

Targeted Probe & Educate (TPE) and the Additional Documentation Request (ADR) Session Two

April 21, 2022



Today's Presenters



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3

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- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
 - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events



4

Objectives

- Provide an understanding of the Targeted Probe & Educate Process
- Provide direction regarding how to respond to an ADR to support your Medicare claim
- Review helpful tools to find ADRs and submit medical record documentation
- Decrease denials for non-submission of medical record documentation (56900)
- Improve provider collaboration of medical record documentation
- Increase utilization of electronic medical record documentation submission (NGSConnex)
- Offer an increased understanding of FISS



5

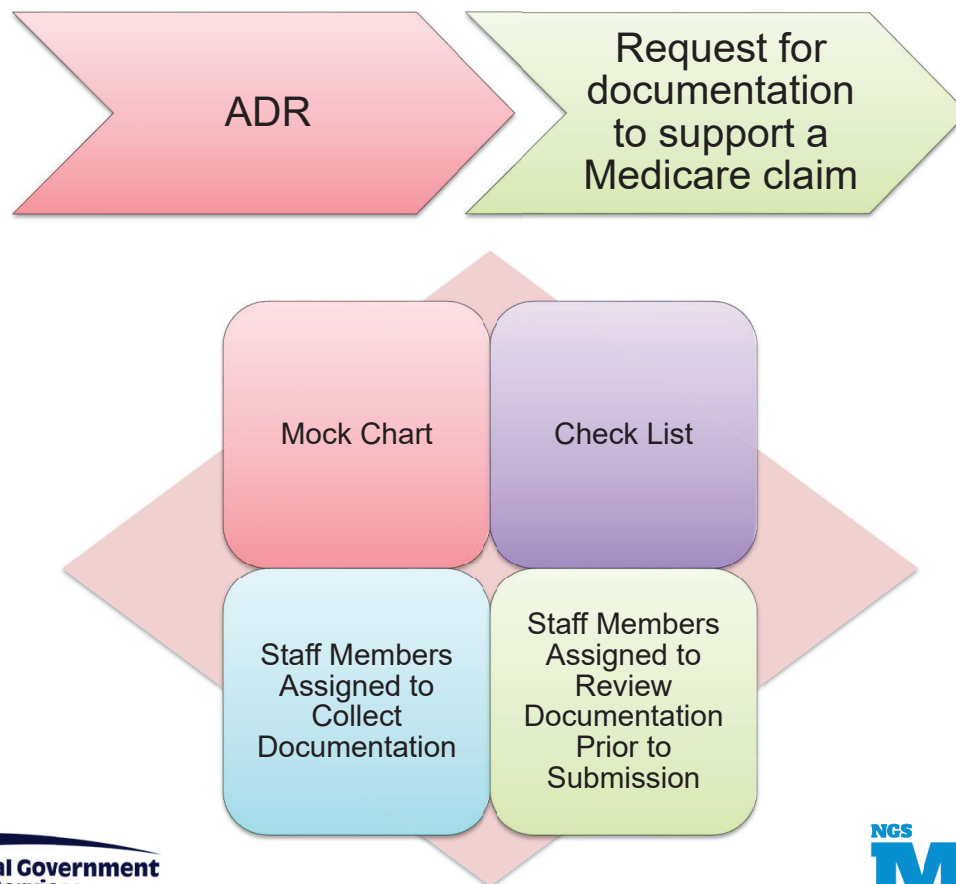
Agenda

- Additional Documentation Request (ADR)
- Targeted Probe & Educate
- Submission of Medical Record Documentation
- NGSConnex
- Navigating FISS
- Helpful Hints
- References and Resources
- Question and Answer



6

Additional Documentation Request (ADR)



ADR

System Issues ADR

- Claim suspends to status/location SB 6001
- ADR is sent to provider
- Provider has 45 days to return records to the MAC

Records are NOT received by day 45

- On day 46 the system will deny the claim and move it to S/L DB 9997
- Claim assigned reason code 56900

Wait one week and recheck status/location

- If the records were received the claim will move to S/L SM 5REC
- If denial code appears, recheck, call the PCC for assistance, if necessary

ADR

- Incorporating the methods and techniques mentioned into policies/procedures will assist in ensuring
 - Appropriate documentation is obtained from outside entities
 - Records are reviewed for accuracy by multiple people prior to submission
 - All eligibility criteria have been met
 - All proper documentation is included in the medical record prior to submission
 - Proper claims payment

ADR

- Utilize instructional information on the ADR to assist in creation of the checklist or mock chart

THIS CLAIM REQUIRES ADDITIONAL INFORMATION IN ORDER TO MAKE APPROPRIATE PAYMENT DETERMINATION AND PROCESSING. PROVIDED BELOW ARE RECOMMENDED SUPPORTING DOCUMENTS, BUT NOT AN ALL INCLUSIVE LIST. THE DOCUMENTATION SHOULD SUPPORT THE VERIFICATION OF THE ISSUE THAT GENERATED THIS REQUEST. FOR FURTHER INFORMATION, ENTER THE REASON CODE(S) LISTED BELOW IN THE APPROPRIATE FIELDS IN THE ON-LINE SYSTEM. WE ACCEPT DOCUMENTS VIA PAPER, FAX, CD/DVD AND ESMD OMB #0938-0969

PLEASE NOTE:

****MEDICAL**** RECORDS ARE DUE TO THE MAC WITHIN 45 CALENDAR DAYS.

NON-MEDICAL RECORDS ARE DUE TO THE MAC WITHIN 14 CALENDAR DAYS.

**Records
DUE: 45 Days**



11

ADR

- The ADR provides helpful hints to help appropriate claims payment

MEDICARE REQUIRES A LEGIBLE IDENTIFIER FOR SERVICES PROVIDED AND ORDERED.

MEDICARE WILL ACCEPT CLEARLY LEGIBLE HANDWRITTEN SIGNATURES, HANDWRITTEN INITIALS OR ELECTRONIC SIGNATURES. STAMPED SIGNATURES ARE NOT ACCEPTABLE ON ANY MEDICAL RECORD.

**STAMPED
SIGNATURES**



12

ADR

PATIENT IDENTIFICATION, DATE OF SERVICE, AND PROVIDER OF

THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON THE SUBMITTED DOCUMENTATION. IF

THE RENDERING PROVIDER SIGNATURE IS NOT CLEARLY LEGIBLE, ATTACH A SIGNATURE

LOG/KEY THAT INCLUDES THE TYPED NAME OF THE PROVIDER WITH CREDENTIALS, THE

SIGNATURE, AND THE INITIALS FOR EACH PROVIDER FOR WHICH THE RECORDS ARE

REQUESTED. IF YOU QUESTION THE LEGIBILITY OF YOUR SIGNATURE, YOU SHOULD

SUBMIT AN ATTESTATION STATEMENT IN YOUR DOCUMENTATION RESPONSE. IF THE

SIGNATURE REQUIREMENTS ARE NOT MET, THE REVIEWER WILL CONDUCT THE REVIEW

WITHOUT CONSIDERING THE DOCUMENTATION WITH THE MISSING OR ILLEGIBLE

SIGNATURE. THIS COULD LEAD THE REVIEWER TO DETERMINE THAT THE MEDICAL

NECESSITY FOR THE SERVICE BILLED HAS NOT BEEN SUBSTANTIATED.

PLEASE SUBMIT THE SUPPORTING DOCUMENTATION WITHIN 45 DAYS FROM THE DATE OF

THIS NOTICE. THIS DOCUMENTATION MUST BE CLEAR AND LEGIBLE.

Date

Signature

Legibility



13

ADR

- The ADR does not provide an all-inclusive list of what should/should not be included for medical record submission
- **Reminder:** It is important to review the records prior to submission to ensure documentation supports eligibility criteria



14

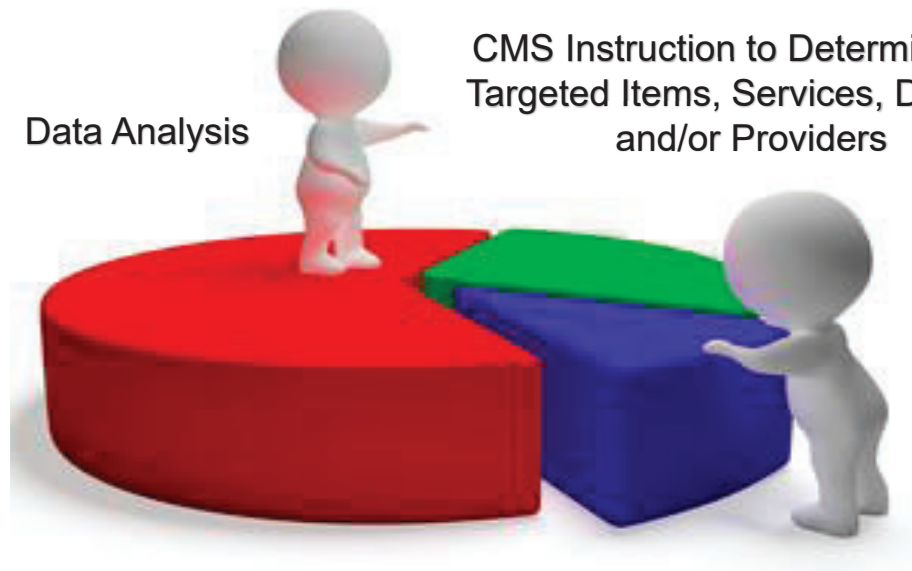
Targeted Probe & Educate (TPE)

TPE

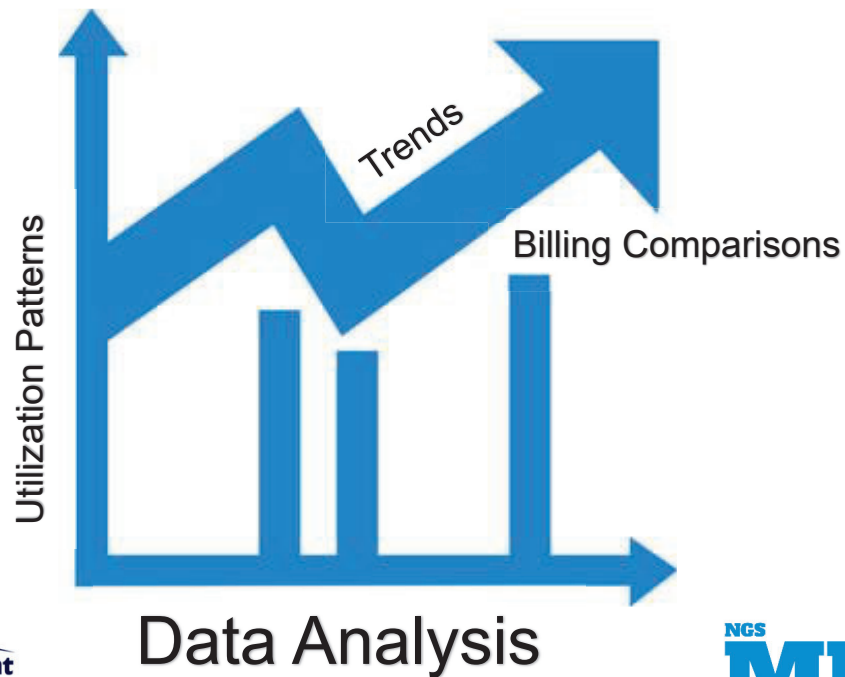
Data Analysis

CMS Instruction to Determine the
Targeted Items, Services, Devices
and/or Providers

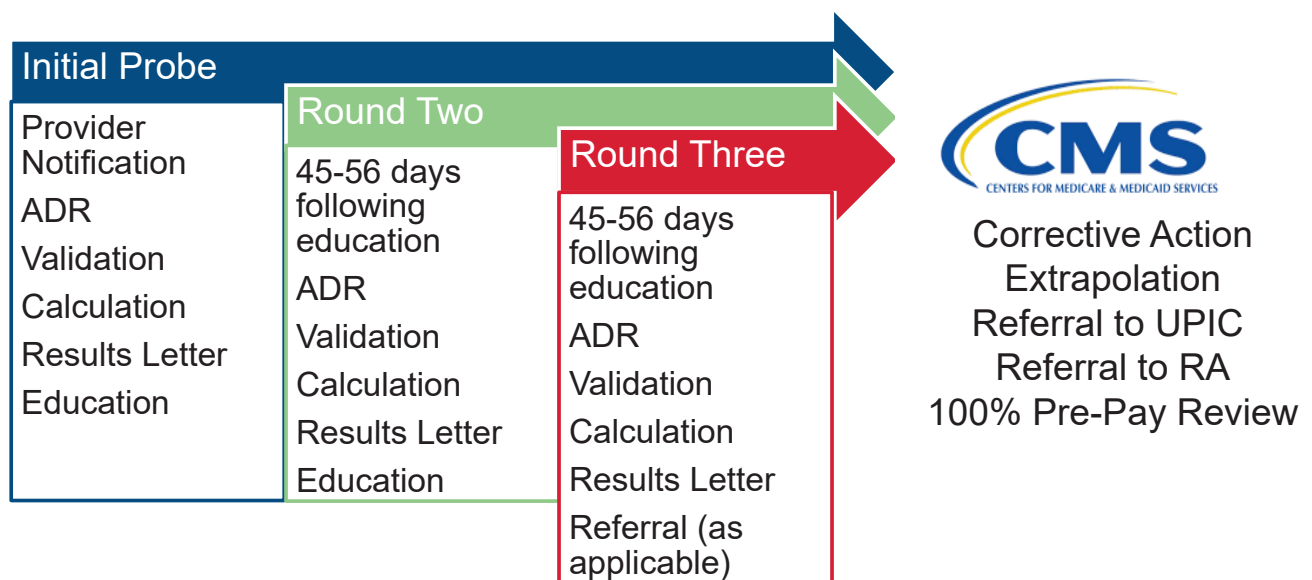
Improper Payment
Reduction Strategy



TPE



TPE



TPE

- Notice of review includes reason for review
- Request 20 – 40 claims
- Do not send documentation until ADR received for each claim
- ADRs generated via the usual process
- 45 days to respond
- Non-responders could be referred to the RA or UPIC
- Records Reviewed within 30 days of receipt
- Results letter offers 1:1 education



19

TPE

- Additional Rounds of Review
 - Payment error >15%
 - Additional rounds include education with Medical Review staff following each round of review
- Payment Error Rate
 - Payment/Payment Denied
 - $1,000/500 = 50\%$ PER
- Claims Error Rate
 - # of Claims/Claim in Error
 - $10 \text{ Claims}/5 \text{ Claims Denied} = 50\%$ CER

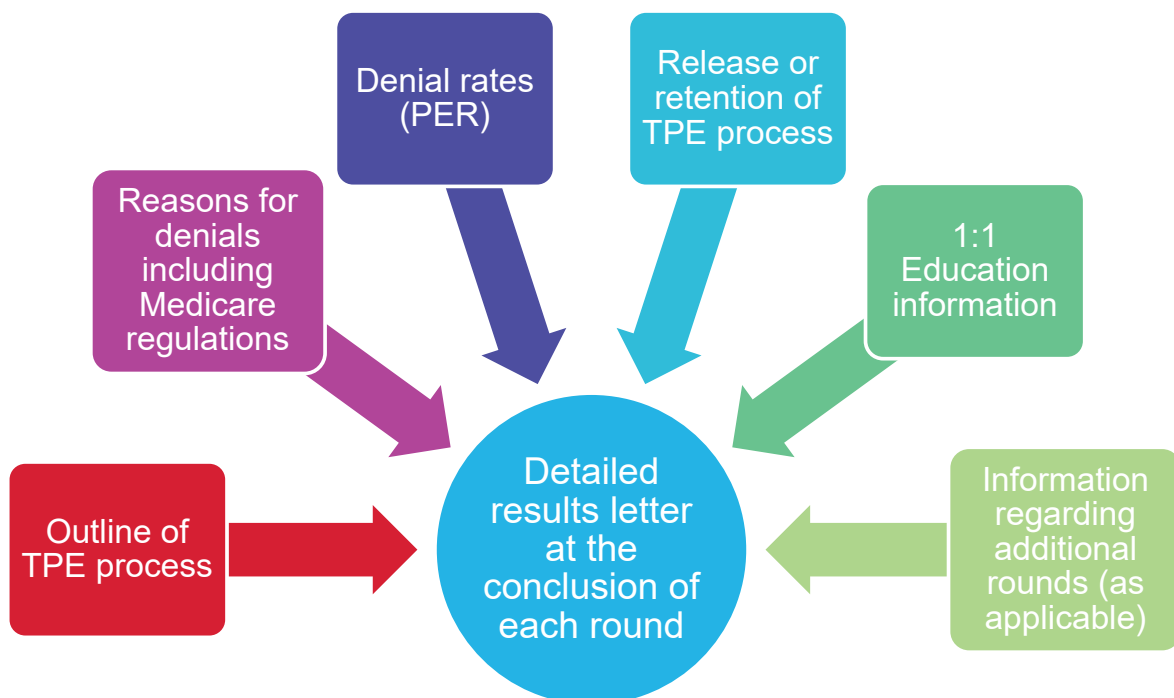


20

TPE

- Medical Review of Records for:
- Technical Components
 - Physician certification
 - Physician orders
 - Beneficiary election statement
- Eligibility Requirements
 - Medicare coverage guidelines
 - Medical necessity
 - Documentation to support services billed

TPE



Submission of Medical Record Documentation

Submission of Medical Record Documentation

- Documentation Collaboration

Discharge
summary

Progress
notes

History &
physical

Plan of care

Case
Management
records

Discharge
planning
documentation

Therapy
records

Submission of Medical Record Documentation

- Documentation Preparation
- Prior to submission of documentation, it is imperative that all medical record documentation is completely reviewed to ensure
 - All pages are for the appropriate patient
 - PECOS – Validation for all physicians involved in the patient's care for all DOS in the period of care
 - Appropriate OASIS submission
 - Any and all therapy evaluations and reevaluations are included
 - The patient's name is on each page (front and back where appropriate)
 - The correct dates of service for the claimed period of care
 - Dates and signatures are clear and appropriate
 - Legibility of all handwritten documentation



25

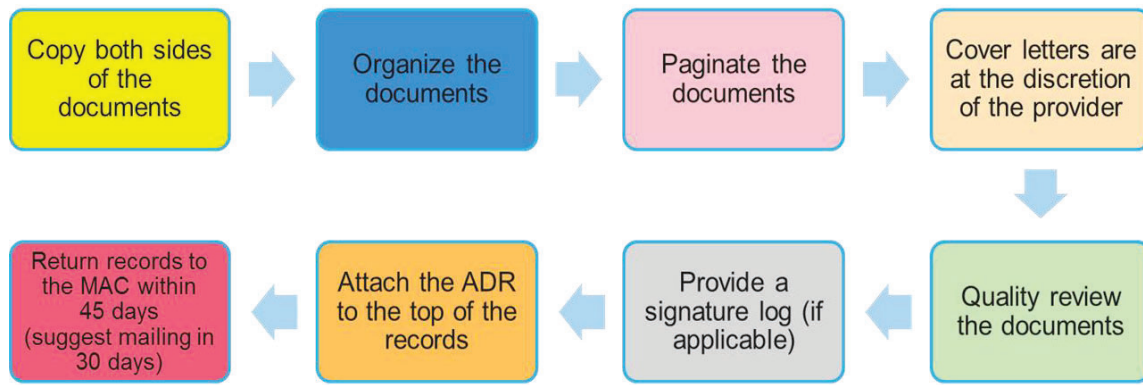
Submission of Medical Record Documentation

- Documentation Preparation
- Prior to submission of documentation, review all records to ensure
 - Identifiable credentials for each clinician signature
 - Signature sheets as appropriate from agency and referring facility/office
 - Accuracy of documentation
 - All staples, paperclips, binder clips, sticky notes, rubber bands, etc. are removed prior to submission
 - Pages are not folded over, cut off or crinkled during copying/printing/faxing
 - Highlighter is not utilized
 - ADR is placed on the top of the medical record
 - Reminder: Black ink copies best
 - Provider contact name and telephone number



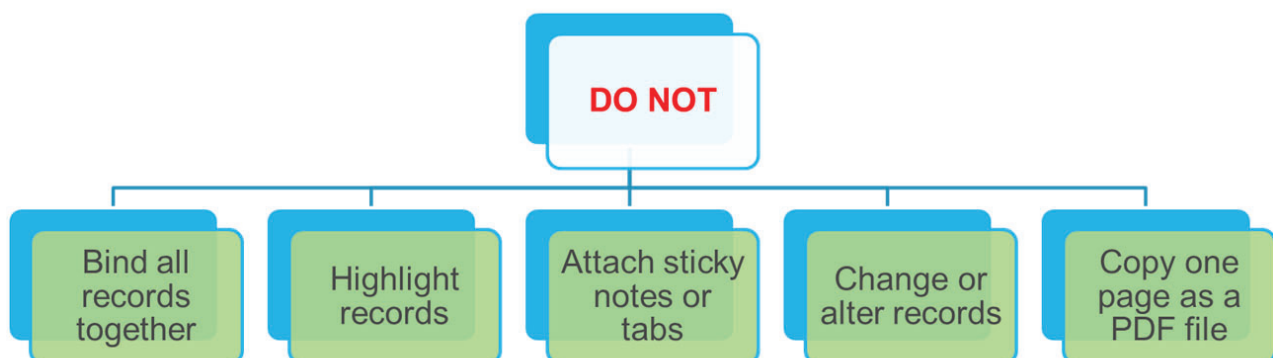
26

Submission of Medical Record Documentation

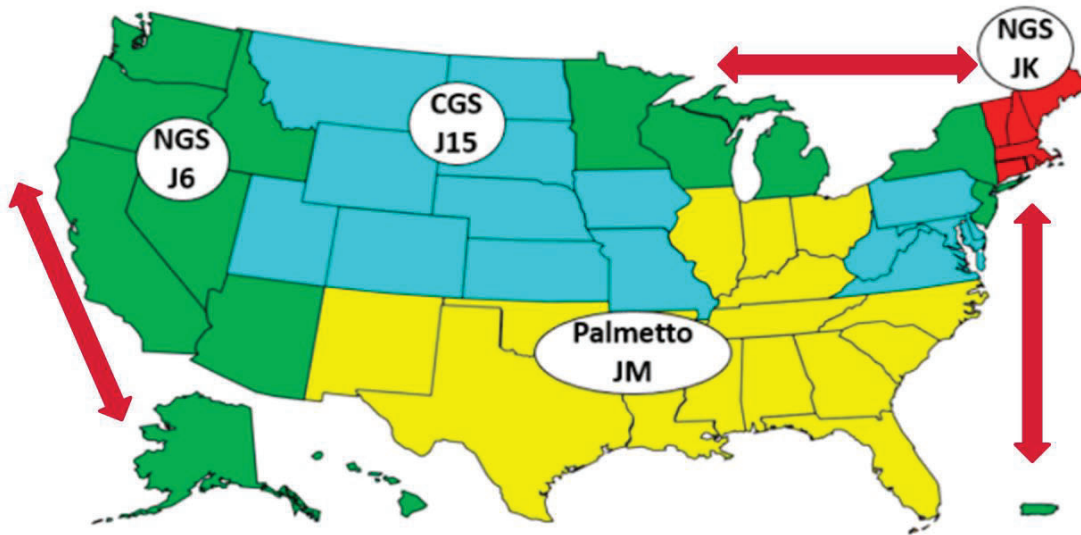


Submission of Medical Record Documentation

Documentation Preparation



Submission of Medical Record Documentation Home Health & Hospice Jurisdictions



Submission of Medical Record Documentation J6

 <p>NGSConnex esMD</p>	 <p>National Government Services Inc. 8115 Knue Rd Indianapolis, IN 46250 Attn: Mail & Distribution</p>	 <p>National Government Services Inc. PO Box 7108 Indianapolis, IN 46206-6474</p>	 <p>FAX: 315.442.4154</p>
<p>Always check www.NGSMedicare.com for the most current information</p>			

56900 Denials

Records Not Received

56900



DENIED

Helpful Hints

Timely Submission of Medical
Record Documentation

Staff Education

Responsibility

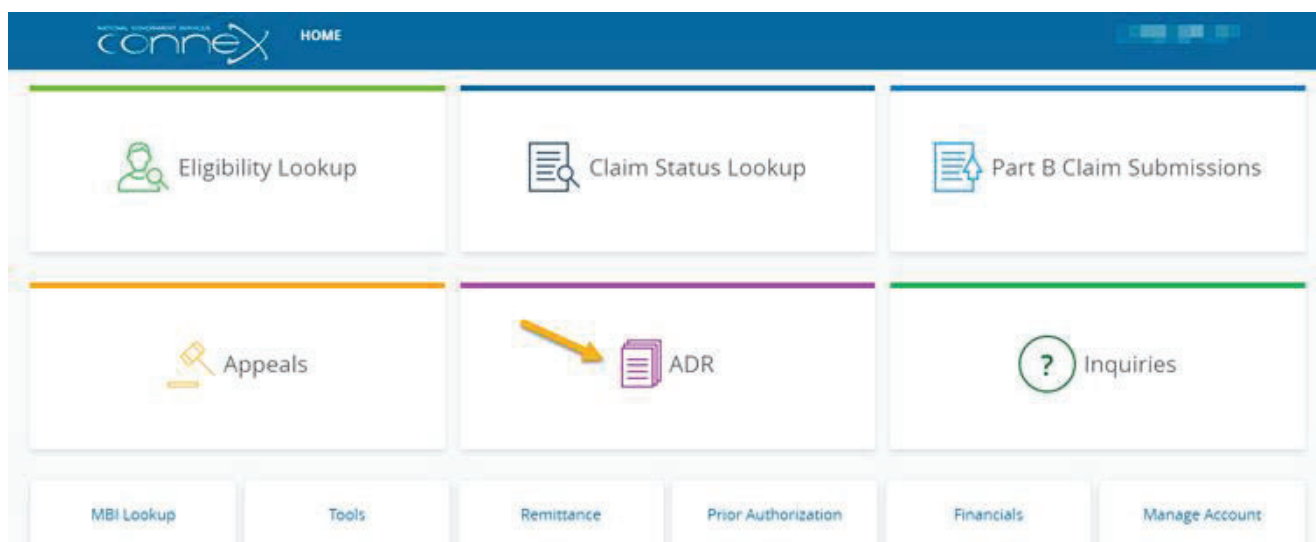
Medical Necessity

Comprehension
Of the Anti-Kickback
Statute & Stark Laws

Report
Fraud

NGSConnex

NGSConnex: Homepage



NGSConnex: Select a Provider

Select a Provider

Search Provider

Search

Reset Search

PTAN	NPI	TIN	Provider/Supplier	City	State	LOB	
						Part B	Select
						HHH	Select
						Part A	Select
						Part A	Select
						Part A	Select
						Part A	Select
						Part A	Select

NGSConnex: ADR Summary Panel

ADR Summary

Submission History

The last forty-five days of Medical Review (MR) ADRs for the provider selected are displayed. To search for other MR ADRs or to narrow/expand your search, use the filter options.

Filters:

ADR From Date

ADR To Date

ADR Status

Claim Number

CaseID

02/05/2022

03/22/2022

Select

Search

Reset Search

ADR not in list

 Export to Excel

Claim Number	Beneficiary Name	ADR Date	ADR Status	Due Date	Case ID	Nurse Review Decision	Remittance Advice Date
<input type="checkbox"/> 222		02/16/2022	Awaiting Documentation	04/02/2022			
<input type="checkbox"/> 222		02/15/2022	Documentation Received	04/01/2022		No Finding/Documentation Approved	03/17/2022
<input type="checkbox"/> 222		02/15/2022	Documentation Received	04/01/2022		No Finding/Documentation Approved	03/16/2022
<input type="checkbox"/> 222		02/15/2022	Awaiting Documentation	04/01/2022			

NGSConnex: Respond to an ADR

Respond to ADR

Claim Number	Beneficiary Name	ADR Date	ADR Status	Due Date	Case ID	Nurse Review Decision	Remittance Advice Date
<input checked="" type="checkbox"/> 22.		02/16/2022	Awaiting Documentation	04/02/2022	1300		



37

NGSConnex: ADR Information – Step 1

Medical Review ADR

1 ADR Information 2 Attachments 3 Submit

Created Date: 03/22/2022

Provider Name *

Provider Address

Provider Address 2

Provider City

Provider State

Provider Zip

Provider NPI *

Provider PTAN *

Beneficiary First Name *

Beneficiary Last Name *

Medicare ID *

DCN *

Reason Code *

Case Number *

Verify Information



38

NGSConnex: ADR Information – Step 2

Home > ADR Summary > New MR ADR

MEDICAL REVIEW ADR

1 ADR Information 2 Attachments 3 Submit

Cancel



Attachments

Note: Please upload required attachments to support the MR ADR submission.

Drop a file here or [browse to upload](#)

Maximum file size: 25 MB

Back Next

  39

NGSConnex: ADR Information – Step 3

Home > ADR Summary > New MR ADR

MEDICAL REVIEW ADR



1 ADR Information 2 Attachments 3 Submit

Cancel

Ready To Submit?

Have you verified your Medical Review Additional Documentation response is complete, all supporting documentation is attached and you are ready to submit your request?

Back Submit

  40

Navigating FISS

FISS: Accessing ADRs in the Claim Summary Option

- ADRs can be accessed by filtering the claims by status/location
 - ADRs are housed in S/LOC S B6001
- At the **Claims Inquiry** screen, type **SB6001** in the **S/LOC field** and press **<Enter>** - all claims in the SB6001 status and location will be displayed
 - (SB6001 status indicates that an ADR has been generated for a claim)
- At the desired claim, type **S** to the left of the claim under the **SEL field** and press **<Enter>**
- The ADR letter follows page 06 of the claim
- Please be sure to **not** press the **<P9>/<PF9>** key while viewing a claim in the SB6001 status—this will cause the claim to recycle and generate a second ADR letter
- **Note:** requested records are due to NGS 30 days from the date the claim went to **S/LOC SB6001** in FISS

FISS: DDE Main Menu

MAP1701
TC98548

NATIONAL GOVERNMENT SERVICES, #13001 UAT
MAIN MENU

ACMMA561 02/13/13
C201313P 11:22:52

- 01 INQUIRIES
- 02 CLAIMS/ATTACHMENTS
- 03 CLAIMS CORRECTION
- 04 ONLINE REPORTS

ENTER MENU SELECTION: █

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT



43

FISS: Inquiries Sub-menu

MAP1702
MXG9282

NATIONAL GOVERNMENT SERVICES, #13001 UAT
INQUIRY MENU

ACMFA561 03/11/20
A2020200 13:18:11

- | | | | |
|-------------------------|----|-------------------------|----|
| BENEFICIARY/CWF | 10 | ZIP CODE FILE | 19 |
| DRG (PRICER/GROUPER) | 11 | OSC REPOSITORY INQUIRY | 1A |
| CLAIM SUMMARY | 12 | CLAIM COUNT SUMMARY | 56 |
| REVENUE CODES | 13 | HOME HEALTH PYMT TOTALS | 67 |
| HCPC CODES | 14 | ANSI REASON CODES | 68 |
| DX/PROC CODES ICD-9 | 15 | CHECK HISTORY | FI |
| ADJUSTMENT REASON CODES | 16 | DX/PROC CODES ICD-10 | 1B |
| REASON CODES | 17 | CMHC PAYMENT TOTALS | 1C |
| INVOICE NO/DCN TRANS | 88 | PROV PRACTICE ADDR QUER | 1D |
| | | NEW HCPC SCREEN | 1E |

ENTER MENU SELECTION:



44

FISS: Claim Summary Option 01/12

```

MAP1741          NATIONAL GOVERNMENT SERVICES, #13001 UAT          ACMFA561 04/01/21
KXT2938  SC          CLAIM SUMMARY INQUIRY          A20212CF 05:29:13

          NPI
          MID          PROVIDER          S/LOC S B6001          TOB
OPERATOR ID KXT2938  FROM DATE          TO DATE          DDE SORT
MEDICAL REVIEW SELECT          DCN
          MID          PROV/MRN  S/LOC          TOB  ADM DT  FRM DT THRU DT  REC DT
SEL LAST NAME  FIRST INIT  TOT CHG  PROV REIMB PD DT  CAN DT REAS NPC #DAYS
XXXXXXXXXXXX  XXX100      S B6001          131          022221 022221  013121
ABCDEFG      H          3502.90          39700

          PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT
  
```



45

FISS: Reason Code File (17) or PF1 (page 1)

```

MAP1881          NATIONAL GOVERNMENT SERVICES, #13001          UAT          ACMFA561 04/01/21
KXT2938  SC          REASON CODES INQUIRY          A20212CF
06:07:17

          MNT: CIE3820 082720
PLAN REAS  NARR  EFF  MSN  EFF  TERM  EMC  HC/PRO  PP  CC
IND CODE  TYPE  DATE  REAS  DATE  DATE  ST/LOC ST/LOC  LOC  IND
1  5FGFP  E  060120          S B6000 S B6000  E
TPTP A  B  NPCD A  B  HD CPY A 2  B 2  NB ADR 1  CAL DY 45  C/L L
-----NARRATIVE-----
MEDICARE REQUIRES A LEGIBLE IDENTIFIER FOR SERVICES PROVIDED AND ORDERED. MEDICARE WILL ACCEPT CLEARLY LEGIBLE HANDWRITTEN
SIGNATURES,
HANDWRITTEN INITIALS OR ELECTRONIC SIGNATURES. STAMPED SIGNATURES ARE NOT ACCEPTABLE ON ANY MEDICAL RECORD. PATIENT
IDENTIFICATION, DATE OF
SERVICE AND PROVIDER OF THE SERVICE SHOULD BE CLEARLY IDENTIFIED ON THE SUBMITTED DOCUMENTATION. IF THE RENDERING PROVIDER
SIGNATURE IS NOT
CLEARLY LEGIBLE, ATTACH A SIGNATURE LOG/KEY THAT INCLUDES THE TYPED NAME OF THE PROVIDER WITH CREDENTIALS, THE SIGNATURE AND
THE INITIALS
FOR EACH PROVIDER FOR WHICH THE RECORDS ARE REQUESTED. IF YOU QUESTION THE LEGIBILITY OF YOUR SIGNATURE, YOU SHOULD SUBMIT
AN ATTESTATION
STATEMENT IN YOUR DOCUMENTATION RESPONSE. IF THE SIGNATURE REQUIREMENTS ARE NOT MET, THE REVIEWER WILL CONDUCT THE REVIEW
WITHOUT CONSIDERING THE DOCUMENTATION WITH THE MISSING OR ILLEGIBLE SIGNATURE. THIS COULD LEAD THE REVIEWER TO DETERMINE
THAT THE MEDICAL
NECESSITY FOR THE SERVICE BILLED HAS NOT BEEN SUBSTANTIATED.

          PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT  PF6-SCROLL FWD  PF8-NEXT
  
```



46

FISS: Page 2 of Reason Code

MAP1881 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 04/01/21
 KXT2938 SC REASON CODES INQUIRY A20212CF 06:10:46
 MNT: CIE3820 082720

PLAN	REAS	NARR	EFF	MSN	EFF	TERM	EMC	HC/PRO	PP	CC
IND	CODE	TYPE	DATE	REAS	DATE	DATE	ST/LOC	ST/LOC	LOC	IND
1	5FGFP	E	060120				S B6000	S B6000		E
TPTP	A	B	NPCD	A	B	HD CPY A 2 B 2 NB ADR 1	CAL	DY 45	C/L	L

-----NARRATIVE-----

THIS ADDITIONAL DEVELOPMENT REQUEST (ADR) IS PART OF A SERVICE SPECIFIC POST-PAYMENT REVIEW.

***** WOUND DEBRIDEMENT SERVICES; HCPCS 11042*****

LOCAL COVERAGE DETERMINATION (LCD): DEBRIDEMENT SERVICES (L33614)

LOCAL COVERAGE ARTICLE: BILLING AND CODING: DEBRIDEMENT SERVICES (A56617)

1. HISTORY AND PHYSICAL
2. PROGRESS NOTES DOCUMENTING PHYSICAL FINDINGS AND EFFECTIVENESS OF TREATMENT
3. AN OPERATIVE NOTE OR PROCEDURE NOTE FOR THE DEBRIDEMENT SERVICE. THIS NOTE SHOULD DESCRIBE THE ANATOMICAL LOCATION TREATED, THE INSTRUMENTS USED, ANESTHESIA USED IF REQUIRED, THE TYPE OF TISSUE REMOVED FROM THE WOUND, THE DEPTH AND AREA OF THE WOUND AND THE IMMEDIATE POST PROCEDURE CARE AND FOLLOW-UP INSTRUCTIONS.
4. IDENTIFICATION OF THE WOUND LOCATION, SIZE, DEPTH AND STAGE EITHER

PROCESS COMPLETED --- PLEASE CONTINUE

PRESS PF3-EXIT PF6-SCROLL FWD PF8-NEXT



47

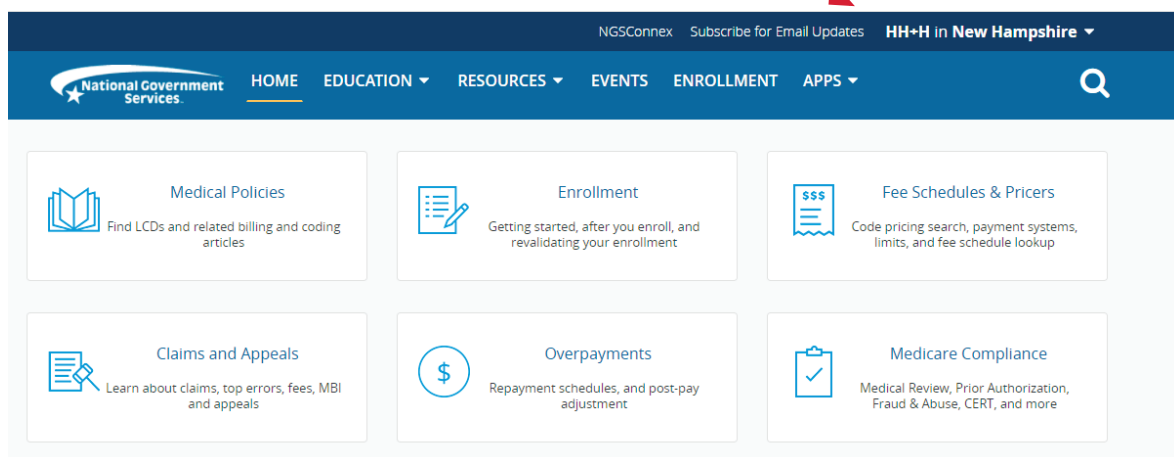
Home Health & Hospice References and Resources

References & Resources

- [NGS Website](#)
- [NGSConnex](#)
- [NGSMedicare YouTube Videos](#)

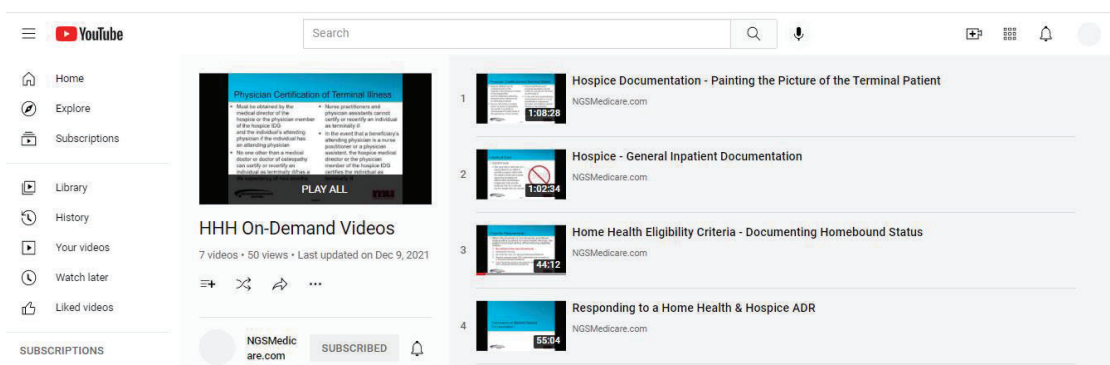
NGS Email Updates

- [Subscribe to receive the latest Medicare information](#)





NGS HHH On-Demand Videos



51

Medicare University

- Interactive online system available 24/7
- Educational opportunities available
 - Computer-based training courses
 - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- [Medicare University website](#)



52

Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs



53

Provider Contact Center Procedures

- The Provider Contact Center should always be your first option when contacting National Government Services
 - Required to log and track all incoming inquiries
- Tiered system to respond accurately to all provider inquiries



54

Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California , Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT



55

Thank You!

- Questions?



56