TPE, UPIC and CERT Medicare Audits: What to Expect

2026

Presented by:
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Stephanie Allard is an expert in Medical Coding, Billing, Reimbursement, and Compliance. She is a multispecialty auditor with proficiency in more than 40 specialties including, but not limited, to behavioral health, rheumatology, orthopedics, lab services, dental, neurology, general surgery, OB/GYN, PM&R, and PT/OT. In addition to performing external audit reviews, Stephanie conducts revenue cycle reviews to help organizations maximize their workflow and repair the disconnects throughout the administrative side of their business. She uses her training and education experience to help clients implement practices and strategies that will reduce risk in the future. She also performs forensic auditing as an expert that includes focused reviews to be used in court cases and payer investigations.

Stephanie brings 20 years of medical and management experience with a strong understanding of the entire medical billing and coding process. She has managed large teams of coders and understands the importance of quality reviews, productivity tracking and coding education. Clients appreciate that Stephanie stays current with the ever-changing regulations and is able to convey new information in a way that helps improve their overall results. She often provides guidance and support to other coding professionals and has enjoyed mentoring others throughout the years.

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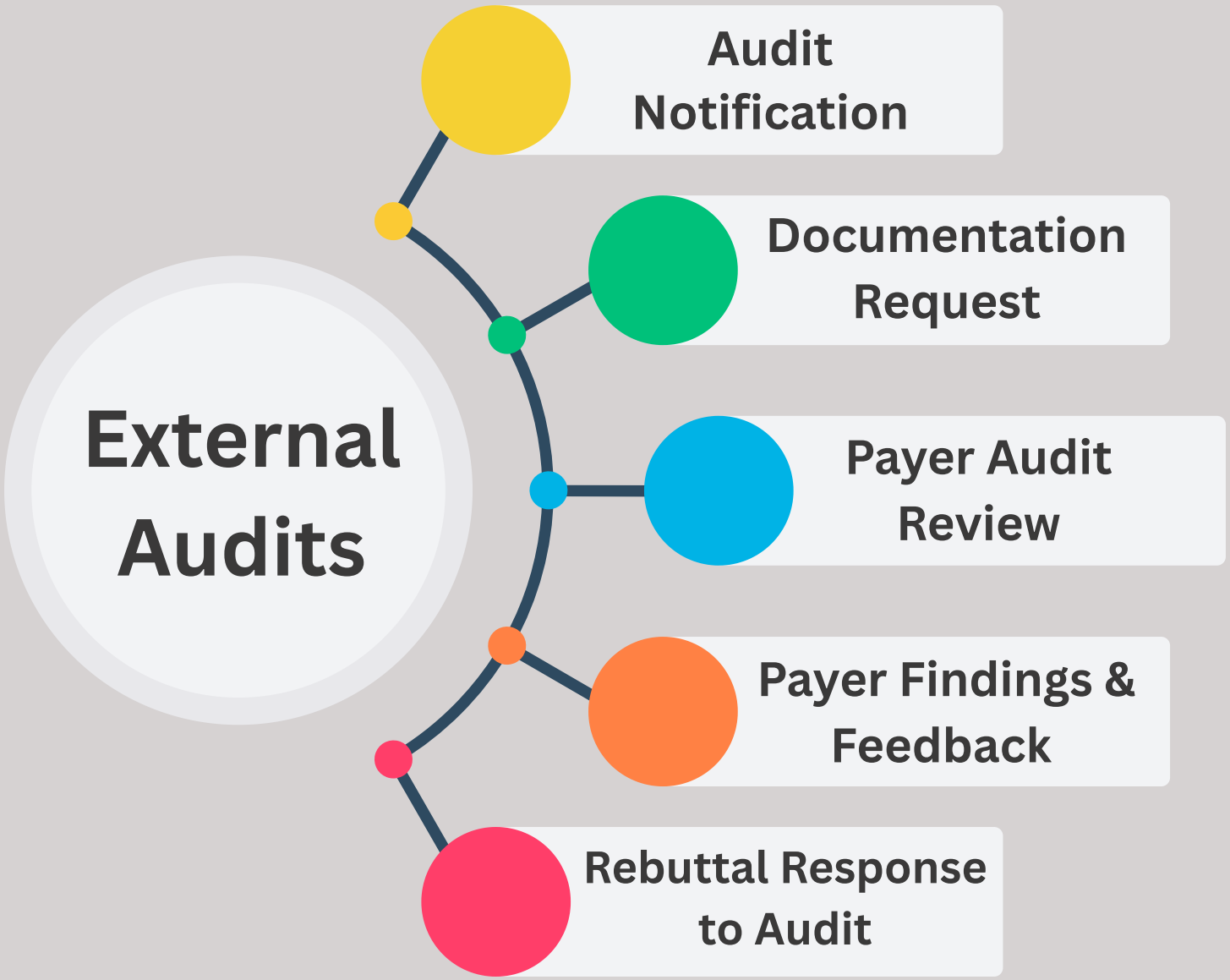
UNDERSTANDING EXTERNAL AUDITS



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WHAT IS AN EXTERNAL MEDICAL CODING AUDIT?

A review of a healthcare organizations documentation and medical coding practices conducted by the payer or a contractor on their behalf. The reviews are completed to ensure compliance with established guidelines and policies and to assess fraud, waste and abuse.

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COMMON EXTERNAL AUDITS

- Targeted Probe & Educate (TPE) Program Audits
  - These audits focus on specific areas where errors or inconsistencies have been identified, often involving Medicare Fee-For-Service billing errors.
- Unified Program Integrity Contractor (UPIC) Audits
  - These audits are conducted by contractors under contract with the Centers for Medicare & Medicaid Services (CMS) and focus on various program integrity areas.
- Supplemental Medical Review Contractor (SMRC) Audits
  - These audits are conducted by contractors who focus on medical review of claims.
- Comprehensive Error Rate Testing (CERT) Audits
  - These audits are a key part of Medicare's effort to identify and reduce billing errors.
- CMS Program Integrity Audits
  - These audits are conducted by CMS to ensure that program integrity requirements are being met.
- SIU investigations with commercial payers

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AUDIT NOTIFICATION & DOCUMENTATION REQUESTS

- Workflow must be in place to ensure all communication is read by each payer TIMELY
  - Many issues can arise with missed deadlines and that can result in claim denial/rejection
- Staff that handle the mail and communication must be aware of what the letters look like
- A process must be in place to ensure the appropriate compliance team members review the letter ASAP

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UNDERSTANDING THE REQUESTS

- Once the request is reviewed the following detail needs to be identified:
  - Type of notification
    - Pre-payment vs. post-payment review
  - Payer requesting documentation
  - Department and/or contractor that is asking for the information
  - Number of requests previously received
  - Timeframe that is going to be reviewed
  - Providers and services that the payer is requesting to review
  - Due date for the requested information

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RESPONDING TO THE REQUESTS

- Review the due date and ask for an extension if you are not able to gather the information within their requested time
- Do an internal review of the claims the payer is requesting to see if there are concerns with the services
- Based on your internal concerns and/or the type of audit/investigation that is going to be conducted on your organization you need to consider engaging a health law attorney and compliance consultant
  - They will typically handle all of the correspondence with the payer/investigator
- Timeliness is extremely important
  - The response to the payer must be timely
  - Do not wait to retain an attorney when there are concerns, waiting can make defense more difficult in the future

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Part B TPE Topics for review

Topic and education	Related CPT/HCPCS	Review status	Documentation checklist	Results
Rehabilitation Services (Outpatient) • L33413 Therapy and Rehabilitation Services (Retired 03/31/2023)	97110, 97112, 97116, 97124, 97140 and 97530	Inactive	Checklist Therapy and Rehabilitation Services	Rehabilitation Services Results Rehabilitation Services with KX Modifier Results
Ambulance Services • L3767 Emergency and Non-Emergency Ground Ambulance Services (Retired 02/09/2023)	A0428 and A0425	Inactive	Checklist Ambulance Services	Ambulance Services Results
Psychotherapy Services • L33252 Psychiatric Diagnostic Evaluation and Psychotherapy Services	90832, 90834 and 90837	Inactive	Checklist Psychotherapy Services	Psychotherapy Services Results
End-Stage Renal Disease (ESRD) Services • L37564 Frequency of Hemodialysis	90960	Inactive	Checklist End-Stage Renal Disease (ESRD)	ESRD Results
Evaluation & Management (E/M)	99202-99205; 99211-99215; 99221-99223; 99231-99233; 99281-99284	Active	Checklist Evaluation & Management (E/M)	Evaluation and Management Office Visit Results Evaluation and Management Hospital Visit Results
L36393 Laboratory Services	87150, G0480, G0481, G0482, G0483 and G0659	Active	Checklist Laboratory Services	Laboratory Services Results
L33674 Diagnostic Radiology	93975-93976 and 93978-93979	Inactive	Checklist Diagnostic Radiology	Diagnostic Radiology Results
Annual Wellness Visit (AWV)	G0438 and G0439	Active	Checklist Annual Wellness Visit	AWV Results Coming Soon
Transitional Care Management (TCM) services	99495 and 99496	Active	Checklist Transitional Care Management services	TCM Results Coming Soon

Checklist: Evaluation and Management (E/M) services documentation

This checklist is intended to provide healthcare providers with a reference for use when responding to additional nddocumentation retain responsibility to submit complete and accurate documentation. Additional tools and interactive score sheets are available to

Check	Documentation description
	Documentation is for the correct beneficiary.
	Documentation is for the correct date(s) of service.
	Documentation contains a valid and legible signature, which follows CMS Signature Guidelines for Medical Review Purposes.
	Documentation supports that a face-to-face visit occurred.
	Documentation supports medically reasonable and necessary E/M service as outlined in CMS IOM, Pub. 100-04, Claims Processing Manual, Chapter 12, Section 30.6.
	If billing service based on medical decision making, all relevant documentation that supports the level of service billed (e.g., office and/or progress notes, physician's orders and intent, emergency room records, consultations/procedure reports, radiology/diagnostic tests, EKG, lab, and pathology results, etc.): • Number and complexity of problems addressed • The amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management
	If billing service based on time (if applicable), documentation to support time spent performing E/M service.
	Documentation to support any applicable modifiers billed with the E/M service.
	Documentation to support "incident to" guidelines (if applicable), that includes evidence of the billing provider's presence in the office suite and prior, ongoing participation in patient care.
	Documentation includes an advanced beneficiary notice of non-coverage was provided (if applicable and required).
	Any additional documentation to support medical necessity or any applicable policy guidelines for the services billed.

Top denial/partial denial reasons:

The most common reasons for denial or partial denials are the following:

1. **Medical Necessity** – The documentation submitted does not support medical necessity as listed in coverag

2. **Insufficient Documentation** – Insufficient documentation was provided to support the services as billed to that we were not able to resolve:

- Documentation submitted for review did not support the level of care billed.
- Documentation submitted for review did not support the billing of the service as "incident to" a physician.
- Documentation submitted did not support the billed services.
- Documentation lacked a comprehensive assessment.
- Documentation submitted for review did not support the billed date of service.
- Documentation submitted supported the key elements for a lower level of service.
- Documentation submitted did not support the incident-to criteria was met.
- Documentation submitted was reduced due to a change in rendering provider.
- Documentation did not include a valid signature and/or credentials.
- Documentation did not support the modifier billed to sup[ort a separately identifiable E/M service.
- Documentation submitted was a duplicate for a service previously submitted by the provider.
- Non-response to documentation request.

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Announced or Revised	Agency	Title	Component	Report Number(s)
November 2024	Centers for Medicare and Medicaid Services	Medicare Part B Payments for Incident-To Services	Office of Audit Services	OAS-25-01-003

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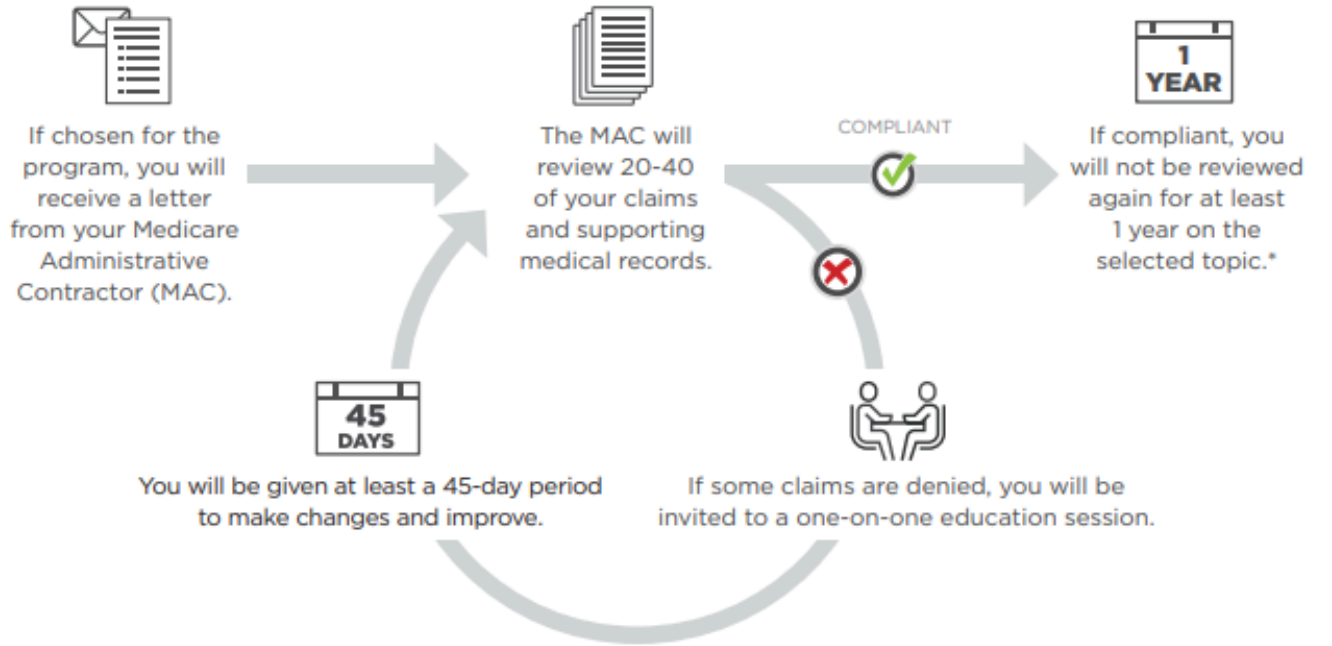
TARGETED PROBE AND EDUCATE

HOW DOES IT WORK?



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

WHAT IF MY ACCURACY STILL DOESN'T IMPROVE?

This should not be a concern for most providers and suppliers. The majority of those that have participated in the TPE process increased the accuracy of their claims. However, any who fail to improve after 3 rounds of TPE will be referred to CMS for next steps.

WHAT ARE SOME COMMON CLAIM ERRORS?

- The signature of the certifying physician was not included
- Encounter notes did not support all elements of eligibility
- Documentation does not meet medical necessity
- Missing or incomplete initial certifications or recertification

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IMPORTANCE OF A COMPLIANCE PROGRAM

OIG (Office of Inspector General) guidelines strongly encourage and essentially require healthcare providers and practices to have a robust compliance program. While not always explicitly mandated by law, having a strong program demonstrates good faith and can help mitigate potential penalties and legal issues. The OIG's General Compliance Program Guidance (GCPG) provides a framework for building these programs.

This is often a requirement of participation with payers as well.

https://oig.hhs.gov/compliance/general-compliance-program-guidance/#:~:text=The%20General%20Compliance%20Program%20Guidance,to%20present%20voluntary%2C%20nonbinding%20guidance.

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IMPLEMENT AUDIT READINESS AND RESPONSE STRATEGIES

- Communication is the key factor when it comes to compliance
- It is important to have “someone at the table” from each perspective
  - Legal
  - Medical Coding & Compliance
  - Revenue Management
  - Clinical
  - Administration
- Policies and workflows must be in place to ensure that there are no disconnects and the organization is constantly on alert
  - Compliance is not a one time thing or done at a low frequency
    - The industry is constantly changing and you must be on top of the trends with organized plans internally

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STAY ON TOP OF INDUSTRY AND AUDIT TRENDS

- Artificial Intelligence
  - on the payer and provider side
- Constantly changing payer policies
- Medical weight loss
- Behavioral health integration
- Lifestyle medicine
- Know where to find the current external audit topics
  - CMS MAC's often publish their Targeted Probe and Educate audit topics
  - Review the OIG Work Plan
  - Pay attention to trends that are coming internally through documentation requests and pre-payment reviews

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NEXT STEPS...

- Pause and evaluate where you are currently at
  - Who is responsible for the different areas of compliance?
  - What audits are being done currently to improve your organization?
    - External input is invaluable as objective reviews and feedback ultimately help challenge disconnects internally
  - Consider how does your organization handle the feedback when changes must be made?
- Evaluate the individual departments like compliance, quality, finance, the administrative teams, etc. to determine whether everyone is collectively working together or if changes need to be made

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Thank you!

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AUDITING ANTICS
NAVIGATING MEDICAL CODING & AUDITING
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