

Managing and Understanding the Life Cycle of an ADR



A Medicare Additional Document Review (ADR) for Home Health and Hospice is a formal request from a Medicare Administrative Contractor (MAC) or other Medicare reviewer asking the provider to submit specific clinical or supporting documentation related to a claim, episode of care, or patient certification. The request seeks additional records to verify medical necessity, coverage criteria, timeliness, and accuracy of billing for Medicare-covered services

How does an ADR inquiry begin

- To achieve a successful ADR outcome for your agency, start by understanding how the ADR process works.
- Today we'll review the ADR lifecycle and outline steps your agency can take to prepare for a successful response.
 - Understand the purpose of an ADR
 - Preparing for an ADR and minimizing the risk
 - Response Workflow & Submission Best Practices
 - Reviewing common reasons for ADR denials
 - Remediation, Appeals & Continuous Improvement

Triggers for ADR

- **MAC audit, post-payment review, claim denial, claim edit flag**
 - Complaints, billing errors etc.
- **Routine monitoring or targeted review by payer/compliance**
 - Review and monitoring compliance w/in your agency
- **Provider self-identified documentation gaps**
 - Provider issues

ADR Definition & Purpose

- MAC request for additional clinical/supporting documentation
- Purpose: validate medical necessity, support claims, respond to audits
- Applies to: recertifications, SOC/ROC, physician orders, plans of care, encounter notes



Purpose of an ADR

▪ Confirm Medical Necessity

- Requires clear, contemporaneous documentation that links the patient's condition to the skilled services provided and to coverage criteria.

▪ Reconcile documentation with billed services.

- Every billed service/unit should be directly traceable in the medical record to a timely, authenticated clinical entry that **documents who performed the service, why it was need**

▪ Validate physician certification/order

- ADR validation ties the physician's certification/order to Medicare rules, the plan of care, and objective clinical documentation—verifying authenticity, timing, completeness

▪ Resolve ADR – Related/claim and payment issues

- Medicare resolves ADR-related claim/payment issues by reviewing submitted documentation against coverage rules, making a determination (payment, adjustment, or recoupment), notifying providers with appeal rights, and applying follow-up audits or corrective measures as needed..

When does an ADR begin

- The Life cycle of an ADR begins when you admit a patient.
 - How you manage an admission will set the foundation for your patient documentation success.
 - ADR is an Additional Documentation Review. All decisions are based on the documentation you submit.
 - So treating every admission as an ADR response is appropriate.
 - Orders
 - Medical Necessity
 - Consents
 - Admission Documentation

Can you avoid an ADR inquiry

- **The answer is NO. ADR are a way of life in our industry.**
- **However a provider can minimize the Risk associated with and ADR review.**
 - Timely, complete certifications/orders
 - Ensure face-to-face and required encounters (Home Health)
 - Strong medical necessity documentation
 - Complete, legible, contemporaneous notes
 - Link documentation to billed services
 - Use standardized templates and checklists
 - Pre-billing reviews and QA
 - Ongoing staff training
 - Robust coding and claim accuracy
 - Physician engagement and attestation processes

Response Workflow & Submission Best Practices

- Obtain signed physician certifications, recertifications, and orders within Medicare timeframes; ensure dates cover billed services.
- Document face-to-face encounters with content that supports homebound status and skilled need; tie encounter timing to start-of-care/recert periods.
- Record clear diagnoses, objective findings, skilled rationale, measurable goals, and documented response to skilled interventions.
- Document who provided care, when, what was done, clinical findings, patient response, and plan. Sign and credential all entries.
- Map each billed date/code/unit to a supporting clinical entry, physician order, and POC element.
- Standardize intake forms, POC templates, face-to-face templates, and ADR prevention checklists to capture required elements consistently.

Pre-billing reviews and QA

- Perform clinical and coding reviews before claim submission to catch missing signatures, gaps in coverage periods, unsupported units, or coding errors.
- Pre-billing quality assurance for Home Health and Hospice should be a standardized, multidisciplinary process that verifies clinical, administrative, and coding accuracy before claims are submitted. It should include a checklist-driven review of physician orders/certifications and recertifications (timely signed and dated), plan-of-care alignment with billed services, face-to-face documentation for Home Health, and hospice prognostic/certification elements; validation that each billed date/unit links to a contemporaneous clinical note showing the skilled service and medical necessity; accurate patient identifiers, CPT/HCPCS codes, modifiers, and units; and completion of required signatures and documentation legibility.

Reviewing common reasons for ADR denials

- Top reasons Medicare issues ADRs for Home Health and Hospice:
 - Missing, unsigned, or untimely physician certifications/orders or recertifications
 - Lack of required face-to-face encounter documentation (Home Health) or insufficient prognostic/certification evidence (Hospice)
 - Insufficient documentation of medical necessity (no objective findings, unclear skilled need, or goals)
 - Incomplete or missing plan of care elements (frequency, specific skilled interventions, physician sign-off)
 - Visit/encounter notes that don't support billed dates/units or lack contemporaneous documentation of services provided

Reviewing common reasons for ADR denials

- Documentation inconsistencies or contradictions (diagnoses, dates, provider IDs, therapy frequency)
- Missing signatures, credentials, or illegible entries (clinician or physician)
- Administrative/coding errors (wrong patient identifiers, claim linkage, incorrect CPT/HCPCS, units, or modifiers)
- Lack of documentation for skilled versus custodial care (services appear non-skilled)
- Failure to retain or produce requested records, or poor organization of submitted documentation
- Addressing these areas through standardized templates, pre-billing QA, timely physician attestations, and robust intake/tracking can substantially reduce ADR risk.

Managing Appeals

- Build a focused, evidence-based appeal packet
 - Include a concise cover letter mapping each denial reason to specific chart entries (date/time, note author, page/section). Attach only pertinent records (orders, POC, face-to-face, progress notes, labs, physician attestations) to avoid clutter.
 - Obtain targeted physician clarifications/attestations
 - Secure a dated, signed physician statement addressing the exact deficiency cited (medical necessity, timing, face-to-face content, recertification rationale). Use concise templates that reference the denial language.

Managing Appeals

- Demonstrate direct linkage between documentation and billed services
 - For each denied date/unit/code, show the contemporaneous note(s) that document who performed the skilled service, why it was medically necessary, and how it aligns with the POC and physician orders.
- Correct administrative/coding errors promptly and transparently
 - If denial stems from admin issues (wrong identifiers, missing signatures, coding errors), correct the claim or submit missing administrative evidence, disclose the correction in the cover letter, and, where appropriate, adjust/resubmit the claim while pursuing the appeal.
- Follow the appeals ladder and timelines; escalate strategically
 - File timely redetermination/reconsideration with complete evidence. If denied, move to higher-level appeals (ALJ, MAC, Medicare Appeals Council) only with a strong clinical/legal rationale. Coordinate billing actions, hold recoupment disputes, and document all submissions and communications for audit/next-level review.

ADRs aren't going away, but you can stay ahead of the trend and position your agency for successful audit outcomes.





Thank you

Alicia Montelongo Vargas
humbirdconsulting@gmail.com



ACHCU is a brand of Accreditation Commission for Health Care

