PROVIDER NAME
PROVIDER ADDRESS
CITY ST ZIP

Mail Date (ex. December 14, 2014)

PTS Case Number: Case #
Provider NPI Number: Provider NPI

RE: Notice of Review –Targeted Probe and Education Round ____

Dear Medicare (Provider or Supplier)

In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), First Coast, your Jurisdiction N, Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized First Coast to conduct reviews utilizing a Targeted Probe and Educate (TPE) review process. The TPE review process may include up to three rounds of probe review with education. If there are continued high denials after third round of review, First Coast will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Note: discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

The Centers for Medicare & Medicaid Services (CMS) utilizes Medicare Administrative Contractors (MAC) to review clinical documentation in order to prevent improper payments. MACs choose claims for review based on many factors such as the service specific improper payment rate, data analysis, and billing patterns of the provider. CMS is cognizant that this type of review can be burdensome to providers and we are always working to improve the process.

In 2014 CMS began a program that combined a review of a sample of claims with education to help reduce errors in the claims submission process. CMS called this medical review strategy, Probe and Educate. CMS believes results of this program have been favorable, based on the decrease in the number of claim errors after providers received education. CMS is now further improving this strategy by moving from a broad Probe and Educate program to a more targeted one. When performing medical review as part of Targeted Probe and Educate (TPE), Medicare Administrative Contractors

(MACs) focus on specific providers/suppliers within the service rather than all provider/suppliers billing a particular service.

You were recently identified through data analysis and are being sent this notification that a review will be conducted utilizing the Targeted Probe and Educate model described above to ensure services are medically reasonable, billed appropriately, and documentation requirements are met. A random sample of _____ claims will be selected. Please see attached list of claims selected for TPE sample and a list of additional documentation to be submitted for review.

The targeted CPT codes being reviewed are shown below with descriptors:

1.
2.
3.

During the TPE process, First Coast will review the medical records for the claims selected and calculate an error rate based on any dollars denied as errors. Any records not submitted timely as requested will also be calculated in the error rate. Following error rate calculations and summary letter mailing, First Coast will offer to provide one on one education regarding denial reasons and findings.

If the error rate from the review is low then no additional actions will be taken. However, if the error rate is moderate to high, a second round of review will be conducted in 45- 56 days after the education date. If provider refuses education, then next round will begin 45-56 days following date of summary letter. The TPE review process can include up to three rounds of a prepayment probe review with education. If there are continued high denials after third round then First Coast will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Note, discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

The medical records must be received by First Coast within 45 days from the date of this additional development request which is (**date will be calculated**). Authorization for the release of this information is included in Federal Law regulations reference 42 CFR 411.24(a), 424.5(a) (6) and 44 USC 3101. If the requested documentation is not returned within 45 days from the original request, the claim will be denied due to lack of documentation which will contribute to your error rate. It is your responsibility as a provider to provide the requested documentation within the allotted time frame. Additionally, if providers/suppliers do not respond to the ADR request, MACs have the option to refer to the RAC or ZPIC/UPIC as a result.

Post pay TPE probe reviews will be completed within 60 days of the last date of additional documentation received. If during the review process any additional information is needed a

clinical reviewer will contact you with that request. If you have any questions or concerns regarding that request please **contact XXXX XXXXXX.**

Once the Medical review is complete you will receive a review summary letter with detailed claim decisions and error rate calculations. The review summary letter will contain contact and scheduling information for education. The education will be provided via conference call and First Coast will provide a chorus call number for you and your staff to utilize for the education.

If during the review minor errors are noted First Coast reviewers may contact you for intra probe education to correct issues immediately and prevent future denials for the same reasons. During any educational calls whether intra or post review you or your staff will be able to ask questions and receive specific feedback and guidance related to your documentation and specific errors identified.

This letter serves as notification of the TPE process, initiation of the review and request for medical records. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Thank you in advance for your participation with this review. Please contact XXXXXX@fcso.com referencing the case number, if you have any questions or wish to provide a contact person or with any questions regarding the information in this letter.

Instructions
The documentation submitted for this review must be a copy of the patient's medical record for each encounter clearly identified for each requested beneficiary and the date of service. Providers/suppliers are responsible for obtaining supporting documentation from third parties (hospitals, nursing homes, suppliers,etc.).

- Refer to the 'Supporting Documentation' attachment for a list of required supporting documentation to be submitted.
- Providers/suppliers must pay the cost of providing this documentation; it cannot be billed to CMS or the MAC program.
- Providers/suppliers are encouraged to respond quickly.
- Please do not include Powers of Attorney, Living Wills, or Correspondence.
- During this review period and at all times, in order to receive payment, providers/suppliers must continue to submit claims for all services performed on a beneficiary.

Submission Methods
Providers/Suppliers may submit documentation in any of the following ways: Additional information on submission of medical records can be found on the medical documentation webpage at http://medicare.fcso.com.

Via postal mail or Encrypted CD/DVD:

1. Include a paper copy of this Post Pay request letter with your documents.
2. Please do not password protect CDs/DVDs
3. Mail to the following:

Regular Mail

ATTENTION: XXXXXXX
FIRST COAST SERVICE OPTIONS INC
MEDICAL REVIEW, PART B
POST OFFICE BOX XXXX
JACKSONVILLE, FLORIDA 32231-4159

Overnight Mail

ATTENTION: XXXXXX
FIRST COAST SERVICE OPTIONS INC
MEDICAL REVIEW, PART B
532 RIVERSIDE AVENUE
JACKSONVILLE, FLORIDA 32202

Via fax:

1. Go to **http://medicare.fcso.com** then medical documentation to located the **Medicare part B post payment Probe Review** fax number and cover sheet
2. Include a copy of this ADR letter with your documents, completed fax cover sheet and fax to (904)361-XXXX.

Questions

If you have any questions please contact XXXX at 904-791-xxxx or via postal mail at the following:

First Coast Service Options, Inc.
532 Riverside Avenue, 19 Tower
Jacksonville FL 32202

Sincerely,

First Coast MAC Jurisdiction N Medical Review

Enc: TPE Process Flowchart
Additional Development Sample list
Additional Documentation requested

This document (letter) contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

Attachments / Supplementary Information

1. Comparative Billing Report and Guide
2. Listing of claims requiring medical documentation
3. Supporting Documentation Required List

Attachment:
Supporting Documentation Required List

Please submit medical records as indicated below:
Include list of staff credentials that rendered services to include names, license numbers and signatures. If the Physicians signature is missing in the documentation, include an attestation signed and dated by the Physician that performed the service. The information should contain sufficient information to identify the beneficiary receiving the services. If the Physicians signature is illegible submit a signature log.

In addition, you are required to submit a copy of any signed Advanced Beneficiary Notices (ABN's/HINN), if applicable. Claims submitted with a GA modifier and an invalid or missing ABN will not transfer liability to the patient. In accordance with CMS Program Integrity Manual Pub 100-08 Chapter 3 sections 3.15 and Pub 100-4 chapter 30 sections 50.6.3.)

- ☐ **Outpatient Rehab**
  - ☐ Physician referral (prescription)
  - ☐ Initial evaluation
  - ☐ Complete plan of treatment, which includes:
    - ☐ Diagnosis
    - ☐ Type of modalities
    - ☐ Frequency of treatments
    - ☐ Duration
    - ☐ Anticipated (measurable) goals (short/long term)
    - ☐ Certification dates
    - ☐ Physician approval
    - ☐ Rehabilitation potential
  - ☐ Progress notes
  - ☐ Itemized breakdown of charges

- ☐ Anesthesia report(s) for any surgical procedure
- ☐ Prescriptions/Physician orders for all diagnostic procedures billed to Medicare
- ☐ Stress test(s) and technical component(s)
- ☐ Nuclear cardiology report(s) and technical component(s)
- ☐ Holter monitor report(s) and technical component(s) (also include related EKG tracings and Real Time Data Analysis and report(s))
- ☐ If you are not the attending physician, please supply the clinical records that support the medical necessity for the services billed

- ☐ Pulmonary test report(s) and technical component(s)
- ☐ Ambulance run sheets
- ☐ Documentation that supports the medical necessity of the service that was billed, including but not limited to history & physical, progress note(s), medication sheet(s), nurse note(s), etc.…

☐ **Psychotherapy treatment**

- ☐ Treatment plan(s)
- ☐ Initial evaluation
- ☐ Referral source
- ☐ Test result(s)
- ☐ Behavior monitoring flow sheet(s)
- ☐ Group note(s)
- ☐ Progress note(s)
- ☐ Diagnostic interview(s)
- ☐ Referring physician order(s)
- ☐ Coordination of Care efforts
- ☐ Certification

☐ **Skilled Nursing Facility**

- ☐ History and physical from hospital stay (if available)
- ☐ Hospital discharge summary
- ☐ MDS (minimum data set) projecting each rug III billed (during this timeframe)
- ☐ Certification for skilled nursing facility services
- ☐ Nurse's notes
- ☐ Physician orders
- ☐ Physician progress notes
- ☐ Treatment plan, progress notes, evaluations, and certifications for therapy (if A PT, OT, ST patient)
- ☐ Social Worker's notes
- ☐ UB92 to include rug III category(s)
- ☐ MARS & TARS

- ☐ Clinical office records
- ☐ Clinical laboratory reports that substantiate the diagnosis and support the medical necessity of the service billed
- ☐ Diagnostic radiology report(s) and technical component(s)
- ☐ Diagnostic ophthalmology report(s) and technical component(s)
- ☐ Diagnostic neurology report(s) and technical component(s)
- ☐ EKG(s) and interpretation(s)
- ☐ Diagnostic Audiology report(s) and technical component(s)
- ☐ Diagnostic ultrasound report(s) and technical component(s)
- ☐ Non-invasive vascular report(s) and technical component(s) (If you are not the attending physician, please supply the clinical records that support the medical necessity of the billed service, as well as the physician order for the service billed)
- ☐ Anesthesia report(s) for any surgical procedure
- ☐ Prescriptions/Physician orders for all diagnostic procedures billed to Medicare
- ☐ Stress test(s) and technical component(s)

☐ Nuclear cardiology report(s) and technical component(s)
☐ Holter monitor report(s) and technical component(s) (also include related EKG tracings and Real Time Data Analysis and report(s))
☐ Pulmonary test report(s) and technical component(s)
☐ Ambulance run sheets
☐ Other documents:

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