Do the Right Thing!

Leading a Federally Qualified Health Center’s Response to a Medicare Targeted Probe & Educate (TPE) Audit

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HCCA Clinical Practice Compliance Conference

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What are Federally Qualified Health Centers (FQHCs)?

- Community-based and patient-directed organizations that deliver comprehensive, culturally competent, high quality primary health care services
- “FQHC” is a Medicare/Medicaid designation administered by CMS

What are Federally Qualified Health Centers (FQHCs)?

- FQHCs must comply with federal rules that pertain to the Health Center Program as authorized in Section 330 of the Public Health Service Act (42 U.S.C. Section 254b)
- FQHCs serve more than 28 million people (1 in 12 nationwide), including one in three persons living in poverty in the U.S.
March 2, 2018

- Have you ever received a magenta-colored envelope in your mailbox at work, addressed to the Compliance Officer?
- Specifically, a magenta-colored envelope with a return address from your regional Medicare Administrative Contractor (MAC)?
“What the TPE?”

- **T** = Targeted
- **P** = Probe
- **E** = Educate

- Our FQHC had been selected for a TPE review, focusing on Behavioral Health claims

What is a TPE Review?

- TPE involves a review of 20 – 40 Medicare claims selected by the regional MAC
Is the TPE a Random Audit Process?

- No, the TPE is not a random audit process
- TPE reviews focus on providers who have high claim denial rates or who have billing practices that vary significantly from their peers

The TPE Process: Round 1

- The MAC flagged forty (40) of our BH encounters with a TPE code
- We downloaded each encounter from our EHR (Epic)
- We downloaded the treatment plan that preceded the patient’s date of service
The TPE Process: Round 1

- Each encounter and treatment plan was reviewed by the Director of Behavioral Health, the VP of Clinical Affairs, and the Compliance Officer
- For each encounter in the sample, we downloaded a copy of the rendering provider’s license from CT’s Department of Public Health

- This information was submitted securely, using the MAC’s secure portal
- And then we waited for the results...
Results from Round 1
The Payment Error Rate = 79.94%

- The Payment Error Rate: 34/40 (79.94%)
  - The majority (76%) of these encounters were denied due to the MAC’s determination that the individualized treatment plans did not state the type, amount, frequency, and duration of services to be furnished.
Results from Round 1

- The Payment Error Rate: 34/40 (79.94%)
- In addition, 15% were denied due to the rendering provider not being a Medicare “core practitioner”

Follow-up to Round 1

- A webinar was held with the MAC’s TPE Review Team on 07/12/18
- Our inter-disciplinary team: The BH Director, VP of Finance, VP of Clinical Affairs, Compliance Officer, Director of Revenue Services & Billing, and the Medicare Billing Coder
Follow-up to Round 1

- On 07/12/18, the MAC’s Review Team stated that most BH denials that are seen in TPE reviews are based on missing components of treatment plans.
- We were informed that Round 2 would begin on or after 08/27/18.
- Round 2’s cohort would be based on the date of claim submission, not the DOS.

Next Steps following Round 1

- **Plan**: What exactly are we going to do?
- **Do**: When and how will we do it?
- **Study**: What are our results?
- **Act**: What changes will we make?
Next Steps following Round 1

- Develop a Treatment Plan template to address the type, amount, frequency, & duration of BH services

Next Steps following Round 1

- The BH Team met to review and discuss the documentation template
Next Steps following Round 1

- The BH Team implemented use of the new documentation template for treatment plans

- BH providers who are not Medicare approved core practitioners can no longer serve our Medicare enrollees
Next Steps following Round 1

- Medicare enrolled patients were no longer booked for group visits

Next Steps following Round 1

- Our Open Encounters report was produced on a weekly basis, so that any open BH encounters could be billed prior to 08/27/18
Round 2

- Prior to the upload, each encounter & treatment plan was reviewed by the Director of Behavioral Health, the VP of Clinical Affairs, and the Compliance Officer.

Results from Round 2

- The Payment Error Rate = Zero Percent!
- The MAC determined that a Third Round would not be necessary.
Internal Follow-up to Round 2

- An internal audit has been launched during Q-3 of CY 2019 to ensure that there’s been no slippage.

Internal Follow-up to Round 2

- An internal audit will be repeated during Q-1 of CY 2020, because a new BH module will be launched in Epic during October 2019.
Thank you for your participation!

Any questions?

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