
Conquering the ADR Dilemma
Presented by
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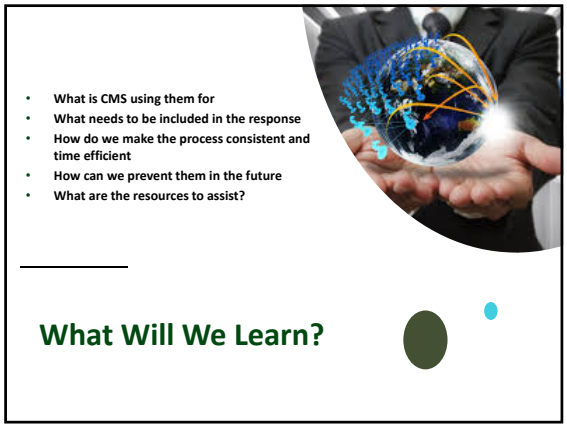
What is CMS using them for
What needs to be included in the response
How do we make the process consistent and time efficient
How can we prevent them in the future
What are the resources to assist?
What Will We Learn?

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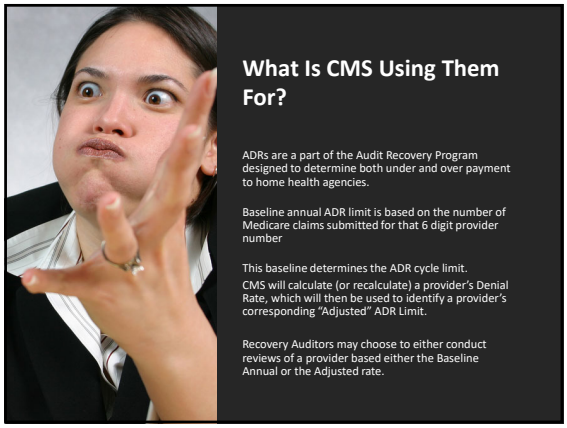
What Is CMS Using Them For?
ADRs are a part of the Audit Recovery Program designed to determine both under and over payment to home health agencies.
Baseline annual ADR limit is based on the number of Medicare claims submitted for that 6 digit provider number
This baseline determines the ADR cycle limit.
CMS will calculate (or recalculate) a provider's Denial Rate, which will then be used to identify a provider's corresponding "Adjusted" ADR Limit.
Recovery Auditors may choose to either conduct reviews of a provider based either the Baseline Annual or the Adjusted rate.

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## What Is CMS Using Them For?

Although the Recovery Auditors may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days.

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## How Does CMS Calculate How many ADRs I Will Be Getting?

Risk-Based, Adjusted ADR Limits (Updated 5/03/2016)

After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider's Denial Rate.

Denial Rate = # of claims containing improper payments (less any determinations that are fully overturned during appeal) divided by total # Medicare claims

New rate is now "Adjusted" ADR Limit, based on Table 1, below. The Adjusted ADR Limit will be used for the next three (3) 45-day ADR cycles.

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## How Does CMS Calculate How Many ADRs I Will Be Getting?

| Denial Rate (Range) | Adjusted ADR Limit (% of Total Paid Claims) |
|---|---|
| 91 – 100% | 5.0% |
| 71 – 90% | 4.0% |
| 51 – 70% | 3.0% |
| 36 – 50% | 1.5% |
| 21 – 35% | 1.0% |
| 10 – 20% | 0.5% |
| 4 – 9% | 0.25% |
| 0 – 3% | No reviews for 3 (45-day) review cycles |

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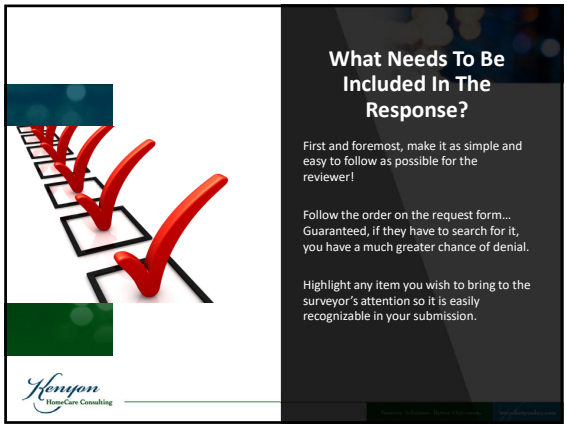
What Needs To Be Included In The Response?
First and foremost, make it as simple and easy to follow as possible for the reviewer!
Follow the order on the request form… Guaranteed, if they have to search for it, you have a much greater chance of denial.
Highlight any item you wish to bring to the surveyor's attention so it is easily recognizable in your submission.
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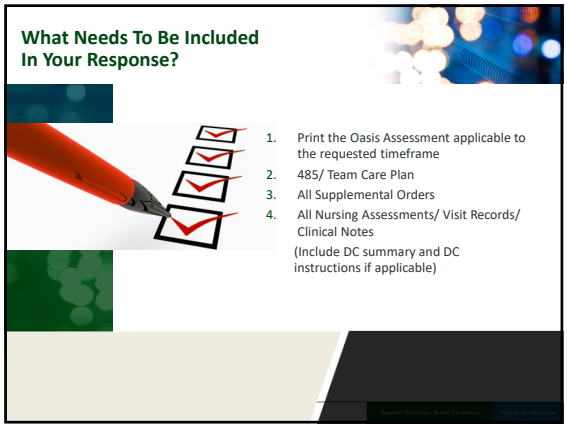
What Needs To Be Included In Your Response?
1. Print the Oasis Assessment applicable to the requested timeframe
2. 485/ Team Care Plan
3. All Supplemental Orders
4. All Nursing Assessments/ Visit Records/ Clinical Notes
(Include DC summary and DC instructions if applicable)

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What Needs To Be Included In The Response?
5. All Therapy Notes if Applicable:
• DC Summary if applicable
• All PTA/ OTA co-signed
• Communication with MD on Evals
• Re-evals/ Continuation of orders
• Did we show reason to continue?
• Is Coordination of care documented
• Include any missed visit notes…
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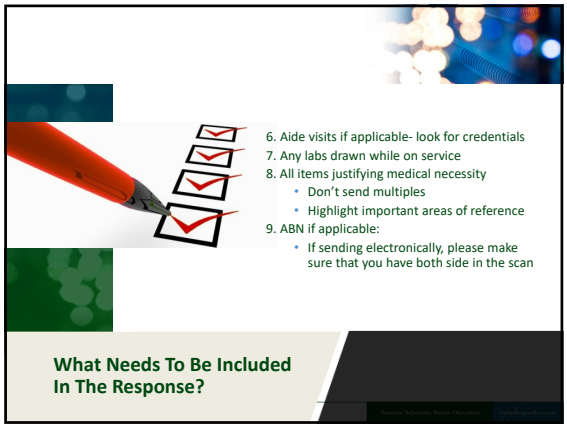
6. Aide visits if applicable- look for credentials
7. Any labs drawn while on service
8. All items justifying medical necessity
• Don't send multiples
• Highlight important areas of reference
9. ABN if applicable:
• If sending electronically, please make sure that you have both side in the scan
What Needs To Be Included In The Response?

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What Needs To Be In The Response?
10. FACE-TO-FACE:
▪ This remains a significant reason for denial
▪ Homebound status is often still missing
▪ Make it simple for the physician to comply with the regulation
▪ Clarify which items are part of the Face to Face on separate sheet in the scan
▪ Narrative can still be used
▪ Send MD note
▪ May use agency generated clarification
▪ USE YOUR 485- great tool for clarifying all items
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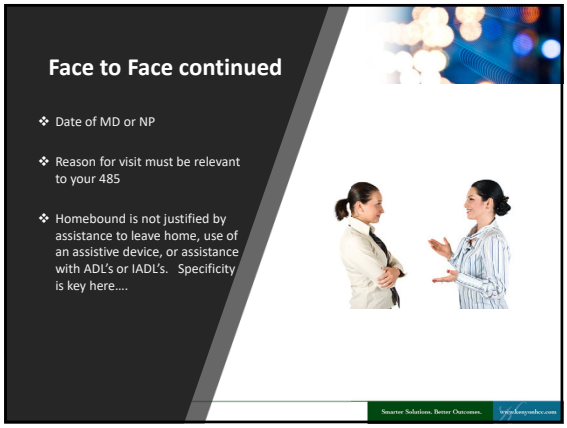
Face to Face continued
❖ Date of MD or NP
❖ Reason for visit must be relevant to your 485
❖ Homebound is not justified by assistance to leave home, use of an assistive device, or assistance with ADL's or IADL's. Specificity is key here....
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## Homebound Examples


- Pt. is unable to execute any uneven ground and therefore poses extreme risk for falls.
- Pt. is severely SOB and can only 5 minutes of activity before long rest periods are needed.
- Pt. is only able to ambulate short distance without extreme weakness and fatigue. Hazardous to leave home.

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## Homebound Examples

- If Pt. has been homebound for extended period of time prior to this episode of illness, have MD add this.
- Pt. requires 24 hour care to complete all activities due to advanced dementia
- It is unsafe for Pt. and others for Pt. to receive outpatient services due to mental incapacities


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## Reminders:

- ❑ If the patient is receiving daily SNV, make sure end dates are written in orders
- ❑ Make sure you have orders signed in compliance for all your visits
- ❑ Check RAP and Final Billing Dates
- ❑ If something is incorrectly billed, acknowledge it and ask for it to be changed

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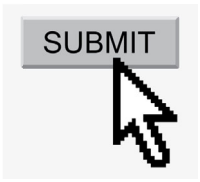
## Submission:

- Do not submit through regular mail
- Electronically submission palmetto e-services or mycgs
- Submission is under Forms
- Use correct provider number
- Receive both confirmations with DCN
- Use the ADR form as your cover pages of the submission
- LCD info needed

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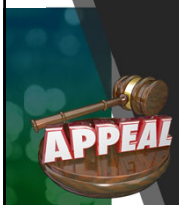
## Appeal, Appeal, Appeal




- Multiple levels of appeal are available
- Most agencies do not appeal and just accept the loss of revenue
- Take to Administrative Law Judge if necessary

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## Next Round Of Probe And Educate:

- ✓ Proposal of average of 20 per agency CCN
- ✓ May be up to 40 per CCN
- ✓ Need to have designated individual to review and submit consistently
- ✓ Use tools to guide yourself in compiling the info


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Questions?
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