Last Updated: May 1, 2022

Institutional Provider (i.e. Facilities) Additional Documentation Request (ADR)

Limits (As of May 1, 2022)

Baseline ADR Limits[1]

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.[2]

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 (RACs) 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 2021. 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[3] to **14** additional documentation requests per 45 days.

- **Provider B** billed and was paid for 255,000 Medicare claims in 2021. 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.

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 2021. 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.

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[1] Skilled Nursing Facility (SNF) Type of Bills (TOBs) and Inpatient Rehab Facilities (IRF) TOBs baseline limits are described later in this document.

[2] This statement excludes Skilled Nursing Facility (SNF) Type of Bills (TOBs) and Inpatient Rehab Facilities (IRF) TOBs.

[3] Rounding is done as follows: numbers ending in less than .5 (i.e. 20.49) will be rounded down to the nearest whole number (20, in this case); numbers ending in .5 or higher (i.e. 20.51) will be round up to the nearest whole number (21, in this case).

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

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[4] 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.[2] 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	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 24%). Using Table 1 above, the Adjusted ADR limit would be 1.0%, which is two (2) times the annual baseline of 0.5%. This new (Adjusted) annual ADR limit is then divided by 8, to get the Adjusted ADR Limit per 45-day cycle. In other words, Provider A had a baseline annual ADR limit of 112, and a 45-day ADR cycle limit of 14. The Adjusted annual ADR Limit is now two times the baseline (2 x 112), which is 224. This Adjusted annual ADR limit is then divided by 8 (224 ÷ 8), to get a new Adjusted ADR limit of 28, per 45-day cycle. This Adjusted ADR limit (28) 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. Therefore, the 45-day cycle limit

[4] Reversals of initial RAC findings resulting from a Discussion Period or a Clerical Re-opening are not considered "overturns".

would not change, and 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 45-day cycle limit, based on the baseline (0.5%) annual ADR limit.

Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IRF) Baseline Limits

In response to feedback from RAC Program stakeholders, CMS has modified the institutional ADR limits for SNF and IRF Provider Types for the RAC Program. For these Provider Types, the baseline annual ADR limit is one percent (1%) of the provider's total number of paid Medicare claims from a previous 12-month period. 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.

For example:

- **Provider A** billed and was paid for 22,530 Medicare claims in 2021. The provider's baseline annual ADR limit would be 22,530 x 0.01, which is 225.3. The ADR cycle limit would be 225.3/ 8, which is 28.16, and would be rounded to 28 additional documentation requests per 45 days.

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.

SNF and IRF Risk-Based, Adjusted ADR Limits

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 2**, 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 2:

Denial Rate	Adjusted ADR Limit (% of Total Paid Claims)
91 – 100%	10.0% (Baseline x 10)
71 – 90%	8.0% (Baseline x 8)
51 – 70%	6.0% (Baseline x 6)
36 – 50%	3.0% (Baseline x 3)
21 – 35%	2.0% (Baseline x 2)
10 – 20%	1.0% (Baseline x 1)
4 – 9%	0.5% (Baseline x ½)
0 – 3%	No reviews for next 3 (45-day) review cycles

The CMS reserves the right to give the RACs permission to exceed these limits. Permission may be granted on CMS's own initiative or upon request by a RAC. 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. Affected facilities will be notified in writing.

If additional assistance is needed please contact CMS at RAC@cms.hhs.gov.