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Report on Medicare Compliance Volume 28, Number 18. May 13, 2019 Providers That Fail Three TPE Audits May Get a Fourth; CMS 'Pauses' QIO Short-Stay Reviews

By Nina Youngstrom

Some providers are audited a fourth time under Targeted Probe and Educate (TPE), according to CMS. When they don't improve their compliance after three audits of a billing error and education sessions with their Medicare administrative contractor (MAC), hospitals and other providers are referred to CMS—and that's been the case for 30% to 40% of Medicare Part A and B providers after the third round of audits, according to materials presented May 8 at CMS's National Provider Compliance Conference in Denver, Colorado. They then face a fourth audit. MACs have referred 25% to 35% of home health agencies and 15% to 25% of durable medical equipment (DME) suppliers that didn't pass the third round of TPE audits to CMS.

The fourth audits are a departure from the expected consequences of three failed audits under TPE, CMS's national medical review strategy. MACs start with a prepayment review of 20 to 40 claims, and there's round two and education for providers with "moderate and high error rates," and then wash, rinse and repeat if the errors persist. Providers that are still flunking after three rounds were originally told they would face extrapolation by CMS, referral to a recovery audit contractor or unified program integrity contractor (UPIC), or 100% prepayment review—but for now, at least, there's a fourth audit.

"The fact that CMS would not confirm that any provider has been referred to the RAC or UPIC should not result in providers letting down their guard," says Ronald Hirsch, M.D., vice president of education and regulations for R1 RCM. A CMS official disclosed the use of the fourth audit at the conference, Hirsch says. "I would recommend that providers continue to monitor their MAC's TPE issue list, and perhaps all MACs' lists, and perform internal audits."

Unfortunately for providers, when they win appeals of TPE claim denials during the discussion period with the MAC or a formal appeal, their denial rate isn't adjusted, Hirsch says. As a result, their TPE audits could continue even though they've been vindicated. However, he says a top CMS program integrity official said at the conference that CMS should be able to rectify this, although it wouldn't be easy.

One Contractor Will Take Over Short-Stay Reviews

Meanwhile, CMS has "temporarily paused" short-stay reviews and higher-weighted (HW) MS-DRG reviews, which are conducted by two Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs), according to an announcement from Livanta, one of the QIOs. Effective May 8, the reviews have stopped for "a brief time" while CMS hires a new contractor. "Two BFCC-QIOs have done HWDRG reviews since 2014 and Short Stay reviews since 2015 for all 50 states and 3 territories. Going forward, Short Stay reviews and HWDRG reviews will resume with a single organization performing reviews on a national basis. CMS anticipates a contract award to be issued by the 3rd quarter of calendar year 2019," Livanta said in an email.

Stephen Gillis, director of compliance coding, billing and audit at Partners HealthCare in Boston, says it's interesting that CMS is assigning all components of the audits to one organization for the entire country. "From an assessment consistency perspective it would seem to be good, but from a customer services perspective, I wonder if they will be able to meet or exceed current expectations," he says.

QIC Telephone Appeals Are Expanded

CMS's May 1 expansion of its pilot of telephone appeals at redetermination, which is the second level of appeals, also was discussed at the National Provider Compliance Conference. The door is now open to Part A and B providers for telephone discussions with qualified independent contractors (QICs), which allows the providers to provide verbal testimony in addition to written appeals, according to materials presented at the conference. The pilot began in 2015, when CMS permitted C2C Innovative Solutions, a QIC, to have telephone discussions with certain DME suppliers in jurisdictions C and D. Three years later, CMS added jurisdictions A and B, except for diabetic supplies. Now it's taking a big leap with a phone discussion and reopening process for far more provider types, which means cases may be remanded from administrative law judges to QICs, with the opportunity to add documentation and conversation. The first letters went out May 1.

CMS said the appeal categories include inpatient and outpatient hospital services, home health, skilled nursing facilities, outpatient therapy, pathology/laboratory, ambulance providers, partial hospitalization, inpatient and outpatient psychiatric services, and hospice.

A CMS official said the supplemental medical review contractor (SMRC) no longer does extrapolation of overpayments, Hirsch says. The SMRC's current audit targets are hospital outpatient dental services, spinal fusion, inpatient bone marrow and stem cell transplant procedures, specimen validity testing/urine drug screens, electrodiagnostic testing, general inpatient hospice, replacement PAP device supplies, and emergency ambulances. CMS also may instruct SMRCs to recoup payments from physicians who order DME after DME MACs deny claims for the supplies because the DME MACs are unable to get supporting documentation from the physicians, Hirsch says.

Another CMS official spoke about templates. CMS doesn't prohibit their use and they have many benefits. Templates standardize medical records, promote legibility and interoperability, and incorporate evidence-based care. But CMS warned against templates that are "focused primarily for reimbursement purposes" because they're "often insufficient to demonstrate that all coding and coverage requirements are met," according to materials from the conference. When physicians and licensed/certified medical professionals use templates during patient visits, CMS "encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coding and coverage criteria are met."

The pitfalls of templates include too many check boxes; no free text entry ability; the absence of subjective, objective, assessment and plan (SOAP) note elements; stock phrases that parrot coverage criteria; and cloned notes ("Copy Paste, Other EHR Shortcuts Threaten Integrity of Chart; CPT Changes May Help," *RMC* 28, no 17).

CMS mostly cited the problems with templates without presenting a solution, Hirsch says. Physicians will pay more attention to contradictory or inaccurate information in the medical records when their claims are downcoded or denied with more frequency because of documentation shortcuts in electronic health records, he says.

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