Medicare Fee-for-Service Recovery Audit Program

Additional Documentation Limits for Medicare Institutional Providers (i.e. Facilities)

Baseline Additional Documentation Request (ADR) Limits

In November 2015, the Centers for Medicare & Medicaid Services (CMS) modified the additional documentation request (ADR) limits for the Medicare Fee-for-Service Recovery Audit Program for institutional providers, which became effective January 1, 2016. ADR limits for Physician/Non-Physician Practitioners and Suppliers remained unchanged and were not affected by this instruction.

A baseline annual ADR limit is established for each provider based on the number of Medicare claims paid in a previous 12-month period that are associated with the provider's 6-digit **CMS Certification Number (CCN)** and the provider's **National Provider Identifier (NPI)** number. Using the baseline annual ADR limit, an ADR cycle limit is also established.

- The baseline annual ADR Limit is **one-half of one percent** (0.5%) of the provider's total number of paid Medicare claims from a previous 12-month period.

- ADR letters are sent on a 45-day cycle. The baseline annual ADR Limit is divided by eight (8) to establish the ADR cycle limit, which is the maximum number of claims that can be included in a single 45-day period. Although the Recovery Audit Contractors may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days.

  For example:

  - **Provider A** billed and was paid for 22,530 Medicare claims in 2014. The provider's baseline annual ADR limit would be 22,530 x 0.005, which is 112.65. The ADR cycle limit would be 112.65/ 8, which is 14.08, and would be rounded to **14** additional documentation requests per 45 days.

  - **Provider B** billed and was paid for 255,000 Medicare claims in 2014. The provider's baseline annual ADR limit would be 255,000 x 0.005, which is 1,276. The ADR cycle limit would be 1,276/ 8, which is 159.375, and

would be rounded to **159** additional documentation requests per 45 days.

[Note: Beginning January 1, 2019, providers whose ADR "cycle" limit is less than one, even though their "annual" ADR limit is greater than one (e.g. 1, 2, 3, or 4), will have their ADR cycle limit set at one (1) additional documentation request per 45 days, until their "annual" ADR limit has been reached.]

For example:

- **Provider C** billed and was paid for 400 Medicare claims in a previous 12-month period. The provider's baseline annual ADR limit would be 400 x 0.005, which is two (2). The ADR cycle limit would be 2/8, which is less than one. Therefore, this provider's ADR cycle limit will be set at one (1) additional documentation request per 45 days, until their "annual" ADR limit, which in this example is two (2), has been reached. In other words, Provider C can receive **one** (1) additional documentation request for **two** (2) of the eight (8) ADR cycles, per year.

- ADR limits must be diversified across all claim types of a facility, based on the Types of Bill (TOB) that the provider was paid for in the previous year. Therefore, a provider will have a separate ADR limit for each TOB.

Risk-Based, Adjusted ADR Limits (Updated 1/29/2018)

- After three (3) 45-day ADR cycles, CMS will calculate (or recalculate) a provider's Denial Rate, which reflects their compliance with Medicare rules. The **Denial Rate** will be calculated using the number of claims containing improper payments that resulted in overpayments (less any determinations that are overturned during appeal) divided by the total number of reviewed claims, expressed as a percentage. CMS will perform this calculation using data from the most recent 12-months of completed reviews. The Denial Rate will then be used to identify a provider's corresponding "Adjusted" ADR Limit, based on **Table 1**, below. Once calculated, the **Adjusted ADR Limit** will be used for the next three (3) 45-day ADR cycles, after which, the Denial Rate (and Adjusted ADR Limits) will be re-calculated.

Table 1:

Denial Rate (Range)	Adjusted ADR Limit (% of Total Paid Claims)
91 – 100%	5.0% (Baseline x 10)
71 – 90%	4.0% (Baseline x 8)
51 – 70%	3.0% (Baseline x 6)
36 – 50%	1.5% (Baseline x 3)

21 – 35%	1.0% (Baseline x 2)
10 – 20%	0.5% (Baseline x 1)
4 – 9%	0.25% (Baseline x ½)
0 – 3%	No reviews for next 3 (45-day) review cycles

For example:

- After three (3) 45-day review cycles, **Provider A** had 20 claims containing improper payments (10 overpayments and 10 underpayments), out of a total of 42 reviewed claims. The Denial Rate would be 10 ÷ 42, which is 23.8% (rounded to 29%). Using Table 1 above, the Adjusted ADR limit would be 1.0% (two (2) times the baseline of 0.5%). In other words, Provider A previously had an ADR cycle limit of 14, and the Adjusted ADR Limit would be 2 x 14, which is 28. This Adjusted ADR limit would then apply to the next three (3) review cycles, after which their Denial Rate (and Adjusted ADR Limit) will be recalculated.

- After three (3) 45-day review cycles, **Provider B** had 144 claims containing improper payments (124 overpayments and 20 underpayments), out of a total of 477 reviewed claims. The Denial Rate would be 124 ÷ 477, which is 25.99% (rounded to 26%). Using Table 1 above, the Adjusted ADR limit would be 1.0% (two (2) times the baseline of 0.5%). However, during this same timeframe, Provider B also received Fully Favorable appeal decisions on 48 previously-reviewed claims. Therefore, the Denial Rate would actually be [124 (overpayments) – 48 (fully overturned appeals)] ÷ 477, or 76 ÷ 477, which is 15.9% (rounded to 16%). Using Table 1 above, the Adjusted ADR limit would be 0.5%, which is the same as the baseline annual ADR limit. This Adjusted ADR limit would then apply to the next three (3) review cycles, after which the Denial Rate (and Adjusted ADR Limit) would be recalculated.

- After three (3) 45-day review cycles, **Provider C** had 0 (zero) claims containing improper payments, out of a total of 24 reviewed claims. The Denial Rate would be 0 ÷ 24, which is 0%. Using Table 1 above, the Adjusted ADR limit would be "No reviews for three (3) 45-day review cycles", which would be a total of 135 days. After this time frame, reviews would begin again, using the baseline (0.5%) ADR limit.

Look-back Period

- Per their Statement of Work (SOW), Recovery Audit Contractors will have 3-year look-back period, based on the claim paid date, unless otherwise

directed by CMS.

Use of Extrapolation

- CMS will consider allowing Recovery Audit Contractors to use extrapolation to estimate overpayment amounts for:
    - Providers who maintain a high denial rate for an extended time period
    - Providers who have excessively high denial rates for a shorter time period
    - Providers with a moderate denial rate, whose overpayments equal a significantly high dollar amount

Exceeding ADR Limits

- CMS often receives referrals of potential improper payments from the MACs, UPICs, and Federal investigative agencies (e.g., OIG, DOJ). At CMS discretion, CMS may require the RAC to review claims, based on these referrals. These CMS-Required RAC reviews are conducted outside of the established ADR limits."

Questions concerning this update can be directed to RAC@cms.hhs.gov.