Home Health Targeted Probe & Educate

PRESENTED BY:
MELINDA A. GABOURY, CEO
HEALTHCARE PROVIDER SOLUTIONS, INC.
WWW.TARGETEDPROBEANDEDUCATE.COM
INFO@HEALTHCAREPROVIDERSOLUTIONS.COM

CMS Targeted Probe & Educate

- CMS expansion on Probe & Educate is for Home Health and Hospice and will be effective 10/1/2017. This is referred to as Targeted Probe & Educate (TPE). This review will include targeted medical review and education along with an option for potential elevated action, up to and including referral to other Medicare contractors including the Zone Program Integrity Contractor (ZPIC), Unified Program Integrity Contractor (UPIC), Recovery Audit Contractor (RAC), etc.
- The goal of TPE is to reduce/prevent improper payments. The purpose of this expansion is to reduce appeals, decrease provider burden, and improve the medical review and education process.

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- All MAC medical record reviews are replaced with three rounds of pre-payment or post-payment TPE. If the provider's error rate remains high upon completion of the first round, then the provider is retained for the second and, potentially, a third round of review.
- Providers with a continued high error rate after three rounds of TPE will be referred to CMS for additional action

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- **Providers are selected based on analysis of billing data indicating aberrancies that may suggest questionable billing practices.**
  OR
- **Provider was already on targeted review and transitioned to TPE based on error rate results.**
  OR
- **Provider error rate results based on service specific review.**

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- **MAC will select the topics for review based upon existing data analysis procedures.**
- The claim sample size for each round of probe review is limited to a minimum of 20 and a maximum of 40 claims
- TPE processes include provider specific education that will focus on improving specific issues without allowing other problems to develop along with an opportunity for the provider to ask questions. Education will be offered after each round of 20 to 40 claims reviewed.

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- Upon completion of each round of review, providers with moderate to high error rate will be offered an individualized educational session. During this education session, an educator will walk through each claim found to be in error, as well as answer any questions regarding the policy or the TPE process. CGS offers webinars, which are web-based presentations using internet technology, and traditional teleconferences. We can offer other methods of direct communication if these methods are not convenient.
- The TPE review process includes up to three rounds of review with education. If there are continued high error rates after three rounds, CGS will refer the provider to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Discontinuation of review may occur if appropriate improvement, or an error rate below the target threshold is achieved during the review process.

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CGS Home Health Edits Active for TPE

HOME HEALTH EDITS

Review Topic	Description	Review Type	Status
Home Health Eligibility and Medical Necessity	This edit selects providers who submitted home health claims with errors as identified in HH probe and educate round 2.	Targeted Probe and Educate Prepayment Review	Active
LOS with Hypertension	This edit selects home health claims for providers who submitted diagnosis Hypertension and a length of stay greater than 120 days.	Targeted Probe and Educate Prepayment Review	Active
No response to ADR	This edit selects providers who fail to respond to ADRs (additional documentation requests)	Targeted Probe and Educate Prepayment Review	Active

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- **Tips for Success**
- Providers targeted for TPE will receive a notification letter about the upcoming review and additional development requests (ADRs) will be used for the specific claims selected for review.
  - **The letter will outline reason for selection**, overview of TPE process, and contact information.
- Providers should ensure that medical records are submitted promptly upon request.

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- **NOTE:** CGS does not recommend sending your documentation overnight via Fed Ex or UPS. If prompt mailing of your documentation is necessary to meet the due date, CGS recommends overnight delivery via the US Postal Service to the address above. Using myCGS to submit your documentation is also a option.
- **myCGS** is a free web portal that allows you to submit your ADR documentation directly to CGS, and will help to ensure a timely response to an MR ADR. For more information on submitting MR ADR documentation via myCGS, refer to the **myCGS User Manual, Chapter 7: 'Forms' Tab**. myCGS also provides a secure message confirming receipt of the documentation, and a second message confirming it was accepted.
- The **Electronic Submission of Medical Documentation (esMD)** process may be used as an alternative to mailing your documentation. For more information on the esMD process, refer to the CGS "Electronic Submission of Medical Documentation" Web page.

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- **RECEIPT OF DOCUMENTATION** – When your documentation has been received by CGS, the claim is moved from status/location S B6001 to S M50MR for review. Providers can monitor the S M50MR status/location in FISS, to verify that their documentation has been received by CGS. Confirmation of receipt is also provided when using myCGS to submit your documentation.
- **REVIEW OF DOCUMENTATION** – A CGS nurse reviewer will examine the medical records submitted to ensure the technical components (OASIS, certifications, election statement, etc.) are met, and that medical necessity is supported. CGS has 30 days from the date the documentation is received to review the documentation, and make a payment determination. For demand denials (condition code 20), CGS has 60 days from the date the documentation is received to review the documentation.

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- Provider nonresponse to medical records requests will count as an error.
- MACs may conduct a "related claim review" of services related to a denied claim and such reviews may be conducted outside of the TPE process.
- The TPE process does not replace or change appeal rights.

Home Health **PEPPER**

P Program for
E Evaluating
P Payment
P Patterns
E Electronic
R Report

Home Health PEPPER

Target areas – services and/or discharges considered vulnerable to improper payments

Provider specific

- **National**
- **State**
- **MAC jurisdiction**

Annual release – July 2017 - Update

Home Health PEPPER

HHA Improper Payment Risks

- PEPPER does not identify improper payments.
- HHAs can be at risk for improper payments.
- Target areas were identified based on review of the HHA PPS, review of studies related to improper payments, analysis of claims data and coordination with CMS subject matter experts.

Home Health PEPPER

PEPPER Data Restriction

- **Due to CMS data restrictions, the HHA PEPPER will not display statistics when the numerator or denominator count is less than 11 for a target area in any time period.**
- **Some HHAs may not see any data for some target areas or time periods.**
- **About 450 HHAs will not have a PEPPER available.**

Target Areas

Target Area	Target Area Definition
Average Case Mix	*Numerator (N):* sum of case mix weight for all episodes paid to the HHA during the report period, excluding LUPAs (identified by Part A NCH HHA LUPA code) and PEPs (identified as patient discharge status code equal to '06') *Denominator (D):* count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs Note: reported as a rate, not a percent
Average Number of Episodes	*N*: count of episodes paid to the HHA *D*: count of unique beneficiaries served by the HHA Note: reported as a rate, not a percent

Target Areas

Target Area	Target Area Definition
Episodes with 5 or 6 Visits	*N*: count of episodes with 5 or 6 visits paid to the HHA *D*: count of episodes paid to the HHA
Non-LUPA Payments	*N*: count of episodes paid to the HHA that did not have a LUPA payment *D*: count of episodes paid to the HHA
High Therapy Utilization Episodes	*N*: count of episodes with 20+ therapy visits paid to the HHA (first digit of HHRG equal to '5') *D*: count of episodes paid to the HHA
Target Area	**Target Area Definition**
Outlier Payments	*N:* dollar amount of outlier payments (identified by the amount where Value Code equal to '17') for episodes paid to the HHA *D:* dollar amount of total payments for episodes paid to the HHA

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Compare Targets Report, Four Quarters Ending Q4 CY 2015

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target count) in the most recent time period. Percentiles indicate how a home health agency's target area percent/rate compares to the target area percents/rates for all home health agencies in the respective comparison group. For example, if a home health agency's national percentile (see below) is 80.0, 80% of the home health agencies in the nation have a lower percent/rate value than that home health agency. The home health agency's Medicare Administrative Contractor (MAC) jurisdiction percentile and the state percentile values (if displayed) should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target area indicate that the home health agency may be at a higher risk for improper Medicare payments. The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Target Count/ Amount	Percent/Rate	Home Health Agency National %ile	Home Health Agency Jurisdict. %ile	Home Health Agency State %ile	Sum of Payments
Average Case Mix	Proportion of the sum of case mix weight for all episodes paid to the HHA during the report period, excluding LUPAs and PEPs, to the count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs	296	1.14	77.1	78.0	74.0	Not Calculated
Average Number of Episodes	Proportion of the count of episodes paid to the HHA during the report period, to the count of unique beneficiaries served by the HHA during the report period	284	1.30	13.9	7.6	10.6	$753,471
Non-LUPA Payments	Proportion of the count of episodes paid to the HHA that did not have a LUPA payment during the report period, to the count of episodes paid to the HHA during the report period	264	93.0%	44.9	34.8	81.7	$747,540
High Therapy Utilization Episodes	Proportion of the count of episodes with 20+ therapy visits paid to the HHA during the report period (first digit of HHRG equal to '5'), to the count of episodes paid to the HHA during the report period	22	7.7%	51.6	49.0	44.2	$111,702

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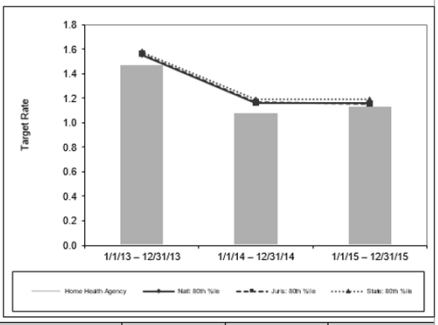
Link to Definitions Worksheet

Average Case Mix

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Rates over time resulting in greater risk of improper Medicare payments
- Your Target Rate (first row in the table below) is above the national 80th percentile



YOUR HOME HEATLH AGENCY	1/1/13 – 12/31/13	1/1/14 – 12/31/14	1/1/15 – 12/31/15
Target Area Rate	1.48	1.09	1.14
Target Count: (Numerator: sum of case mix weight for all episodes paid to the HHA during the report period, excluding LUPAs (identified by Part A NCH HHA LUPA code) and PEPs (identified as patient discharge status code equal to '06'))	172	204	296
Denominator Count (Denominator: count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs)	116	187	259
Denominator Average Length of Stay	46.4	50.1	50.8

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	1.56	1.16	1.16
Jurisdiction 80th Percentile	1.56	1.17	1.16
State 80th Percentile	1.58	1.19	1.19

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

Note: HHRG case mix weights changed (decreased) in CY 2014 from CY 2013

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Episodes with 5 or 6 Visits

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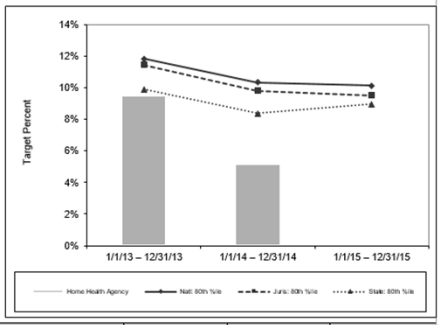

YOUR HOME HEALTH AGENCY	1/1/13 – 12/31/13	1/1/14 – 12/31/14	1/1/15 – 12/31/15
Target Area Percent	9.6%	5.2%	*
Target Count: (Numerator: count of episodes with 5 or 6 visits paid to the HHA during the report period)	13	11	
Denominator Count (Denominator: count of episodes paid to the HHA during the report period)	136	213	
Target (Numerator) Average Length of Stay	33.0	25.5	
Denominator Average Length of Stay	44.8	46.8	
Target (Numerator) Average Payment	$1,468	$1,174	
Target (Numerator) Sum of Payments	$19,084	$12,911	

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	11.8%	10.3%	10.1%
Jurisdiction 80th Percentile	11.5%	9.8%	9.5%
State 80th Percentile	9.9%	8.4%	9.0%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

Home Health Agency PEPPER
Top Diagnoses

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Home Health Agency Top Diagnoses, Most Recent Calendar Year
In Descending Order by Total Episodes

CCS Diagnosis Categories	Total Episodes for CCS Category	Proportion of Episodes for CCS to Total Episodes	Number of Visits for CCS Category	Average Number of Visits for CCS Category
Other aftercare	59	20.8%	1,079	18.3
Chronic ulcer of skin	23	8.1%	493	21.4
Congestive heart failure; nonhypertensive	23	8.1%	347	15.1
Rehabilitation care; fitting of prostheses; and adjustment of devic	22	7.8%	343	15.6
Other connective tissue disease	15	5.3%	349	23.3
Late effects of cerebrovascular disease	12	4.2%	200	16.7
Diabetes mellitus without complication	11	3.9%	151	13.7

Using the Information

- WHO should have the information?
- HOW should it be used?
  - Identifying where a home health is different
  - Understanding why a home health agency is different
  - Utilizing national and state data

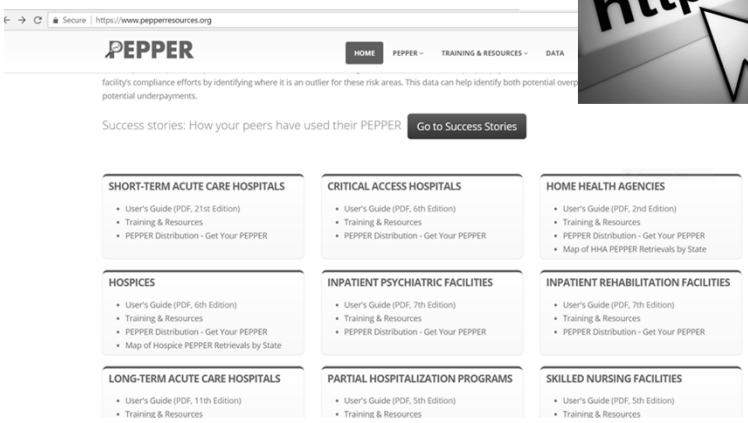
Using the Information

- Utilization review/quality
  - Consider selecting records for review from the numerator.
  - You may wish to further target records for review (e.g., readmissions, short stays, high therapy utilization, long stays, etc.).
- Billing errors
  - Patient discharge status, site of service, occurrence, condition codes; ancillary charges

Using the Information

- Compliance – support auditing, monitoring and benchmarking activities. – Audit results used to develop specific action plans for ensuring compliant documentation, providing education regarding admission/treatment necessity and improving coding accuracy.
- Preparation for Recovery Auditors

Where to Get The Report



Information Needed to Apply for Report

- What do I need to access PEPPER via the PEPPER Resources Portal?
- Six-digit CMS Certification Number (also referred to as the provider number or PTAN)
  - Not the same as the tax ID or NPI number
- For verification purposes: Patient Control Number (form locator 03a) or Medical Record Number (form locator 03b) from paid claim of traditional fee-for service Medicare beneficiary receiving services during the specified time period (see PEPPERresources.org Distribution page).

Melinda A. Gaboury, CEO
Healthcare Provider Solutions, Inc.
www.targetedprobeandeducate.com
info@healthcareprovidersolutions.com
615-399-7499

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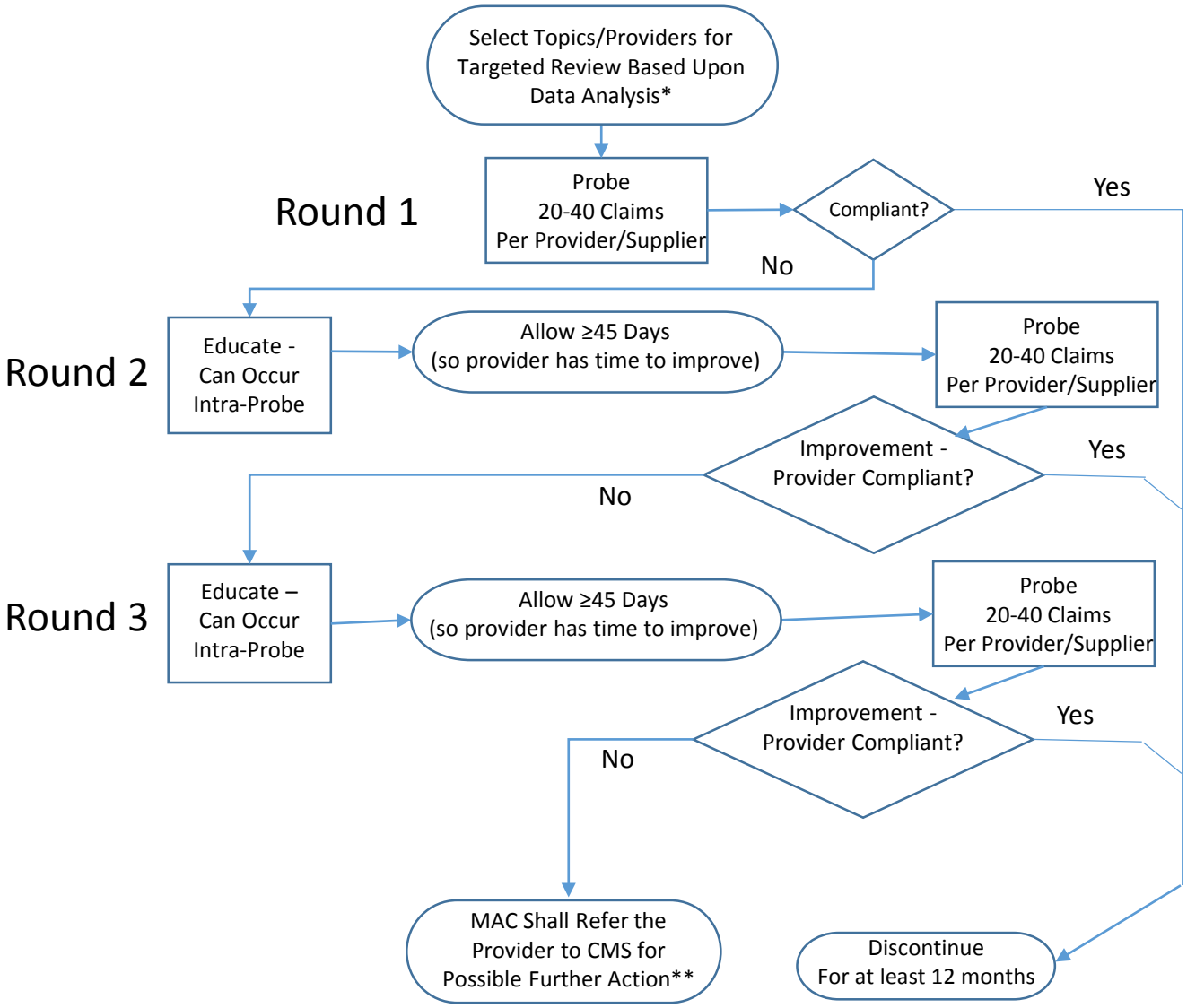

*Data Analysis definition per PUB 100-08, §2.2

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

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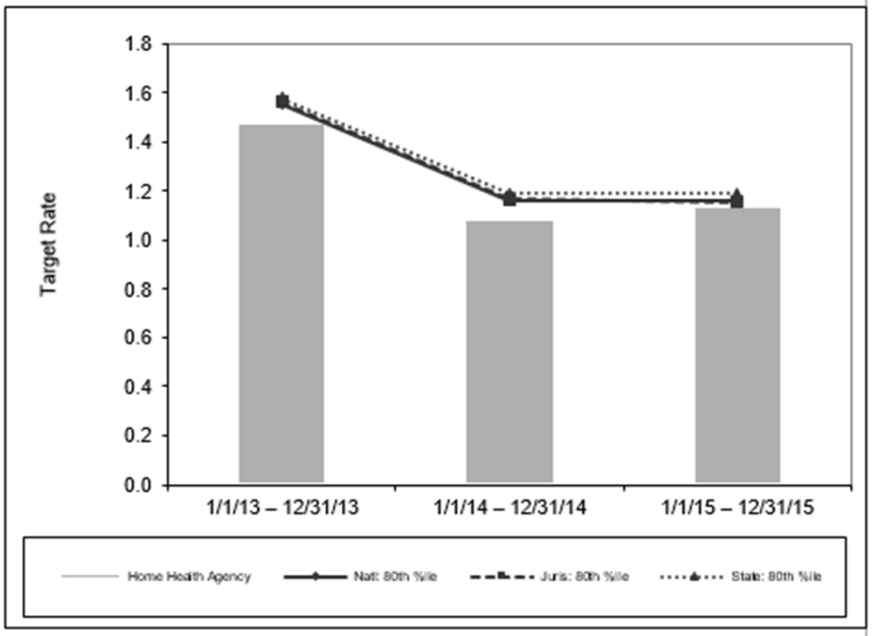

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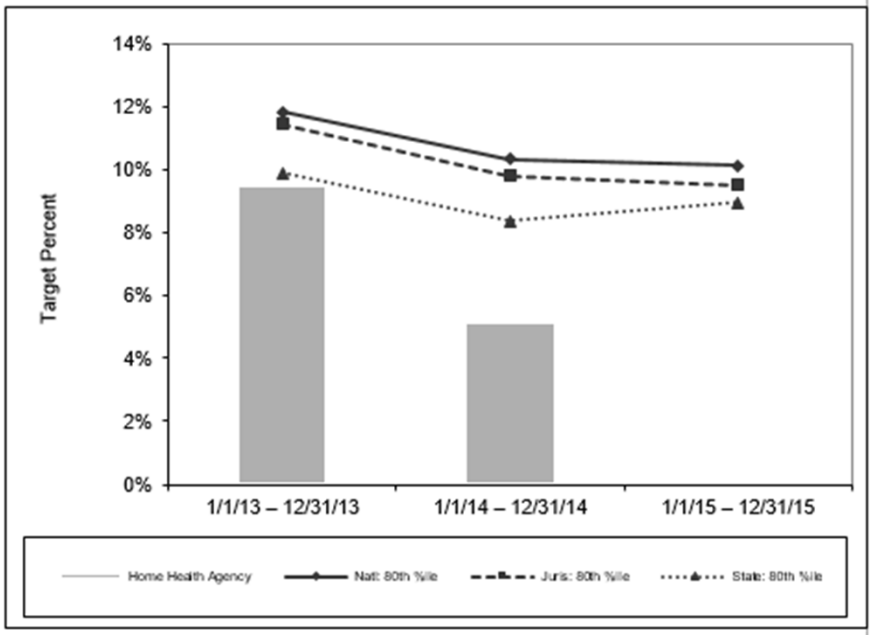

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