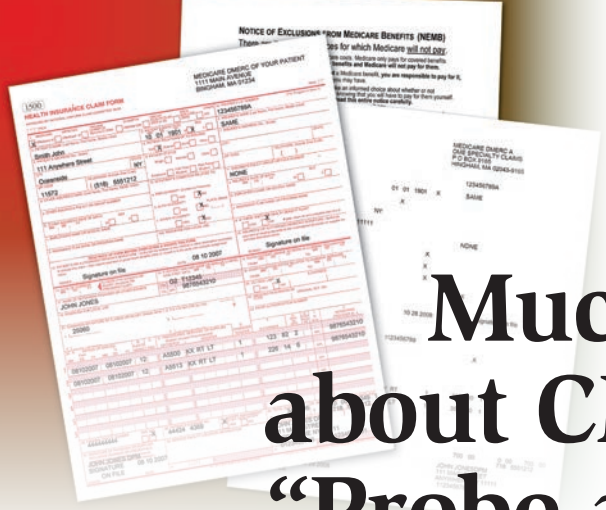

Much to Fear about CMS' Targeted "Probe and Educate"

Welcome to Medicare's new age of auditing.

BY PAUL KESSELMAN, DPM

This past summer, CMS introduced a significant change in the way it would educate (AKA audit) all healthcare providers. Currently, audits are conducted wide-scale based on specific CPT or HCPCS codes. These are random audits of large numbers of providers, based only on the specific CPT/HCPCS code. These audits are based on the "luck of the draw" and are on a claim-by-claim basis. They do not necessarily take into account the frequency of those services being provided. Medicare's new methodology for auditing will now target specific healthcare providers based on several factors. These include but are not limited to: frequency of specific service(s), high claim submission error rates, and those practices which failed multiple previous audits.

For DME suppliers, this new approach was initially welcomed as a reprieve and greeted as long overdue. For other providers, this was met with much skepticism. This month's column will review Medicare's new approach to auditing and whether or not this program will live up to its hype.

Beginning in 2014, Medicare began testing a pilot program which combined a review of claim samples with education aimed at reducing future errors in the claim submission process. CMS called this medical review strategy "Targeted Probe and Educate" (TPE). Because of the alleged success of this program, in July 2017, CMS announced it was expanding this program nationwide to all providers. With this announcement, it appears that CMS is ready to abandon its current system of wide-scale audits, targeting large numbers of providers based only on specific CPT or HCPCS codes. The wide-scale "random" audits of therapeutic shoe claims, targeting 4% of the total claims processed each day, appears to have ended. The same is true for routine foot care or house call claims. The Targeted Probe and Educate Program, as announced, instead will focus on only a subset of specific providers through data analysis of claims with follow-up ed-

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The current auditing system is flawed and does not work well for providers or contractors.

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ucational programs. Now, instead of being subjected to a "random" audit, your practice will be the subject of a targeted audit.

The rationale for Medicare's decision to abruptly change course on its auditing process is varied. Some experts suggest it is due to budget constraints for all administrative carriers. Others cite an increasing and insurmountable number of claims destined for appeals within the beleaguered Administrative Law Judge (ALJ) system. Still others cite increasing pressures from legislative offices and professional and consumer associations.

The Facts

The current auditing system is flawed and does not work well for providers or contractors. Change is most definitely needed. The number of DME claims rejected for incorrect or frivolous omissions has skyrocketed. DME claims now exceed 50% of all claims sent for review to Administrative Law Judges (ALJ). Waiting times of five years are the norm rather than the exception. This far exceeds the statutory requirements set by CMS. Despite lawsuits brought by prestigious associations (e.g., American Hospital Association) against CMS, waiting times and the number of cases waiting for ALJ hearings continue to increase. Doubling the number of ALJ officers may still not offset or reduce the waiting time for a hearing. CMS contractors have come under further scrutiny by CMS for failure to properly educate auditors. Contractors have complained that

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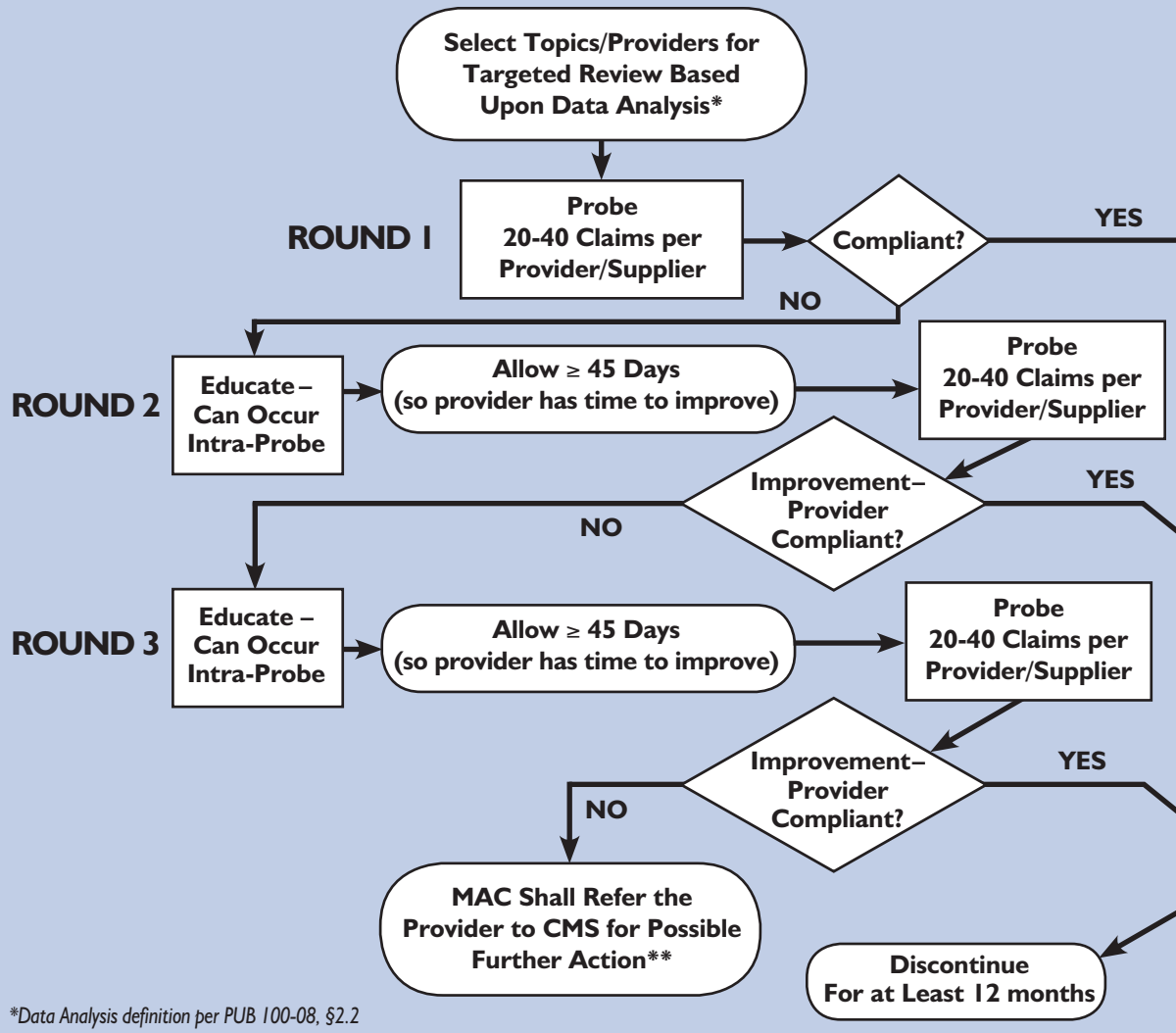
FIGURE 1:

Targeted Probe & Educate



**Data Analysis definition per PUB 100-08, §2.2*

***Further Action May Include Extrapolation, Referral To ZPIC/UPIC, etc.*

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they continue to face increased financial expenditures in order to comply with the more complicated and increasing number of CMS regulations.

How Exactly Will this New Auditing Process Work?

CMS contractors will now target providers billing a high frequency of specific billing codes (CPT and/or HCPCS), or those with the highest claim denial rate for a set of specific services or providers having failed previous audits. One can assume some the data CMS contractors will use is derived from those innocent Comparative Billing Reports (CBR) many have received over the last few years. CMS and its contractors will choose the specific CPT and HCPCS codes to audit based on those which continue to demonstrate the highest frequency of fraud, abuse, or misuse.

The exact workflow on the TPE was recently provided by CMS and is found in Figure 1.

For example, a CBR report may identify many podiatrists submitting a similar number of total claims to the same MCR contractor. From that data, the contractor may identify some practices submitting two hundred percent more therapeutic shoe or routine foot claims, or claims for mid-level office visits (CPT 99213) than other practitioners proximate to your practice location(s).

Carrier-wide or nationwide data may also be used to compare you to other podiatrists or similar suppliers. The practice with the highest frequency of providing specific services may now be targeted for a TPE audit. The CMS contractor could then request anywhere from 20-40 claims per round, for up to a total of three rounds, each six to eight weeks apart per CPT or HCPCS code. The CMS contractor for each round will request all pertinent materials from the provider to support those claims by a specific date. The contractor will then review the claims in a timely fashion and respond either favorably or unfavorably to the provider.

The contractor is also required to offer an in-service educational review with the provider addressing the errors found in the reviewed claims. The provider also has the option of asking for an educational review prior to the completion of a TPE. Depending on the outcome of the first TPE, the contractor may choose to schedule future audits six to eight weeks after its initial completion. Thus, favorable outcomes on a TPE, CMS officials have suggested, reduce a provider's risk of being subjected to future audits, whereas unfavorable outcomes will result in your practice being repeatedly targeted.

A solo or small group practitioner could literally be buried under a mountain of paperwork in order to comply within the required time frame.

What has been omitted is the requirement for responding to a TPE with a significant amount of documentation over a very short period of time. The implications for a small practice with few employees and few financial resources are enormous. A solo or small group practitioner could literally be buried under a mountain of paperwork in order to comply within the required time frame.

Let's examine how this can affect the average podiatric practice for DME and Part B physician services.

A) DME:

1) The most prominent pre-payment probe affecting most podiatrists is for claims associated with Therapeutic Shoes (A5500 and A5512/A5513);

2) Most podiatric suppliers would not have the 20-40 (possibly times 3) claims volume for Therapeutic Shoes in the short time frame stipulated by this new program. Thus, most podiatrists selected for a TPE may only be subjected to an audit on a few claims;

3) A small solo or two-partner podiatry practice would have a reduced risk of being subjected to a Therapeutic Shoe audit as compared to a large DME supplier (based solely on the CBR);

4) Conversely, large practices, especially those with a dedicated shoe store, could be buried under mountains of paperwork. But a large practice could afford the EHR/EMR consultant's fee necessary to successfully negotiate a TPE audit;

5) Should you be targeted for a TPE, you could be asked for the same documentation under the current pre-payment audit probes. Unlike the current system, if your charts are found to be non-compliant, your practice will continue to be subject to future audits, as no longer will the DME MAC only conduct "random" audits. Thus, you are now "Targeted".

6) The DME MAC will schedule in-office educational sessions with your staff, or your practice may opt to schedule them with the DME MAC.

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B. Local MAC Services

Here are some scenarios which may be of significant concern:

I. Routine Foot Care Services

A) Your MAC performs a TPE on at-risk foot care services (e.g., 1172X, 1105X, 11719);

B) Practices providing routine foot care services will be compared based on their respective CBR and

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either be selected or rejected for TPE;

C) If your practice is selected (either due to high numbers of claims for those CPT codes or high claim rate submissions errors for those CPT codes), your local MAC will request up to 40 charts per audit. Ultimately, your MAC could request up to 120 charts in a six-month period;

D) If you fail the first round of audits, the Local MAC will require an educational session with you and your staff, or again you may opt to schedule those at any time during the audit process.

II. CPT 99213

A) Your MAC selects to perform a TPE on established patient evaluation and management codes;

B) Podiatrists providing the highest numbers of those codes (e.g., 99212 and 99213) will be compared against one another based on their CBR. Your practice may be selected or rejected for TPE because it is providing an inordinate number of claims for those codes or has a high submission error rate for those CPT codes;

C) If your practice is selected, your local MAC will request up to 40 charts per audit; ultimately they could request up to 120 charts in a six-month period;

D) If you fail the first round of audits, the Local MAC will require an educational session with you and your staff, or again you may opt to schedule those at any time during the audit process

In all cases, those who fail a TPE, will either be forced to refund money on claims already paid (similar to a post-payment audit) or be denied on claims not already adjudicated (pre-payment audits). It is conceivable that should a practice fail multiple TPEs on multiple CPT/HCPCS codes, it may face mandatory pre-payment TPE reviews on all claims, extrapolation, referral to a recovery audit contractor (RAC), or other action.

On the other hand a practice which demonstrates competence on three or fewer rounds may actually be removed from the review process, should they demonstrate low error rates or improvement in error rates.

TPE's new approach can either be viewed as kinder and gentler (if you pass) or a more aggressive approach to auditing. Your viewpoint may also be based on the size of your practice and the services offered by your practice. As opposed to a "random" audit selection process, providers (or suppliers) will now be selected for audits based on how they score in comparison to other practices of the same or similar specialty for specific codes.

Each practice's billing patterns will be compared against other podiatrists in your community, MAC, and nationally.

Depending on the outcome of each round of your TPE, your contractor will either require an in-office one on one educational training session or your practice can opt to request this session during each audit round. A practice will not be required to wait until one or subsequent audits are concluded to ask your MAC for educational training. This part of the process seems very effective, but only if the auditors are well trained. Unfortunately, a recent experience by one prominent practice suggests that auditors can be poorly trained and provide inaccurate information. In this scenario, intervention by a high level MCR official was required to resolve the conflicts between the LCD and the misinformation provided by the auditors. On the bright side, having a contractor provide you with a free analysis and assistance is similar to having been provided with a free, no-cost consultant. The cost to your practice of providing up to 120 charts to a carrier may include dedicating a single employee, or the hiring of additional personnel, to facilitate providing the required documentation in such a short time.

There is cautionary advice to those who think they can fly under the radar screen by billing lower level CPTs or not billing for popular codes such as those covered under the "routine or at risk foot care" policies. Each practice's billing patterns will be compared against other podiatrists in your community, MAC, and nationally. CMS claims that TPE will be an opportunity for those with excellent documentation to prove that they are the "cream of the crop" and thus significantly reduce their exposure to future disruptive audits. On the surface, this sounds too good to be true. The reality is that most practices will see their burdens increased, despite perhaps a lower risk of audit for some.

After a thorough analysis, TPE sounds like another CMS program which may not live up to its intent. TPE sounds similar to the intent of the Paper Work Reduction Act (PPWA) when that was first initiated. Most readers know how that has turned out. Providers thus should continue to do their utmost to remain compliant and up-to-date on all LCD policy matters and do their due diligence on documentation matters. One can only hope that CMS is correct in their assertions, in that this new initiative will permit auditors to continue to identify abusive/fraudulent practitioners, while reducing the burden on honest providers. **PM**

Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.