TPE audits target high volume providers

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**By Paula Hartman-Stein, Ph.D.**

A wave of Medicare audits has triggered anxiety among many psychologists and often costs them time and money as they spend hours tediously compiling records instead of seeing patients, not to mention payment delays for months even if their documentation is up to par.

Psychologists whose caseloads are made up mostly of Medicare patients are the most likely targets of the 2019 audits.

The TPE audits, which stands for Target, Probe and Educate, are intended "to reduce burden on providers by combining medical review with education," according to the Center for Medicare and Medicaid Services (CMS). But in an online publication that monitors CMS' oversight of providers, attorney Knicole Emanuel wrote, "Medicare TPE audits are a wolf in sheep's clothing."

CMS authorized Medicare Administrative Contractors (MACs) to begin the current round of TPE audits earlier this year. MACs are private healthcare insurers contracted by Medicare to process claims.

The nation is divided geographically among 12 MACs that process more than a billion Part B claims a year. It is under Part B – "medically necessary services" – that most psychologists are paid.

The audits are generally performed as a review of claims prior to payment for a service but CMS also allows for post-payment TPE audits. The CMS website says most providers will never need TPE. The process is only used with those who have "unusual billing practices."

In other words, once a psychologist is marked for an audit it's assumed something is wrong with billing practices and it's up to the practitioner to show otherwise.

According to Julie Schmitt Gersch, Ph.D., vice president of organizational development of Cotler Healthcare in Florida, high patient volume is the main underlying similarity she can determine from providers under TPE review. Whether time spent in the psychotherapy session is 16 minutes to over an hour does not appear to be the trigger for this round of audits.

Gersch confirmed the current wave of pre-payment TPE reviews instituted by the MAC in Florida, First Coast, has been under way for psychologists and licensed clinical social workers beginning in January and concluding in mid-June.

Providers who see patients on a full time basis seem to be most likely candidates for TPE reviews, Gersch said.

According to Julie Futrell, Ph.D., associate clinical director for CHE Behavioral Health Services in Los Angeles, the providers in her company under review by the MAC, Noridian, also worked full time and had higher billing rates. The clinicians under review in Florida and California received a letter indicating their selection was based on analysis of claims processing and billing patterns.

Gersch said they are strong clinicians who are committed to working in skilled nursing facilities and have good patient outcomes.

In a letter to CMS administrator Seema Verma, APA's chief of professional practice, Jared Skillings, Ph.D., addressed the unfairness of TPE audits. He wrote, "Under this structure Medicare does not recognize or reward

psychologists who are more willing to treat the elderly, complex, and/or disabled; instead it subjects them to even greater scrutiny."

According to Gersch, "An unfortunate possible side effect of CMS' approach to managing quality and protecting taxpayer dollars is an inadvertent discouragement of specialty practice by experts in clinical geropsychology,"

"If simply committing to being a geropsychologist as a professional means you are much more likely to be selected for a costly, time-consuming and somewhat illogical dance with the government, then Medicare will not be able to build the strongest workforce for its beneficiaries," she said.

**TPE review process**

TPE is conducted in three phases. Round 1 includes probing 20 to 40 claims per provider. Each claim could include up to six therapy sessions per claim form.

In order to show medical necessity for one psychotherapy session in question, supporting documentation requested includes the physician order, psychological screens, behavior monitoring sheets, diagnostic interviews, treatment plans, consent forms and other progress notes for previous sessions with that patient.

In Round 2 providers receive a letter detailing the results of the reviews and are offered a one-on-one education session by an analyst. During the education session, usually held via teleconference or webinar, the MAC analyst walks the provider through any errors found in the reviewed claims.

While the review goes on, the provider must continue to see the patient because the audit is based on future work with the patients in order to continue to move through the process.

According to Gersch, some analysts said the audits would conclude as soon as the error rate dips below 20 percent. The CMS website said an error can be something as simple as missing a signature. Gersch said the focus has been on demonstrating medical necessity.

She trains the providers in the Cotler group on Medicare compliance regulations, fraud, abuse and the newer concept of medical insurance waste. As the Inspector General recommends, clinicians receive annual training on these concepts.

Futrell said, "Although all the clinicians reviewed passed 100 percent, the process required a great deal of work, time and energy that was non-billable and that directly cut into direct patient care time."

Round 3 involves more education if the provider's errors have not been reduced, allowing an additional 45 days or longer for the provider to show improvement. If errors continue, the MAC can refer the provider to CMS for "possible further action," according to the CMS website.

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