Documentation to Determination:

Winning the ADR, Denial & Appeal Battle

Functional Pathways

Clinical Reimbursement Series

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Documentation to Determination:

Winning the ADR, Denial & Appeal Battle

Agenda

- What are ADRs?
- Responding to ADRs Effectively
- Medical Review and Education
- Understanding Denials
- Denial Management Strategies
- The Appeals Process
- Crafting a Strong Appeal
- Compliance Preparedness
- Lessons Learned

Presenter Details

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ADRs

Objectives:

1. Define Additional Documentation Requests and their role in the claims review process.
2. Identify the entities that issue ADRs and common triggers for these requests.
3. Demonstrate how to compile and submit complete, timely documentation in response to ADRs.
4. Apply best practices to reduce the risk of claim denials due to incomplete responses.

What Is an ADR?

ADR Definition

Additional Documentation Requests (ADRs) are requests for additional information from payers to support healthcare claims. The purpose is to verify that the services billed were medically necessary and properly documented. ADRs is a request for medical records and related documentation for the item(s) or service(s) reported on the claim.

Who Issues ADRs?

Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Supplemental Medical Review Contractors (SMRCs), Unified Program Integrity Contractors (UPICs), Commercial Insurance Companies, and Medicare Advantage.

Response Timelines

Timely and accurate responses to ADRs are crucial to avoid claim denials. Pre-payment and Post-payment response time is 30-45 calendar days depending on the MAC. Commercial insurance companies may have a different response timeline.

Common Triggers

Triggers include billing practices, coding inconsistencies, missing documentation and medical necessity questions.

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Responding to ADRs Effectively

Essential Documentation

Include complete medical records, physician notes, and supporting evidence to validate the claim.

Organized Submission

Organize documents clearly and ensure all required information is included for effective responses.

Timely Response

Submit responses within the designated timeframe to avoid delays or denials in the process.

Accuracy and Thoroughness

Emphasize accuracy and thoroughness to prevent further delays or claim denials.

Initial Response to the ADR

Managed care and Medicare send out a result letter outlining the reason for downcoding or denying services and *may* allow the provider to submit any other supporting documentation within 30 days to avoid denial.

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Medical Review

Objectives:

1. Explain the purpose and scope of Medicare's medical review and education programs.
2. Utilize feedback from reviews to improve documentation and compliance practices.

Types of Medical Review

Targeted Probe and Educate (TPE): CMS' TPE program is designed to help providers & suppliers decrease claim denials and appeals through one-on-one help. Some common claim errors include:

1. Certifying physician signature missing.
2. Documentation does not meet medical necessity.
3. Encounter notes do not support all elements of eligibility.
4. Missing or incomplete initial certifications or recertifications.

Comprehensive Error Rate Testing (CERT): The CMS implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare Fee-for-Service (FFS) program. CERT is designed to comply with the Payment Integrity Information Act of 2019 (PIIA).

Supplemental Medical Review Contractor (SMRC): CMS contracts with a SMRC to help decrease improper payment rates and protect the Medicare Trust Fund. The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A & B, and DME to determine whether claims follow coverage, coding, payment, and billing requirements.

Unified Program Integrity Contractor (UPIC): Performs fraud, waste, and abuse activities for Medicare and Medicaid claims process. The UPICs perform integrity related activities associated with Medicare Part A, B, DME, Home Health and Hospice, Medicaid, and the Medicare-Medicaid data match program (Medi-Medi).

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Types of Medical Review Continued

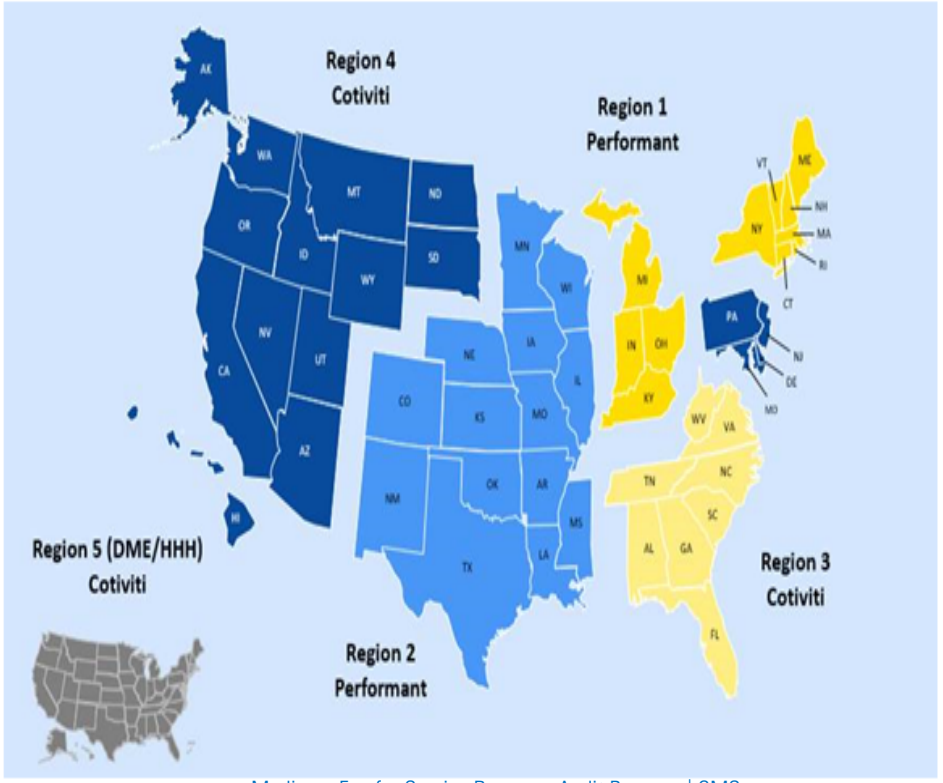
Recovery Audit Contractor (RAC): Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

RAC Topics:

Stay in the know on proposed and approved topics that RACs can review. These topics will be updated monthly on the RAC reviews topic page and include:

- Name of the Review Topic
- Description of what is being reviewed
- States / MAC regions where reviews will occur
- Review Type (complex review / automated review)
- Provider Types
- Affected Codes
- Applicable Policy References

RACs in Regions 1-4 will perform post payment review to identify and correct Medicare claims specific to Part A and Part B. Region 5 RAC will be dedicated to review of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health / Hospice.



Medicare Fee for Service Recovery Audit Program | CMS

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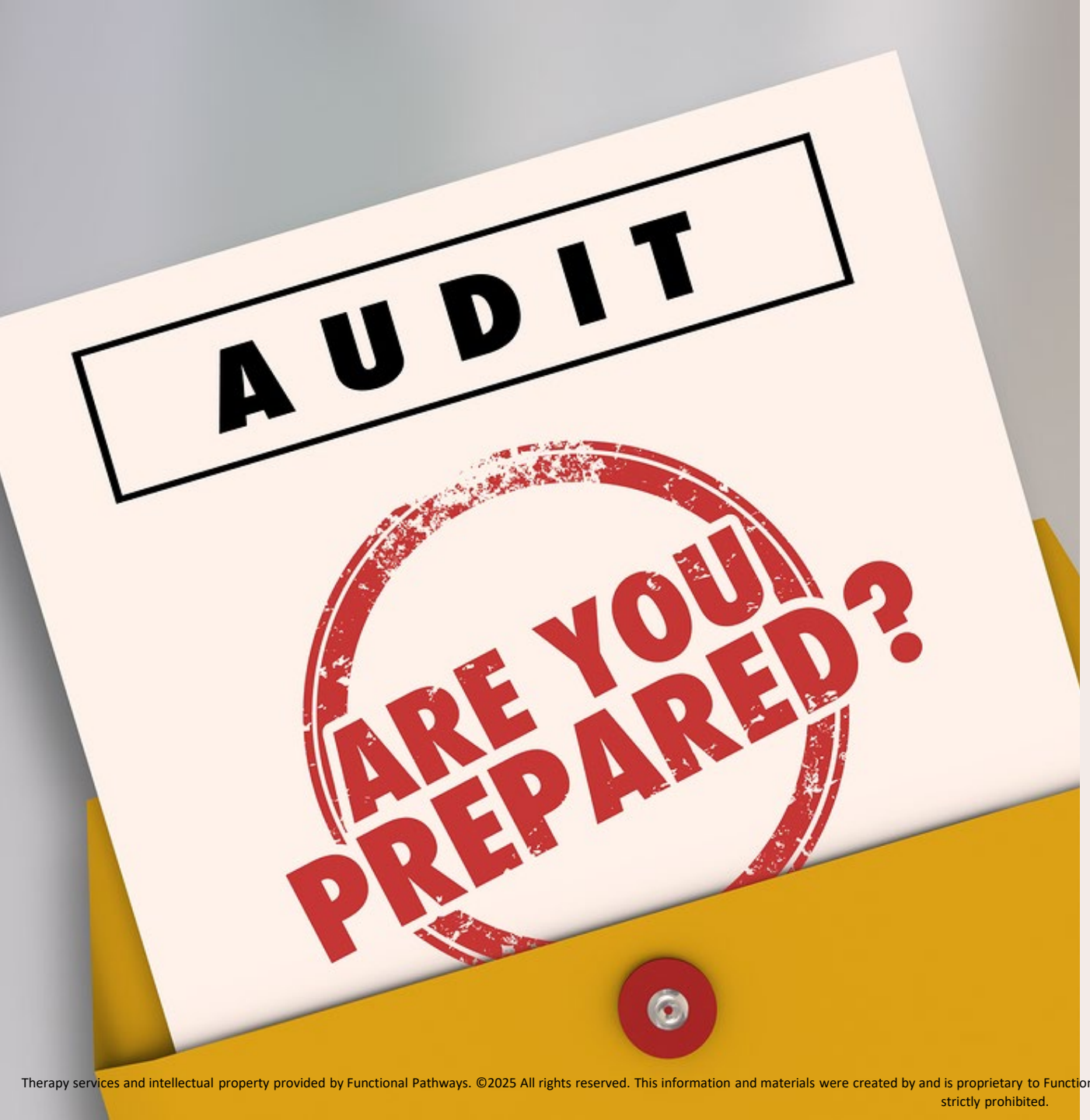

Prepare

Timely Response

Submit responses within the designated timeframe to avoid delays or denials in the process.

Organize documents clearly and ensure all required information is included for effective responses.

Accuracy and Thoroughness

Emphasize accuracy and thoroughness to prevent further delays or claim denials.

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Denials Management

Objectives:

1. Distinguish between technical and clinical denials.
2. Analyze common causes of denials
3. Develop and implement strategies to prevent and reduce denials.

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Understanding Denials

Types of Denials

Technical denials arise from administrative errors, while clinical denials relate to medical necessity or documentation issues.

Common Causes of Denials

Common denial causes include incorrect coding, missing information, and failure to meet medical necessity criteria.

Payer-Specific Trends

Awareness of payer-specific denial trends help organizations tailor denial management strategies effectively.

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Reasons for Denials

- Therapy supporting diagnosis not on UB-04;
- Services billed with a -59 modifier;
- KX modifiers not applied/not on UB-04;
- Missing or Incomplete Physician cert/recert;
- Therapy Plan of Care not signed and dated by physician / NPP;
- Medical necessity not supported;
- Additional Documentation Request (ADR) submissions missing supporting documentation and/or therapy service logs;
- Provider did not respond to ADR request;
- Treatment provided over the number of authorized visits or not meeting the insurance level criteria (managed care).

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Physician Certification & Recertification

To meet requirements the certification or recertification statement **must clearly indicate posthospital extended care services were required because of the individual's need for skilled care on a continuing basis for which he/she was receiving inpatient hospital services.**

Timing of Certification/Recertifications

- The initial Certification is due at the time of admission, or as soon thereafter as is reasonable and practicable.
- The first recertification must be signed and dated by the physician and made no later than the 14th day of inpatient extended care services.
- Subsequent recertifications must be signed and dated by the physician and are required at intervals not to exceed 30 days.

Delayed SNF Certification/Recertifications

- Delayed SNF certifications and recertifications are allowed for an isolated oversight or lapse. The delayed SNF certification or recertification *must* include an explanation of the delay along with any other information the SNF considers relevant to explain the delay.

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Denial Management Strategies

Prevention

Staff training, audits, and descriptive documentation prevent claim denials effectively.

Root Cause Analysis

Analyzing denial patterns identifies underlying issues to target improvements. Triple Check is a must!

Workflow Optimization

Streamlining processes ensures timely and accurate claim submissions to reduce denials.

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Appeals Process

Objectives:

1. Outline the steps involved in the appeals process, including timelines and escalation levels.
2. Determine when and how to initiate an appeal based on denial type and payer guidelines.
3. Construct effective appeal letters using clinical evidence and regulatory support.
4. Evaluate examples of successful appeals to identify key components and strategies.

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The Appeals Process

The CMS 5 Levels of the Appeals Process

1. Redetermination
2. Reconsideration
3. Administrative Law Judge Hearing
4. Appeals Council Review
5. Judicial Review in U.S. District Court

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The Appeals Process

Differences with Medicare and Managed Care

Medicare	Managed Care
Defined timelines for each level of the appeal.	Each managed care plan defines their own timeline & can differ based on participating or non-participating provider.
Appeal levels are specific.	Sometimes just one level of appeal called, “reconsideration”.
Providers have all levels of appeal available to them.	Some plans don’t have appeal rights; denial is based on the provider’s contract.


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Crafting a Strong Appeal

Key Components of Appeal

Effective appeal letters need a clear issue explanation, supporting documents, and policy references.

Tone and Structure

Maintain a professional, assertive tone with a logical and easy-to-follow structure in appeals.

Enhancing Appeal Success

Make it personalized to the resident. Use their name. Defend the care you provided and why the services were required to treat the resident's condition.

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Compliance Preparedness

Objectives:

1. Identify strategies in preparation for medical review.

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Compliance Preparedness

Risk Mitigation Strategies

- Emphasizes compliance audits, staff education, and thorough record keeping to reduce risks. Triple Check is a must!
- Code to the Highest Level of Specificity. Use the most detailed ICD-10, CPT, or HCPCS codes supported by documentation. Avoid vague or unspecified codes unless absolutely necessary. Conduct regular coding audits and training to stay current with payer requirements.
- Improve all care provider documentation quality.

Ensure Complete and Accurate Documentation.

- Document medical necessity clearly.
- Use standardized assessments.
- Train staff on payer-specific documentation requirements.
- Invest in nursing and therapy documentation training to improve documentation practices.

Verify Patient Eligibility and Coverage Thoroughly.

Confirm insurance coverage requirements and communicate with your care providers what those requirements are.

Audit Preparedness

- Being audit-ready is important. Ensure processes to respond to regulatory inquiries effectively.
- Review denial logs monthly and categorize by type.
- Training staff on audit findings and denial trends.
- Develop an appeal team.

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Compliance Preparedness: Audit

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- Identify risk areas and develop audit parameters.
- Conduct audits regularly (quarterly or biannually).
- Review claims against services rendered. Cross reference codes with clinical documentation.
- Ensure documentation supports MDS coding.
- Ensure documentation support medical necessity.
- Document findings and corrective action.
- Educate providers based on audit findings.

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Compliance Preparedness: Triple Check

Purpose: To review, verify, and crosscheck the Medicare claim by key interdisciplinary team members to ensure the claim is accurate, regulatory compliant, and free of errors ***prior*** to submission.

Importance:

1. Ensure accurate billing for skilled services provided.
2. Ensure residents receive their entitled benefits.
3. Prevent False Claims submission.
4. Reduce denied or adjusted claims/reimbursement.
5. Demonstrate the correlation between clinical and financial data.
6. Gives opportunity to correct data prior to submission of claims.
7. Gives opportunity to identify supportive documentation requirements are met.
8. Facilitates improvements with facility monitoring and identification areas of discrepancy and opportunity.
9. Organizes the review of critical elements on the MDS and UB-04.
10. Provides a roadmap for process improvement.

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Compliance Preparedness: Section GG

Capturing Function GG Scores

- Record the resident's *usual performance* not their worst or best performance. Collaboration between Nursing and Therapy is critical to determine the resident's *usual performance.*
- Record the resident's actual performance. Do not record the staff's assessment of the resident's *potential* to perform the activity.
- Usual performance does *not* use the rule of three.
- The admission function score should reflect the resident's baseline status prior to any benefit from therapy interventions.

*Remember: the first three days of the resident stay is the observation window for Section GG. **

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Compliance Preparedness: Nursing Documentation

Documenting Nursing Skill

When completing skilled nursing documentation keep in mind the following:

- Skilled notes must reflect the need for the continuation of skilled care.
- Documentation of Medicare A residents must be completed at least once every 24 hours and more often if warranted by their condition or per facility policy.
- Skilled Documentation should include vital signs, why they are receiving skilled services, and a detailed description of the resident's current condition.
- Make sure your documentation is specific to the clinical reason for coverage; services being delivered and the resident's response to the care they are receiving.

Four Principle Skilled Nursing Services Required When Documenting:

1. **Assure the management and evaluation of the resident's care plan by completing the following:**
   a. The creation, ongoing monitoring, and constant evaluation of the resident's care plan. This is based off the physician/physician extender's orders and supporting documentation contained in their progress notes and/or History and Physical specific to their noted treatment plan.
   b. Document the need of services provided that requires the interventions of skilled nursing staff to meet the resident's medical needs, progressing their recovery, and ensuring their safety.
2. **Observation and Assessment:**
   a. Nursing documentation must display the resident's current condition as well as the probability of change in a resident's condition knowing where they are going with their rehabilitation.
   b. Nursing must identify and evaluate their need for modification to treatment or additional medical procedures needed until there condition is stabilized.
3. **Teaching and Training:**
   a. The skilled documentation must contain all education to residents, care giver, responsible party and their responses to the education. Be sure to include failed attempts to educate as well.
   b. Education topics include ostomy care, wound care, diabetes management, prosthesis care, catheter care, tube feeding process, and IV administration process.
4. **Skilled nursing services provided to residents:**
   a. Determining if skilled nursing services are considered skilled. By answering the question, why they are complexed enough that they only can be safely and effectively be performed by or under the supervision of a Registered Nurse.
   b. Some examples of skilled documentation would be surgical wounds, diabetes management with injections, ulcer care, tube feedings, IV feedings, IV medications, suctioning and trach care.

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Compliance Preparedness: Therapy Documentation

Documenting Therapy Skill

- Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation."
- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist.
- A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision.
- If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

Skilled therapy must meet all the following conditions:

1. Services must be directly and specifically related to an active written treatment plan based on the initial evaluation of the therapist;
2. Services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a qualified therapist;
3. The services must be provided with the expectation that the condition of the resident will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a therapist for the performance of a safe and effective maintenance program.
4. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
5. The services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

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Lessons Learned and Conclusion

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Real Cases

Common Challenges

Lessons for Improvement

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Resources:

Additional Documentation Request | CMS

Targeted Probe and Educate | CMS

Comprehensive Error Rate Testing (CERT) | CMS

Medicare Fee for Service Recovery Audit Program | CMS

CMS RAC – Performant

CMS RAC | Cotiviti

Unified Program Integrity Contractor (UPIC) - JD DME - Noridian

IMPROVING THE MEDICARE CLAIMS REVIEW PROCESS

ICD-10-CM Guidelines FY25 October 1, 2024

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