Eli's Hospice Insider

Medical Review: ADR Responses To Become Crucial In Targeted Probe & Educate Era

Here's how to check for an ADR.

Nonresponses to ADRs as a systemic problem is nothing new to the hospice industry, but the behavior is now a luxury hospices can't afford.

Change: In a transmittal issued in August, the **Centers for Medicare & Medicaid Services** directed Medicare Administrative Contractors to "include claims denied due to no response to Additional Development Requests when calculating the provider error rate" starting Sept. 19. The instruction in CR 10210 implied that MACs hadn'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."

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."

Nonresponse to ADRs is a well-documented, long-standing problem for hospice providers.

"Reason code 56900 continues to be one of the top medical review denial codes for home health and hospice providers," HHH MAC **CGS** said in an article posted to its website in August. "This denial occurs when a claim is selected for medical review and the provider is requested to submit medical record documentation. Documentation must be received by CGS within 45 calendar days. If the documentation is not received by day 46, the claim is denied with reason code 56900 (documentation not received or not received timely)."

Including ADR nonresponses in the error rate is going to have big consequences under the Targeted Probe & Educate program now underway, notes billing expert **M. Aaron Little** with **BKD** in Springfield, Missouri.

Recap: Under TPE, MAC medical reviewers will conduct three rounds of review, selecting 20 to 40 claims per round. As the program's name suggests, the review will target certain at-risk providers, but details on the threshold for inclusion are still fuzzy. HHH Medicare Administrative Contractor **National Government Services** did say in a TPE webinar this fall that TPE applies when "a high payment error rate above 15 percent" occurs. Providers must have a PER "of less than 15 percent in order to be released from additional rounds of review" under TPE, the MAC clarified (see Eli's Hospice Insider, Vo. 10, No. 12).

"Providers ... with continued high error rates after three rounds of TPE may be referred to CMS for additional action, which may include 100 percent prepay review, extrapolation, referral to a Recovery Audit Contractor (RAC), etc.," CMS warns on its Home Health Medical Review webpage.

NGS confirms that failing to respond to an ADR will count against you under TPE. "Provider nonresponse to medical records requests will count as an error," NGS said in a Sept. 22 article about the program.

Including ADR nonresponses in providers' error rates is likely to both get hospices 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 tells **Eli**. "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** warns "if agencies truly have not been negatively impacted by the nonresponses 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."

Watch Out For These Pitfalls

Why is the ADR nonresponse problem so widespread and common? It's a complex issue.

Put simply, many providers are not checking the 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.

Identifying an ADR may not be as simple as you think. In its article, CGS 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.

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 [it] 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 argues.

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."

Some providers 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.

Or providers may deliberately decide not to 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 nonresponse wasn't tracked in the denial stats."

Agencies may even go so far as to pull the record, and then decide to not reply. They figure getting a denial for non-submission of paperwork is better than sending "blatant evidence" that billing occurred without required documentation, Haydel says.

Here's How To Check For An ADR

If you have been relying on paper letters for your ADR notifications - or haven't been checking for them at all - use these instructions from CGS to identify the requests:

1. 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.

2. Access the FISS Pages 07 and 08 to determine what is being requested and the date it must be received by the MAC. Pages 07 and 08 only apply to claims in the status/location 'S B6001.' FISS Page 07 displays the due date, which is the 45th day. Page 08 provides details of the information being requested.

3. When submitting your ADR response, attach a copy of FISS Page 07 as the top page of your documentation to ensure it is matched to the appropriate claim.

Note: Note: CR 10210 is at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R738PI.pdf. The article with the ADR checking instructions, including screen shot examples, is at www.cgsmedicare.com/hhh/pubs/news/2017/0817/cope4170.html.