# Part B Insider (Multispecialty) Coding Alert

## Part B Billing: Review ADRs and Correct Problems ... or Else, CMS Warns

**New Targeted Probe and Educate revamp punishes wrongdoers.**

If you've been lax in your response to your MAC's Additional Development Requests, you might want to rethink that. A new change request from CMS suggests that ignoring those inquiries may land your practice in hot water.

**Framework:** In a transmittal issued in August, CMS directed the MACs to "include claims denied due to no response to Additional Development Requests (ADRs) when calculating the provider error rate" starting Sept. 19. The instruction in CR 10210 implies that MACs haven't been including ADRs in their provider error rates up to now.

The error rate is important because "if the MAC identifies a provider-specific problem, the provider error rate is an important consideration in deciding how to address the problem," CMS explains in the transmittal. "For instance, a provider with a low error rate with no history of patterns of errors may require a fairly minor corrective action plan such as education with recoupment of overpayment."

**Important:** The error rate isn't the only statistic that matters. "Other factors such as the total dollar value of the problem and the past history of the provider also deserve consideration," CMS tells MACs. "The MAC assesses the nature of the problem as minor, moderate or major and uses available tools such as data analysis and evaluation of other information to validate the problem."

**Get Ready For 'Real Awakening'**

Including ADR non-responses in the error rate is going to have big consequences under the Targeted Probe and Educate program that gets underway this fall, notes billing expert **M. Aaron Little** with BKD in Springfield, Missouri.

Including ADR non-responses in providers' error rates is likely to get them onto TPE's list in the first place, and hinder them in getting off of it, experts note. "TPE, in and of itself, is really substantial and in many ways a game changer," Little says. "Layering on top of TPE the prospect of denials for lack of response could be incredibly problematic, because it would likely cause the provider to continue on TPE and possibly even be referred to CMS for additional actions."

Billing guru **Melinda Gaboury** with Healthcare Provider Services in Nashville warns "if agencies truly have not been negatively impacted by the non-responses in the past, this will be a real awakening."

Thanks to the widespread practice of not responding to ADRs, "once again we end up with the noose getting tighter," observes **Cindy Krafft** with Kornetti & Krafft Healthcare Solutions. The error rate calculation change "increases the risk for agencies who have approached ADRs with laxity and will put additional pressure to comply or risk higher denial stats, which can lead to more reviews."

**Warning:** Don't expect Medicare to back down on the ADR non-response issue. Why? "A provider receives a $3,000 reimbursement for a complete episode this time last year. They receive an ADR and non-respond, the $3,000 is recovered by Medicare," offers **Lynn Olson**, owner of billing company Astrid Medical Services in Corpus Christi, Texas. "To me it looks like a one-year interest free loan. Even without a nefarious intent, it is money that is not available to Medicare."

Also, the recovery-to-work ration for MACs to review one $3,000 claim versus many smaller-dollar claims from physicians, for example, make home health claims an enticing target, Olson believes.

**Watch Out For These Pitfalls**

Why is the ADR non-response problem so widespread and common? It's a complex issue, experts say.

Put simply, many agencies are not checking the Direct Data Entry (DDE) system for ADRs and thus have no idea they have requests to which they need to respond, Little points out.

There are a number of reasons that checking for ADRs gets overlooked. A common one that **Julianne Haydel** with Haydel Consulting Services in Baton Rouge, Louisiana, sees is having an inexperienced biller. "Some agencies can go a long time with no scrutiny from a contractor," Haydel relates. "When a relatively new biller is in place, an ADR may be set aside with every intention of going back to it because they don't know what it is." Then, in the hectic workload, the circling back never happens.

**Caveat:** Identifying an ADR may not be as simple as you think. MAC CGS Medicare instructs billers that "to check for MR ADRs, use Option 12 (Claim Inquiry), key your NPI number and the status/location 'S B6001' and press Enter. Claims selected for MR ADR will appear with reason code 39700."

These directions "are simple for an experienced biller. They are not so simple for a new biller," Haydel judges.

**Consider this:** Even experienced billers may not prioritize ADRs because they either don't know they should, or they don't know how. "Newer agencies and those with poor management consider billing to be a data entry task and is not given the respect that it deserves," Haydel contends. Billing itself may indeed be a data entry task. But "managing the process, following up on claims, verifying claims were paid at the amount they were billed is not merely data entry," Haydel argued.

Failing to allow enough time and resources for billing and related tasks is a problem, Haydel suggests. "In small agencies, even when the biller has experience, he or she may be under pressure to get billing out so payroll isn't a problem if the biller took vacation or sick leave," for example.

Billing staff may also be less likely to respond to ADRs if billing systems don't support it, Haydel adds. "Some computer systems allow an agency to print a chart. [For] others, the process involves going in and printing off each note and order and care plan individually," she notes. "This is labor intensive and it doesn't take much to convince someone to defer the task until later - which never comes."

**Reminder:** Some agencies still wait for the paper copies of ADRs. But MACs have discontinued paper notices altogether, or use them inconsistently.

If agencies are identifying the ADRs but still don't respond, it may be "due to ambiguous lines of responsibilities - one person or department not recognizing it's their responsibility to respond," Little observes.

Providers in the past ignored the requests, opting to just not respond. "Some agencies choose to just repay for the handful of claims in the ADR without submitting additional required information, seeing that as lower cost than the resources it takes to send things in," Krafft notes. "Especially if a non-response wasn't tracked in the denial stats."

Agencies may even go so far as to pull the record, and then decide to not respond. They figure "getting a denial for non-submission of paperwork is better than sending blatant evidence that billing occurred without signed orders or visit notes were not submitted," Haydel says.

**Bottom line:** "It doesn't have to happen," Haydel stresses of non-response denials.

**Resource:** To read the Medicare CR 10210 on Additional Development Requests, visit www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R738PI.pdf.

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