



EDUCATIONAL RESOURCES

Understanding and Responding to an ADR

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 HOME HEALTH  HOSPICE



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Welcome

- So happy you were able to attend today's webinar
- We hope you find it insightful and it helps in developing an ADR proof environment for your agency.

Our Agenda Today

- What is an ADR
- Who sends you an ADR
- Why is an ADR being sent
- How do you respond to an ADR

What is an ADR?

- An additional documentation request (ADR) is generated when documentation is necessary to adjudicate a Medicare claim. This request is for medical record documentation to support payment of an item(s) or service(s) reported on the claim to ensure compliance with Medicare's coverage, coding, payment and billing policies.

Who is sending the ADR Review?

- MACs - A Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries.
- CERT auditors - A medical auditor reviews coding accuracy, policies, and procedures to ensure that an organization is running an efficient and liability-free operation.
- Recovery Auditors- A Recovery Audit Contractor (RAC) is a third-party entity working on behalf of the United States government [Centers for Medicare and Medicaid Services](#) (CMS) to identify and recover improper payments made in Medicare transactions between providers and payors.
- UPICs - Unified Program Integrity Contractors (UPICs) are CMS's only program integrity contractors that safeguard both the Medicare fee-for-service (FFS) and the Medicaid programs from fraud, waste, and abuse.

What types of ADRs does CGS generate?

- CGS generates two types of ADRs:
 - Medical Review
 - Is generated under reason code 39700
 - A Medical Review is generated when medical record documentation is needed too support medical necessity, to ensure claim is in compliance with Medicare coverage, coding, payment and billing policies.
 - Non- Medical Review
 - Is generated under reason code 39701
 - A Non – Medical Review is generated for Home Health and Hospice include a KX modifier and the remarks field is either blank or insufficient

Why are you receiving an ADR?

- High volume of visits per beneficiary
- High payments per beneficiary
- High number of late episodes
- High average outlier payment amounts per beneficiary
- High number of therapy visits per beneficiary
- Dramatic change in frequency of use
- Homebound status
- Reasonable and necessary services /medical necessity
- Length of stay

Why are you receiving an ARD (cont.)

- High volume of visits per beneficiary
 - Example:
 - Visits exceeding the standard for patient under same DX

- High Payments per beneficiary
 - Total national outliner payments for home health services annually will be no more than 2.5 percent of estimated total payments under home health PPS.

Why are you receiving an ARD (cont.)

- High number of late episodes
 - Timing. Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods in the sequence (second or later) are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next.
- The system generated an ADR

What to do when you receive and ADR review

- The first thing to do is **not panic**.
 - Remember this is a normal occurrence in the home care industry.
- The second thing you should do is get your QA department or person to conduct a complete audit on the request.
 - If you don't feel the QA department has the skills or time to conduct an ADR response audit, contact an ADR specialist to conduct the ADR response audit begin working on your response.

TIPS for conducting a self ADR audit

- Identify all episodes and services provided for patient in question.
- Identify whether the dates in question apply to two different episodes
 - If data is in two episodes you have to ensure that the data for both episodes is provided to ADR requestor.
 - This would include but is not limited to:
 - Original Order
 - Signed POC for both cert periods
 - Face to Face encounter which covers both cert periods

Preventing Documentation Red Flags

- First let's define what a red flag is
- Red Flags are a cause for concern when reviewing your documentation
 - RED FLAGS prompt more inquiries

Audit Red Flags

- Evidence of alteration:
 - Obliterated sections
 - Missing Pages
 - Inserted pages
 - Multiple corrections
 - Excessive late entries
- Missing Signature from forms
 - Order will be disregarded

What should you send?

- The ADR request is very clear in what needs to be sent:
 - Plan of Care
 - Face-to-Face encounter
 - Physician/practitioner certification or recertification statement/orders
 - OASIS assessments
 - Clinical notes
 - Therapy Assessments
 - Therapy Orders
 - Supplemental physician / practitioner orders
 - Other supporting documentation

There is a time frame on submissions

- Medical Review ADRs: within 45 days of notice
- Non-medical review ADRs: within 30 days
- Any submission received even 1 day past due date will not be accepted.

Common Denial Reasons

Requested records
not submitted

Physician narrative
statement not
present or not valid

Not hospice
appropriate

Invalid notice of
election

GIP documentation
not
reasonable/necessary

Continuous care
hours not
documented or
documented
incorrectly

Continuous care
hours not
reasonable/necessary

Certification not
present, timely or
valid

Face-to-Face
encounter
requirement not met

Common Home Health Denials

F2F does not meet regulatory requirements

Failure to submit records (#1 reason for denials)

No POC or certification / recertification

OASIS not submitted to determine HIPPS code

Medical necessity not supported in documentation

Diagnosis codes inaccurate to support medical necessity for services

Failure to document changes in treatment/medical condition

Claim and documentation of services/supplies inconsistent

Services provided non-reimbursable per Federal and State regulations

No signed orders for skill provided

Failure to follow physician/practitioner orders

Therapy functional re-evaluations not performed in

Timely manner

- Illegible documentation, signature, and/or date
- Homebound status not supported in documentation

Common Documentation Issues

- Incomplete
- Inconsistent evidence to support diagnoses
- No skill documented
- Lack of coordination of care
- Failure to communicate issues/concerns with physician/practitioner
- Care incongruent with issues identified or case-mix diagnoses
- Legible documentation, signatures, and/or credentials
- Failure to proofread documentation before submission
- Care fails to follow plan of care

Documentation issues (cont.)

- Legible signatures
 - Need signature log or signature attestation
 - Printed or typed name/credential accompanying signature
 - No stamped signatures allowed (special exception applies for physician disability)
- Failure to meet signature requirement
 - Auditor disregards documentation
 - Referral to UPIC if suspected fraud



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TIPS on Documentation

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Reasonable and Necessary Services

- Medically reasonable and necessary services for:
 - Treatment of injury
 - Illness
 - Disease/condition
- Treatments must be:
 - Safe and effective
 - Not experimental or investigational

Reasonable and Necessary Services...continued

- Frequency/duration appropriate to treatment of disease or illness
 - Appropriate to patient's needs and condition
 - Any changes in care should be documented through a POC and signed by referring physician.
 - Furnished by qualified personnel
- Meets but does not exceed patient's need
 - If condition changes it is imperative that a new assessment and POC are done and effective
 - Not experimental or investigational

Medical Necessity

- Justifiable reason for agency to provide care:
 - Plan of Care
 - Meets standard and acceptable medical practice standards
 - Proper coding that reflects primary reason for services and level of care.
 - Medication to support DX
 - Service are consistent with nature and severity of
 - Illness and/or
 - Injury
 - Document barriers to recovery
 - Unstable caregiving situation, language barriers, education, anxiety, co-existing conditions

Homebound Status

- Patient must:
 - Need physical assistance to leave home
 - Leaving home is medically contraindicated
 - The conditions of the patient is such that there exist a normal inability to leave home and consequently, leaving home would REQUIRE A CONSIDERABLE AND TAXING EFFORT as evidence by DX

Coordination of care

- Care coordination needs to be continuous
- Care coordination needs to be documented:
 - Clinician with office
 - Clinician with other clinician on patient's service
 - Clinician with supervisor
 - Clinician with Dr. Office

Face to Face encounter

- 90 days prior to- or 30 days after SOC
- Encounter related to reason for home health services
- Signed/dated by eligible practitioners
- All required elements addressed
- May use supporting documentation to meet required elements; must be signed/dated by certifying practitioner

Face-to-Face Encounter Hospice

- Within 30 days prior to 3rd benefit period recertification & every subsequent benefit period.

Sample ADR Request

Dear [REDACTED]

ADDITIONAL DOCUMENTATION REQUEST
DUE DATE - 10-16-2020

You may respond by one of the following methods:

- * Electronic - Registered myCGS users may upload documents through the myCGS web portal at <https://mycgsportal.com/>
- * Mail - CGS - DME MAC 3C, P.O. Box 20010, NASHVILLE, TN 37202
- * Fax - 615-782-4624
- * esMD - For more information about esMD, see www.cms.gov/esMD.
- * CD/DVD - May be mailed by any means.

Patient Account Number (if submitted on the claim): 7

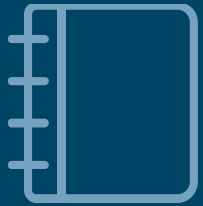
We have received your claim for the item(s) listed below. Additional documentation is needed to assure these items are covered and coded correctly. You must provide the documentation indicated below and any additional documentation you deem appropriate within 45 days of the date of this letter. Failure to do so may result in a medical necessity denial of this claim (please refer to Social Security Act (SSA) section 1815(a), 1833(e), and 1862(a)(1)(A)). Thank you for your cooperation.

1

- IMPORTANT -
PUT THIS PAGE ON TOP OF THE INFORMATION YOU RETURN TO US.

2

Medicare Claim Number:
Medicare Number:
Beneficiary Name:



Case Study 1

Home Health Example

Case Study 1 Liability of 3.2 Million

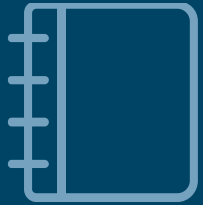
- Home Health Receives an ADR and inquiring about claims in 2020.
- Home Health Delivered all services and has signed documentation services were delivered.
- Not all POC were signed

Case Study 1 continued

- Provider submitted all requested documentation.
 - POC
 - Signed acknowledgements of services
 - MD Orders
 - All documentation was submitted on time
- In addition Provider wrote an apology letter for any error that had been made.

Case Study 1 Failure

- The cover letter was followed by an apology letter stating.
“In these times we might have made mistakes but they were not done with malice.”
 - Guilt of wrongdoing was acknowledged before any documentation was reviewed.
- POC were not signed and dated.
 - Leaving the document open ended with no real POC approved.
- All ADR requests were denied and denial ranged for the life of the patients at the agency not just the requested episodes



Case Study II

Hospice

Case Study 2 Liability?

- ADR request was for 1 of 4 episode periods.
- All POC, Orders and Medical Necessity were 100% in compliance.
- Sign in sheet for continuous care were submitted.
 - Error on first day was found as
 - Provider was 15 min. late to first day
- Claim was rejected and opened the inquiry to 20 more claims.

Case Study II

- This case has not been closed and errors on continuous care were found in 3 more which prompted 20 more inquiries.
 - Total inquiries to date 51.
 - 50 additional due to error found in one document.

In Conclusion

- Before responding to an ADR you should:
 - Conduct a complete audit on documentation being sent
 - Send only required documentation
 - Be timely in your response

References

- [Inappropriate and Questionable Billing by Medicare Home Health Agencies \(OEI-04-11-00240; 08/12\) \(hhs.gov\)](#)
- [Home Health PPS | CMS](#)
- CMS.gov



Achieving Excellence

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NEW PROGRAMS:

Expert educators will conduct focused tracks for home health and hospice leaders, and attendees also will have networking opportunities with outstanding peers.



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Thank you

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