



**BLACKTREE**  
HEALTHCARE CONSULTING

The Time to Prepare For  
An ADR is Before the ADR  
Arrives

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### Objectives

- Identify how QAPI program can proactively identify high risk areas within organization
- Identify the most common denial reasons for ADRs and steps agency can take to lower risk
- Identify best practice initial steps in preparing an ADR submission



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## QAPI It's More Than A Requirement



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### QAPI Requirement

An ongoing agency wide data driven program that reflects the complexity of the organization and services provided.

With a focus on indicators related to:

- Improved outcomes related to health, patient safety and quality of care
- Adverse events
- Hospital admissions/readmissions
- Agency performance across spectrum of care
- Prevention/reduction in medial errors
- Infection Control

The agency must maintain documentary evidence of its QAPI program and demonstrate its operation to CMS



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### Additional QAPI Data Items

➤ Audits performed across agency

- Compliance
  - Aide/LPN/PTA,COTA supervisory visits
  - Prebill Documentation Review
  - Chart Reviews
  - Face to Face Encounters

➤ Prior Survey Deficiencies

➤ Key Performance Indicators

- Productivity
- Days to RAP/Days to Final, AR Days
- Visit Utilization
- Budget Items



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### Using the Data

- Track and Trend Data
- Identify Benchmarks or Goals
- Utilize Dashboards
  - Executive Level
  - Manager Level
- Staff Scorecards

DATA will help agency identify early on changes to indicators and agency can respond faster



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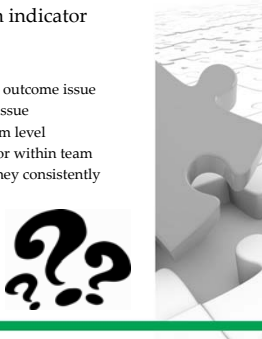
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**Next Step: QAPI Program Activities**

- Develop Action Plans for each indicator below benchmark or goal
  - Start with analysis of 5 W
    - What – is it compliance issue or outcome issue
    - Why – is it a process or person issue
    - Who – drill down to staff or team level
    - Where – is it across the agency or within team
    - When – trend the changes are they consistently going down or sudden drop



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**Next Step: QAPI Program Activities**

- Determine scope of problem
  - Incidence – Risk to patient or agency
  - Prevalence – New decline or continuing decline
  - Severity – Impact to patient care/agency
- Action Steps
  - Always start with staff education
  - Does the staff have the tools needed
    - Patient education materials
    - Best practice guidelines
  - Identify if additional audits needed
  - Identify how going to continue to evaluate



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**Is a PIP needed**

- Performance Improvement Projects
  - Focus on larger complex issues
  - Issues that require team input
  - Issues that have not improved with program activities
  - Issues that are high risk for patient/agency
  - Reoccurring issues
- CoP require PIP at least annually



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# ADR and Audits: Why our agency? What are they looking for?



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## Understanding ADR Edits

- CMS Edits
  - CGS – diagnosis hypertension with >120 days on service
- Targeted Probe and Educate
  - Started October 1 with threshold of 15 to 20% threshold
  - Data driven based on claim payments
  - Receive letter from MAC stating you have been chosen
  - 20 to 40 ADRs
  - Education after all reviews completed
  - Three rounds



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## Top Denial Reasons

- Missing or invalid Face to Face Encounter
  - Request F2F encounter visit note on intake
  - Review note to meet requirements
  - Include on 485 homebound reason and statement of reviewing F2F
- Therapy services were not reasonable and necessary
  - Use chart audits to identify trends in documentation
  - Educate PTA on not documenting goals met
  - Utilize assessment tools
  - Include changes in repetitions or resistance in documentation



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### Top Denial Reasons

- Skilled nursing services were not necessary
  - Document each visit skilled performed
  - Be specific on education provided
  - Document why patient or caregiver can not perform
- Recertification statement does not include estimate of how much longer services required
  - Include statement on 485
  - Projection should be reasonable in weeks/months
- Documentation not received/received late
  - Educate billing team on identifying ADR requests
  - Keep tracking log of dates received request, due date and date sent
  - Keep copies of any confirmation or certified mail receipts



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### Insight into TPE

- If multi branch expect at least 20 for each branch
- Response time on approval/denial has been running 1 to 2 weeks
- Denial reasons seen (beyond top reasons)
  - Face to Face Encounter date not identified by certifying physician
  - Certifying physician different than F2F doctor and not indication F2F was reviewed by certifying MD
  - Face to Face Encounter visit must contain information related to primary diagnosis on 485
  - Missing diet on 485
  - Therapy documentation without changes in HEP or met goals but continue to go



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### Insight into TPE

- 30 day re-assessment does not include comparison to last evaluation
- Therapy documentation without changes in HEP or met goals but continue to visit
- OASIS does not reflect functional assessment by therapy
- Recertification statement does not include projected date – recommend it be on the 485/plan of care



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### Responding to ADR

- Print the ADR request
- Review your record for all areas
- Print or export entire record (keep copy of what you send)
  - Include initial OASIS, current and recertified OASIS
  - Include Face to Face including actual physician encounter note
  - Include physician signature attestation or policy for electronic signatures
- Number pages
- Cover Letter

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### Time to Prepare is Now




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### QAPI Checklist

Does it include:

- Identify industry wide issues:
  - Face to Face Encounters
  - OASIS timely submission
  - Coding and OASIS accuracy
  - Skilled Need and Medical Necessity
- Identify agency issues:
  - Identified issues found on chart audits
  - Late submission of documentation
  - OASIS submissions
  - Timeliness of physician signatures
  - Adherence to plan of care - frequency

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### Pre-Billing Reviews

Pre-Bill reviews should be done 100% for billing requirements

- Billing requirements
  - OASIS submissions
  - Face to Face Encounters
  - 485/plan of care signed prior to submission final claim
  - Verbal orders signed prior to submission final claim
  - Visits matches visit frequency



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### Pre-Billing Reviews

Documentation Review recommend percentage based on risk level

- Documentation requirements:
  - All services ordered have visits
  - Missed visits communicated with MD
  - Orders present for all care, treatments, medication
  - Visit frequency correct
  - All items on plan of care are addressed
  - Each visit reflects skilled need or medical necessity
  - NOMNC or HHCCN provided prior to last visit
  - Recertification statement present



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### Using Reviews/QAPI Proactively

- Continue with chart Reviews
- Use yes/no responses for easy tally
- Complete data based summary reports
- Trend data monthly/quarterly
- Consider adding focused audits based on results
- Share information with staff
  - Always share chart review with clinician
  - Share overall scores with entire staff
- Add to QAPI plan if new issue
- Document Action Plan



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“I don’t believe in just ordering people to do things. You have to sort of grab an oar and row with them” Harold S Geneen



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### Contact Information:

[www.BlackTreeHealthcareConsulting.com](http://www.BlackTreeHealthcareConsulting.com)

➤ **Diane Link**

- Director of Clinical Services
- (610) 536 – 6005 ext. 775
- [Diane.Link@blacktreehealthcare.com](mailto:Diane.Link@blacktreehealthcare.com)



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