ADR Components

Additional documents required include:

- MDS
- Valid part A (facility) cert/recerts—dates within acceptable range, signed by physician or acceptable non-physician provider (SNF should obtain and submit delayed certification documentation/attestation if needed)
- Physician orders
- Signature logs (if handwritten signatures are present in the medical record and illegible)

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ADR Checklists

- ADR checklists are helpful resources to have and use. Consider creating unique checklists for each of your organization's settings and/or payor types
  - SNF part A
  - SNF part B
  - Outpatient
  - Home Health
- Recommend incorporating:
  - A bulleted list of items that should always be submitted with an ADR
  - A bulleted list of other possible records that may support medical necessity/need for skilled services
  - Helpful reminders (e.g., review documents for required/timely/legible signatures and prompts to include signature logs and or attestations or delayed certification documentation as needed)

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ADR Checklists

ADR checklists:

- Reduce the risk of accidentally omitting required medical records or other supporting documents
- Facilitate a well-ordered packet that will make it easier for the reviewer to find what they need to reach a favorable conclusion quickly and move on to their next review

NOTE:

- Checklists should be used as helper documents only and should NOT be submitted with the ADR packet
- MACs/Payors will sometimes provide a list of required documents—these instructions should be followed

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Possible Part B ADR Decisions

- Approve payment of claim as billed
- Partially deny based on medical necessity or skilled services expectations by disallowing:
  - All services provided by one or more disciplines
  - Specific dates of service for one or more disciplines
  - Specific CPT codes billed (as a whole or on specific dates)
- Partially or fully deny claim due to invalid part B certification(s)
- Deny entire claim based on medical necessity or skilled services expectations

Of the part B denials we have received over time (not just related to recent TPEs), nearly all are related to documented support of skilled services.

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Part B ADR Considerations

Thoughtfully consider what disciplines' documentation should be sent and what pieces of documentation from those disciplines should be sent.

- Remember that progress-type notes support all services provided since the previous note (or eval if the first progress-type note). If services continued beyond the dates under review, the first UPOC/TPN completed in the following month is typically needed to support the dates of service at the end of the month in question.
- Additional notes *may be* included **if** they are believed to support the case for payment of the dates of service under review.
- CPT target for selection may be different than the reviewer's focus for the review. If 97110 billing is the targeted metric for the TPE, you can assume that they won't be reviewing ST documentation. However, you should also assume that they **will be conducting a full review of PT/OT documentation for all CPT codes** and not limiting their scope to only 97110.

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Part B ADR Considerations

- Make sure all part B (therapy) certs/recerts are valid (signed and dated timely)—if not, include fully completed delayed therapy certification form and signature log.
- Rehab staff should be involved in this process. Extra help is always beneficial and they're more likely to notice if supporting documentation is missing based on what they know/remember about that patient and the care that was provided.

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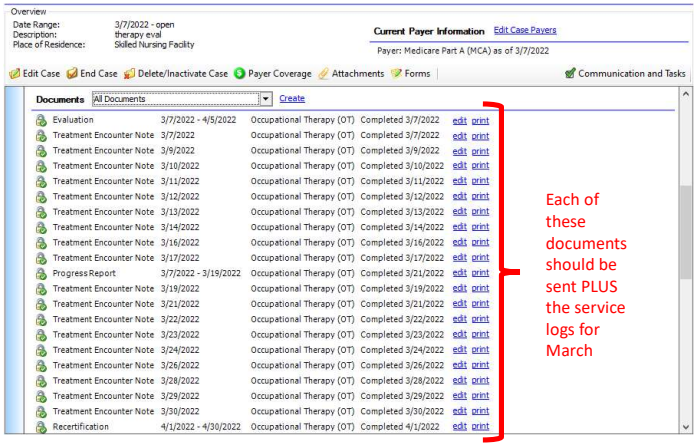
ADR: When to Send Extra Therapy Documentation

Review DOS are:

3/7/22-3/30/22

What would you send?



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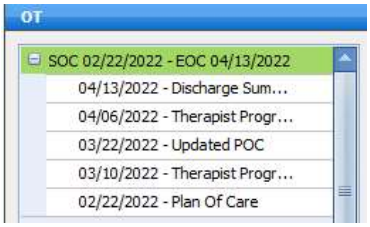
ADR: When to Send Extra Therapy Documentation

Review DOS are 2/22/22-2/28/22

What would you send?



Received second ADR to review DOS of 3/1/22-3/31/22

What would you send?

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TPE Passing Criteria

- The error rate passing threshold may vary by MAC. This threshold has not been disclosed by most MACs. Sources have speculated that it could be as low as 10% for some MACs and as high as 25% for others.
- Error rate could be calculated based on overall claim error %, claim dollar error %, or both.
- Consider this example:
  - 6 partially denied claims ($8,000 in denied services)
  - Sample size = 20 claims ($100,000 in total services billed)
  - Overall claim error rate = **30%**
  - Claim dollar error rate = **8%**

*Palmetto reported on a webinar in April that they require an error rate of 20% or less for BOTH claim error rate and $ error rate to pass.

Takeaway: There are no certainties.

Don't bank on having some degree of cushion. Aim for an error rate of 0%.

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TPE Appeals

Note that ADRs are not just a TPE exercise used to determine pass/fail status. Resultant denials from TPE ADRs **are real denials of payment**. They will require one or more appeals to obtain reimbursement (if successful).

Medicare Appeals

- 1st level appeal—due within 120 days of denial from ADR decision
- 2nd level appeal—due within 180 days of denial from 1st appeal decision
- 3rd level appeal—ALJ Hearing must be requested within 60 days of 2nd appeal decision

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TPE Appeals

- Many of our facility partners want appeal letters to be written quickly. We do our best to accommodate those requests, but not at the expense of appeal letter quality. It's important that we send the best possible appeal argument we can for every appeal level, and sometimes complex arguments take extra time to compose.
- Encourage collaboration between rehab and facility/nursing staff (if SNF/IRF/HH). Perspective from both entities can be beneficial when developing appeal strategy and constructing the appeal argument.
- Recommend tracking incoming ADRs and outcomes from ADRs and appeals. Information is typically delivered via USPS but should be available even sooner by monitoring the status of the ADRed claims on the MAC's online portal and/or in FISS/DDE.
- The appeal deadline countdown may begin on the date of the decision letter or on the date the claim processed (remit date)—check with your MAC. Don't miss appeal deadlines!

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TPE Best Practices

- If you receive a TPE—Take action immediately, notify interdisciplinary team, begin risk assessment and provide education as appropriate.
- TPEs have unique qualities. Be certain that you understand the process and what is expected of you by the MAC. Regardless of previous experience with probe reviews, ADRs, and/or denials, seek guidance and assistance when navigating the TPE process when needed. Additional rounds can negatively impact labor hours and revenue dollars and should be avoided.
- Leverage resources (e.g., MAC Portal access, facility and rehab team expertise, consultants, your assigned contact at the MAC, etc.)
- If one or more ADRs result in denial, do not wait for the round to end or for a paper copy of that ADR decision to arrive in the mail before appealing. Appeal deadlines from early processed ADRs could pass while you wait.
- Providers/agencies should always say YES to the education call offered between rounds and should invite their rehab manager to the call.

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Pre-TPE Action Steps

- Even if you're not under a TPE, talk about TPEs often with the individual(s) that open/sort mail, billing department staff, MDS coordinator(s), and rehab manager(s). Have tentative plans in place and maintain awareness and readiness.
- Consider assessing TPE risk before you receive a TPE notification by evaluating your potential outlier and denials risk. Recommend:
  - Doing chart audits to assess:
    - Documentation quality
    - Signature compliance
    - MDS accuracy
  - Running Comparative Billing Reports through your MAC's online provider portal (if available). This could also be an excellent source of data when assessing potential risk of being an outlier.

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Post-TPE Action Steps

- Denial risk assessment should begin ASAP after receiving TPE notification
- LOS may be a significant contributor to claim selection for ADRs. However, it would not be appropriate to end part A episodes of care or discharge patients from therapy caseloads based solely on current LOS. If services are needed and appropriate, they should be provided, but steps should be taken to ensure the provided services are well supported in the documentation.
- Recommend that providers/agencies work closely with their rehab manager. Apply what is known about the TPE selection (discipline(s) under review, outlier target, pre-pay vs. post-pay) to develop a focused and efficient strategy to promote a favorable outcome from Round 1.

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How to Check DDE for ADR

- Suspended claims with a request for ADRs are held in the claim system under location S B600 or S B6001. To search for all claims in a particular status location:
- Enter your NPI and the status location (S B6000/S B6001).
- Choose Claims option 12.
- Place an "S" in the SEL field in front of the desired claim and press enter. If an ADR is pending, the information will appear beginning on claim page seven.
- See the DDE User's Manual for Medicare Part A for additional information on accessing DDE.

*These instructions are posted on the Noridian website, but would apply to all providers, regardless of MAC assignment.

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Takeaways from our Current TPE Experiences

- There used to be a 4–6-week lag between TPE notification and the initiation of the ADR process. Not anymore! We've had two customers receive 8-10 ADRs within 2 weeks of notification.
- Preventable mistakes are extra painful and costly! The ADR process can be tricky if it is new to you. Get help if you haven't navigated it before. Rehab and facility staff should collaborate. Missing documents = denials. If this happens on multiple claims, it can also result in another TPE round.
- Check for required signatures
- Double check signature dates to make sure the document was signed timely
- Include all required documents
- Don't miss deadlines! There are many deadline calculators available, but Palmetto's version for calculating ADR deadlines and CGS's version for calculating Level 1 and Level 2 appeal deadlines are better than most.

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Takeaways from our Current TPE Experiences

- Be on the lookout for repeat selection of the same patients in subsequent months. This is happening a lot. Avoid denials on the same patient several months in a row by auditing documentation and providing education (if needed). If you know they're looking at that patient, you should be too. Be ready!
- Maintain well-organized records.
  - Develop a system to track ADRs, deadlines, and outcomes.
  - Check in daily or every few days for updates from the online portal. Watch for changes in claim status to identify claims selected for ADRs and outcomes of ADRs. This is the fastest way to get the details needed to keep moving forward.
  - Store ADR notifications, decisions, and MAC correspondence in an online folder. You never know what records might be important down the road. Save everything in labeled folders so you can easily find it if/when needed.

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Takeaways from our Current TPE Experiences

- Recommend submitting ADRs and/or appeals electronically when able.
- If you must submit via mail, remember:
  - Medicare submission dates are hard deadlines. There is typically little to no forgiveness for lateness.
  - A submission deadline is the date on which the ADR or appeal must be received (and sometimes logged) by the reviewing entity. A postmarked mailing on the date of the deadline will be considered late.
  - When a submission deadline falls on a weekend or holiday, you should consider the workday that directly precedes that date to be the deadline.
  - Mail all submissions with tracking and delivery confirmation. Maintain mailing slips, and tracking records. Access and save copies of delivery confirmation details.
- Allow extra time for technology issues—even if faxing or submitting electronically. Don't wait until the last day!

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MAC Specific Details—CGS

- 56900—When an ADR deadline is missed, CGS will deny the claim with reason code 56900 (no records received) on the first day after the missed deadline (day 46). (https://cgsmedicare.com/parta/dyk/mr.html)
- **All deadlines should be monitored closely and met.** But, if a 56900 denial is received from CGS, you will have 125 days from the date on the remittance advice to submit the requested documents to the Medical Review (MR) Department.
- If records are received within the 125-day time frame, the medical review department will review, make a determination, and adjust the claim accordingly. If you are beyond the 125-day time frame, you may request a redetermination (first level of appeal).
- 56900 denials should be remedied immediately with submission of the ADR packet (don't wait the 125 days). If the packet is submitted quickly, the denial *may* be reversed before the close of the TPE round and it *may* not negatively affect the error % rate.
- None of our SNF partners have received a TPE from CGS.

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MAC Specific Details—First Coast (FCSO)

- We had several SNF facility partners receive part B TPEs from First Coast.
- Our observations/outcomes:
  - Both providers received 40 ADRs for their first round
  - Both were selected based on 97110 utilization data
  - Both passed in Round 1 with 0% error rates
  - Both providers requested and were granted extensions to complete the record gathering for the 40 ADRs.
- FCSO strongly encourages the use of their portal (SPOT) for the following:
  - Submit ADR packets and redetermination appeals using secure messaging
  - Request and view Provider Data Summary and Comparative Billing Reports

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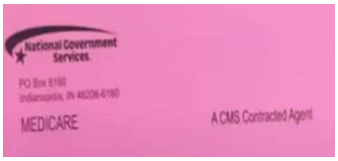
MAC Specific Details—National Government Services (NGS)

- NGS strongly encourages providers to submit ADRs electronically through their portal (NGSConnex)
- Electronic ADR submission will allow you to readily view and monitor:
  - Date documentation was received
  - Date the nurse started to review your documentation
  - Date the nurse completed the review of your documentation
  - Nurse review decision
  - Appeals outcome



- None of our SNF partners have received an NGS TPE yet

Per their website, NGS uses a bright pink envelope to mail TPE notifications.

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MAC Specific Details—Noridian

- Noridian has many educational videos posted on their YouTube channel. The video entitled "Additional Documentation Request (ADR) Responses" (accessed at: https://youtu.be/DWldgrL6-9o) provides information on all ADR submission methods and also demonstrates how to use the Noridian Medicare Portal (NMP) to access ADR notifications, monitor ADR status, and access ADR decisions.

- Our Noridian TPE experience: We have had several SNF partners pass round one of their part B Noridian TPE with a 0% error rate.

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MAC Specific Details—Novitas

- None of our SNF partners have received a TPE from Novitas.
- Results posted on the Novitas website report that the most common denial/partial denial reasons issued for the current "therapy services" TPEs (TPE Edit #5H3A1) are:
  - Medical necessity - The documentation submitted does not support medical necessity as listed in coverage requirements.
  - Insufficient documentation – Insufficient documentation was provided to support the services as billed to Medicare.
    - Insufficient documentation of signed initial certification/recertification.
    - Insufficient documentation of signed therapy progress notes/daily treatment notes. completed by a licensed therapist at least every 10 treatment days to support services billed.
    - Insufficient documentation of therapy evaluation/plan of care to support services billed.
    - Insufficient documentation to support number of therapy minutes/units billed.

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MAC Specific Details—Palmetto

- We have several facility partners in the early stages of a part A TPE with Palmetto.
- Some observations so far:
  - The reviewers have shown a willingness thus far to reach out during the ADR process and request extra records that were identified as missing, which has been appreciated but should never be expected to occur as a safety net.
  - Denials so far have been incredibly vague—"Documentation does not support medical necessity." The more detailed decision will come on the TPE results letter at the end of the round. If desired/needed, Palmetto TPE contact person will read the official results for any decision over the phone (they aren't permitted to email any PHI).
  - 56900 DENIALS: A provider can submit ADR packets for 56900 denials within 120 days of the ADR letter.
  - Providers may request a recalculation of their error rate if denials are overturned on appeal. The recalculation could end your process early if the rate falls below the threshold.
  - Palmetto's online portal also allows providers to run and view Comparative Billing Reports.

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MAC Specific Details—Wisconsin Physician Services (WPS)

- ADR packets for 56900 denials should be submitted through the redetermination appeal process. If submitted timely (within 120 days), the records will be rerouted back to medical review for a reopening.
- The following TPE results were posted on the WPS website on 9/6/22: "Outpatient Therapy for CPT 97110 has a trending error rate of 52%. The top reason for denial is documentation does not support the skills of a licensed professional therapist. It is important for providers to remember that documentation is key when supporting skilled therapy. Asking the following questions of the documentation may assist in claim payment:
  - Does the plan of care relate to the initial evaluation and reason for referral?
  - Is the patient meeting or actively working towards the established treatment goals?
  - Does the therapist need to adjust the goals to meet the current functionality and/or the expected functionality of the patient?"
- We have several facility partners in the early stages of a part B TPE with WPS.
  - One was selected based on 97110 utilization, the other for OT utilization.
  - Denials received have been primarily related to skilled services.

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Final Thoughts

- If you are selected for a TPE, develop a collaborative approach involving the IDT in your process.
- TPEs can be managed effectively and efficiently and can be passed in a single round with no denials. But they can also be incredibly difficult, time consuming, and costly if they are not successfully managed.
- Maintain readiness by:
  - Developing plans and auditing systems before ever being selected for a TPE
  - Reviewing your TPE plan with involved staff regularly. Make sure staff understand what is at risk if a TPE is unsuccessful.
- When in doubt, seek answers!

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Thank you!

Questions?

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