Targeted Probe and Educate (TPE):

Why You Can't Afford to Not be Experienced

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Content Disclaimer

The information shared in today's presentation is shared in good faith and for general educational information purposes only. It is accurate as of the date this slide deck was finalized. Providers should seek further guidance and assistance from CMS, their Medicare Administrative Contractor (MAC), commercial payers, state and national associations, and continue to watch for new developments and information regarding the topics discussed today.

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).

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.
- Current MACs are CGS, First Coast, NGS, Noridian, Novitas, Palmetto, and WPS

Starter Terminology

ALJ: Administrative Law Judge

- An ALJ hearing is the third (and often the 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.
- Up to three rounds of audits with 20-40 claims reviewed each round
- Providers are selected for TPEs based on billing data analysis

5 Claim Probe and Educate

- Audit process mandated in June 2023 by CMS
- One round of five part A claims will be reviewed
- Every SNF provider will receive one of these probes (not targeted)

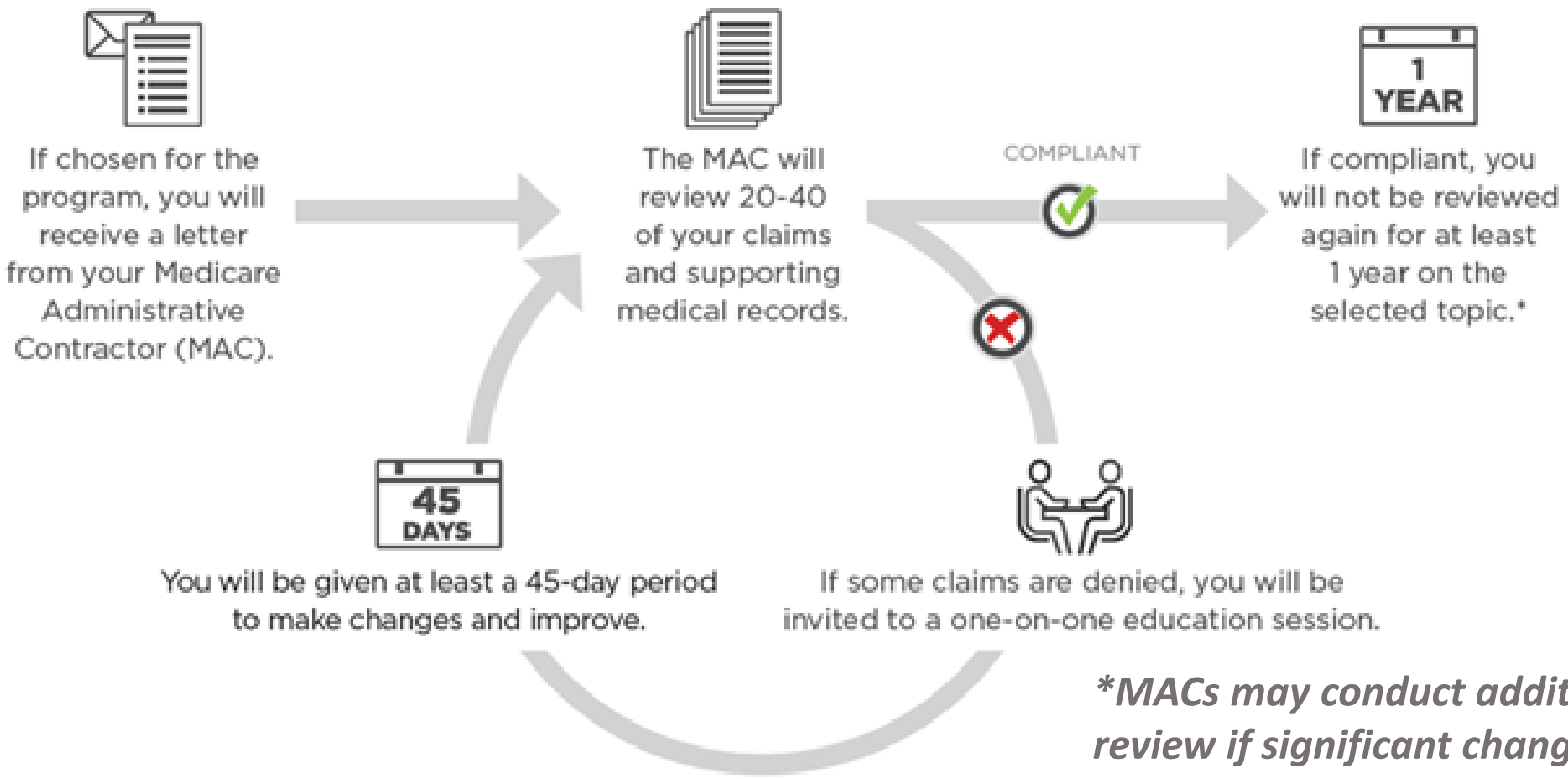
Targeted Probe and Educate (TPE) According to CMS

"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."

How the TPE Process Works



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

Source: CMS.gov

TPE—Things To Remember

- TPEs are initiated to assess outlier billing practices. Outlier status just means it's different from the average.
- Medicare Administrative Contractors are almost exclusively 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 (or under one of the five claim probe and educate reviews).
- Other CMS reviewing entities (SMRC, RAC, UPIC, CERT) are still doing individual ADRs. TPEs are something that only the MACs are doing.
- TPEs can be cleared after the first round with no denials. We've done it.
- Facilities/agencies should include their rehab staff and interdisciplinary team in their TPE process and let them assist.

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.

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 indicators 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.

Which MACs are Doing TPE Auditing?

MAC	Posted/Known TPE Topics Related to Therapy
CGS	SNF Part A (PDPM), SNF part B with and without KX; IRF; HH (new providers and med necessity), OP (97110, 97112, 97140, 97530, 92507-92612, KX)
FCSO	SNF part A (coming soon); SNF part B (97110, 97112, 97140); IRF (CMG); OP (97110, 97112, 97116, 97124, 97140, and 97530)
NGS	SNF part A (PDPM-med necessity); SNF part B (PT Re-eval/97164, W/C Mgmt/97542, Wound Debridement/ 97597/97598, KX); IRF; HH (med necessity, HIPPS review, increased reimbursement, LOS, Q codes); OP with KX
Novitas	SNF part B "Therapy"
Noridian	No specific topics posted. But in the past, our customers have received SNF part B TPEs for PT and OT and SNF part A TPEs
Palmetto	SNF Part B (97110, 97112, 97140, and KX); SNF Part A (HIPPS ID, IE, JD, KA, KD, KE); IRF; HH (general); OP (97110, 97112, 97140, 97530)
WPS	SNF part A (PDPM); SNF part B (97150, 97110, 97535); IRF

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
  - New provider billing
- Number of audits per round: 20-40

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.
- Have a system in place to recognize notification letter upon receipt and to communicate the news appropriately within your organization. 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?
- Notification letters will be sent by the MAC to providers via USPS.
- 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.

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.

TPE Notification Letter Examples

Reason for Review:

Novitas Solutions is tasked with preventing inappropriate Medicare payments which is accomplished through provider education, training, and the medical record review of claims. Novitas Solutions 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,Novitas Solutions has identified a potential aberrancy with your facility in regard to the billing of 97110-Therapeutic exercises to develop strength.

For 97110, between the dates of service of 01-FEB-2022 and 31-JAN-2023, your facility had an average payment per beneficiary of $440.39 which is 57.9% above the average jurisdiction payment per beneficiary. Also, our data indicates that your facility had an average occurrence per beneficiary of 26.8 which is 66.5% above the average jurisdiction occurrence per beneficiary.

A random sample of 20-40 claims will be selected for review to determine if you are billing and coding according to Medicare guidelines and to ensure services are reasonable and medically necessary.

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)

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 wisely.
  - Keep educating and auditing.
  - Be prepared for repeat selection of the same patients in subsequent months
- If the provider is behind on their billing, pre-pay could still represent older claims.
- There is no advantage to holding claims. It will only delay the overall process.

Pre-Pay vs Post-Pay Significance

- Post-pay TPEs may involve claims that predate the TPE notification, but only for the first round. If a second round is needed, the claims selected for round two will be claims for services provided after the education was received and the after the TPE is officially resumed with the initiation of Round 2.
- Even if a TPE is post-pay, documentation auditing and subsequent education efforts should be initiated immediately after TPE notification just in case a second round is needed.
- Rounds 2 and 3 may be either pre- or post-pay.

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

***Applies to part A TPEs and 5 Claim Probe and Educate**

Possible Part A ADR Decisions (cont)

- 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

***Applies to part A TPEs and 5 Claim Probe and Educate**

Part A ADR Components

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

- The HIPPS code captured by the MDS
- The need for 24-hour skilled level of care in a SNF for the dates in question
- Skilled therapy services (if provided)
- The resident's need for these specific services at this point in time (medical necessity)

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
- Valid Physician orders (signed and dated)
- Signature logs (if handwritten signatures are present in the medical record and illegible)

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)

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 also be followed

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 seen over time (not just related to recent TPEs), nearly all are related to documented support of skilled services.

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/Progress Note 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. For example, 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.

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/ attestation documentation and signature log.
- Rehab staff should be involved in this process.

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%.

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

- REDETERMINATION: 1st level appeal—due within 120 days of denial from ADR decision. Appeal submitted to MAC.
- RECONSIDERATION: 2nd level appeal—due within 180 days of denial from 1st appeal decision. Appeal submitted to QIC.
- ALJ HEARING: 3rd level appeal—Hearing must be requested within 60 days of 2nd appeal decision. Hearing request submitted to OMHA.

TPE Appeals

- Be efficient with appeals, but not at the cost of quality.
- Encourage collaboration between IDT collaboration for appeal argument development. Perspective from all entities can be beneficial.
- Recommend developing an organized tracking system for monitoring incoming ADRs and outcomes from ADRs and appeals.
- Don’t miss appeal deadlines!

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.
- Identify and leverage resources (e.g., MAC Portal access, facility and rehab team expertise, consultants, your assigned contact at the MAC, etc.)
- Start appeals right away.
- Always say YES to the education call offered between rounds and invite pertinent IDT members to join it as well.

Pre-TPE Action Steps

- Keep TPEs top of mind and talk about them often, even if you don't have one right now.
- Assess your risk. Recommend:
  - Completing chart audits to assess:
    - Documentation quality
    - Signature compliance
    - MDS accuracy
  - Accessing your Comparative Billing Report 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.

Post-TPE Action Steps

- Again, complete risk assessment based on known TPE parameters
- Continue to provide the care that is needed and appropriate. Don't discharge patients out of fear of denials.
- Develop a strategy for success that includes the entire IDT. Review/establish expectations and provide education as needed.

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.

Takeaways from our Current TPE Experiences

- Don’t bank on having planning time following notification.
- Avoid preventable mistakes.
- Check for required signatures and double check signature dates.
- Include all required documents.
- Make friends with MAC contact person.
- It’s never too soon or too late to audit and educate.
- Don’t miss deadlines!

Takeaways from our Current TPE Experiences (cont)

- Expect repeat patient selection
- Maintain well-organized records.
  - Develop a tracking system
  - Check in daily or every few days for updates
  - Save copies of EVERYTHING in a reliable and easy to access location.

Takeaways from our Current TPE Experiences (cont)

- Recommend submitting ADRs and/or appeals electronically when able.
- If you must submit via mail, remember:
  - Medicare submission dates are hard deadlines.
  - A submission deadline is the date on which the ADR or appeal must be received (and sometimes logged) by the reviewing entity.
  - Weekends and holidays are not viable deadline dates.
  - Mail with tracking and delivery confirmation and maintain mailing slips, and tracking records.
- Expect technology issues.

MAC Specific Details—CGS

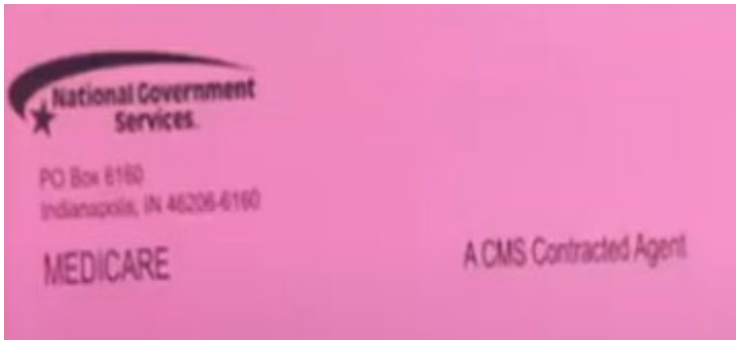
- 56900 denials should be remedied immediately with submission of the ADR packet (don't wait the allowable 125 days). If the packet is submitted quickly, the denial *may* be reversed before the close of the TPE round and it *may* not negatively affect the error % rate.
- None of our SNF partners have received a TPE from CGS.

MAC Specific Details—First Coast (FCSO)

- Our observations/outcomes from our First Coast TPEs:
  - Our facility partners have only had two FCSO TPEs so far.
  - Both had 40 ADRs for their first round and 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) to:
  - Submit ADR packets and redetermination appeals using secure messaging
  - Request and view Provider Data Summary and Comparative Billing Reports

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



- In our experience, the NGS reviewers have been examining ADR packets very closely.
- Education offered has been very thorough.
- NGS uses a bright pink envelope to mail TPE notifications.

****NGS is using the pink envelopes for their 5 Claim Probe and Educate notifications too.****

MAC Specific Details—Noridian

- Noridian has many educational videos posted on their YouTube channel.

- TPE notification letters are mailed and posted in the portal. To access them in the portal go to: Message Center, click on MR Letter Inquiries, then enter a search date range.

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

MAC Specific Details—Novitas

- We have several SNF partners currently working through TPEs from Novitas.
- Results posted on the Novitas website report that the most common denial/partial denial reasons issued for the current “therapy services” TPEs have been:
  - Medical necessity - The documentation submitted does not support medical necessity as listed in coverage requirements.
  - Insufficient documentation –
    - signed initial certification/recertification.
    - signed therapy progress notes/daily treatment notes, completed by a licensed therapist at least every 10 treatment days to support services.
    - therapy evaluation/plan of care to support services billed.
    - to support number of therapy minutes/units billed.

MAC Specific Details—Palmetto

- We have several facility partners with part A TPEs with Palmetto.
- Some observations so far:
  - The MAC contact has been helpful.
  - Denials so far have been vague.
  - 56900 DENIALS: A provider can submit ADR packets for 56900 denials within 120 days of the ADR letter.
  - Processing time has been slow.
  - 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 allows providers to run and view Comparative Billing Reports.
  - May do multiple TPEs simultaneously for the same provider.

MAC Specific Details—Wisconsin Physician Services (WPS)

- WPS posted a trending error rate of 52% for outpatient CPT code TPEs in Q2 2022, 50% in Q3 2022, and 40% in Q4.
- A top reason for denial was documentation that does not support the skills of a licensed professional therapist. They encouraged providers to ask:
  - 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 had several facility partners receive part B TPE from WPS.
  - Outlier metrics used for selection included 97110 utilization, 97140 utilization, and OT utilization.
  - Denials received have been primarily related to skilled services.

Final TPE 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 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!

5 Claim
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Wednesday, May 17, 2023

CMS Transmittal: Announced, Rescinded, Marked Confidential, Then Announced Again

REGULATORY AFFAIRS REPORTERS

In wake of recent CMS announcement instability, rehab industry leaders are asking, is the Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review here to stay?

MACs will begin performing a 5-claim probe and educate medical review on every SNF in their jurisdiction. The purpose of this widespread review is to lower the SNF improper payment rate. As always, if the MAC identifies an improper payment, the MAC will adjust the individual claim payment, as appropriate, in addition to providing education, including their explanation for denial or adjustment of payment.

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12037	**Date: May 15, 2023**
	Change Request 13164

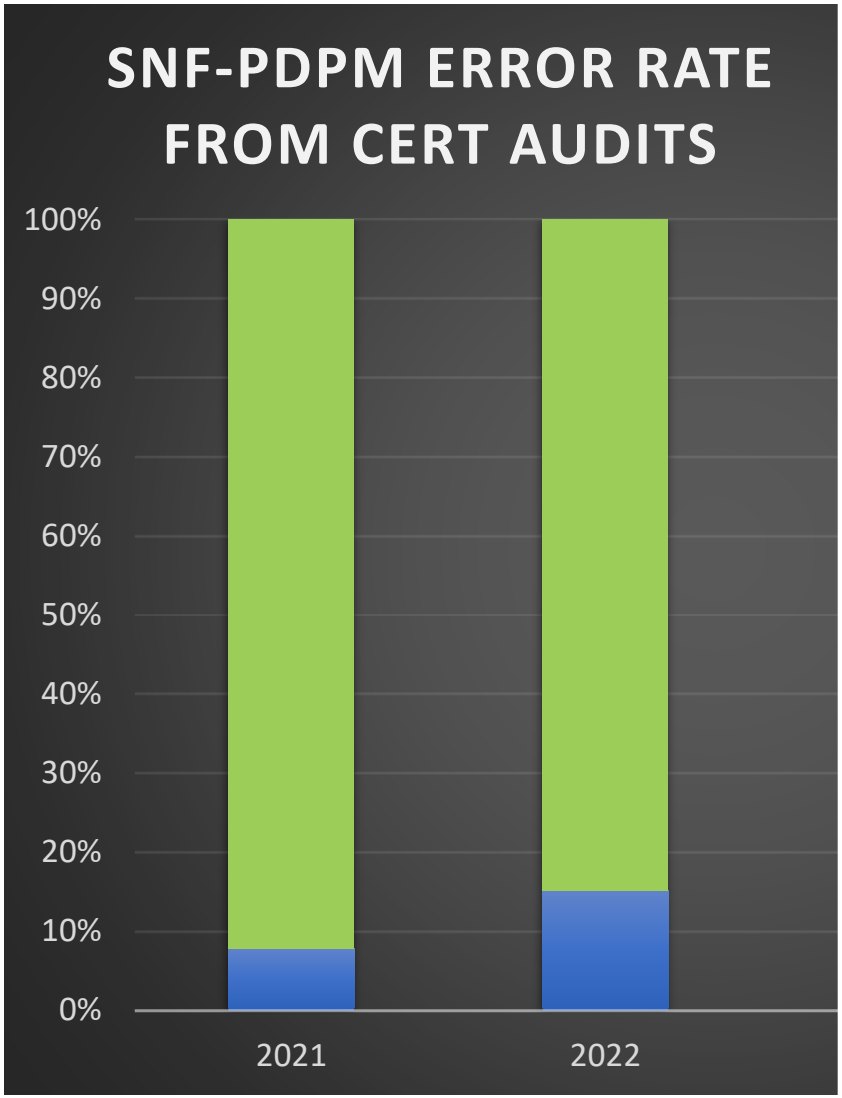
Transmittal 12032 issued May 10, 2023, is being rescinded and replaced by Transmittal 12037, dated May 15, 2023, to make a minor clarification (that claims will be adjusted/denied if an improper payment is identified) and remove the confidential designation. All other information remains the same.

SUBJECT: Skilled Nursing Facility (SNF) 5-Claim Probe and Educate Review

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to have the MACs perform a 5 claim probe and educate medical review on every SNF in their jurisdiction. The purpose of this widespread review is to lower the SNF improper payment rate. As always, if the MAC identifies an improper payment, the MAC will adjust the individual claim payment, as appropriate, in addition to providing education, including their explanation for denial or adjustment of payment.

EFFECTIVE DATE: June 5, 2023

How It All Began—CERT Audits



- CERT (Comprehensive Error Rate Testing) Program
  - CMS reviewing entity
  - Annually reviews a sample of claims for all Medicare covered services
  - Allows CMS to assess provider accuracy with billed claims
- Errors nearly doubled from 2021 to 2022 for SNF-PDPM CERT audits
  - 2021: 7.79%
  - 2022: 15.1%

CMS's Response:
5 Claim PDPM Probe and Educate Review

5-Claim PDPM Probe & Educate

- One round/5 claims selected
- No targeting—every SNF will receive one
- Pre-pay audits
- Education available upon completion

Targeted Probe & Educate

- 1-3 rounds/20-40 claims selected each round
- Targeted selection based on outlier status
- Can be pre- or post-pay
- Education available upon completion

When/How Will This be Rolled Out?

- The 5-Claim PDPM Probe & Educate process began on June 5, 2023.
- MACs have begun auditing.
- CMS has instructed them to begin with 20% of their providers, starting with those that present the highest risk (based on their internal analytics).
- The MACs will continue through this process with a rolling approach working from highest to lowest perceived risk.

Then What Happens?

- **If 0 claims are denied (0% error rate):** **No further action is needed.**
- **If 1 claim is denied (20% error rate):** The facility may request education from the MAC if desired. Denial will need to be appealed.
- **If 2-4 claims are denied (40-80% error rate):** The MAC will contact the facility and offer education. The denials will need to be appealed. **(Note that this *could* increase that facility's odds of being selected for a TPE in the future.)**
- **If all 5 claims are denied (100% error rate):** Education will be offered, and all denials will need to be appealed. **The MAC will prioritize this provider for a part A SNF TPE.**

Final 5-Claim Probe and Educate Review Thoughts

- These 5 ADRs carry significant consequences.
- Denials received are real denials and may lead to a TPE.
- The most common reason for denial is incomplete documentation.
- Steps must be taken to ensure that a complete and well-organized ADR packet is submitted.

Thank you!

Questions?

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