DOCUMENTATION TO DETERMINATION:

WINNING THE ADR, DENIAL AND APPEAL BATTLE

Functional Pathways

30 Years of Excellence

Introduction

Accurate documentation is the foundation of reimbursement integrity in skilled nursing facilities. As CMS and commercial payers continue to expand oversight programs and refine medical review processes, the ability to submit precise, timely, and defensible documentation has never been more important.

Additional Documentation Requests (ADR), medical review findings, denials, and appeals each represent critical control points in the claim's life cycle. When organizations understand how these processes work and implement proactive strategies, they can strengthen compliance, protect revenue, and ensure the delivery of medically necessary services is supported by clear, thorough records.

This white paper provides a comprehensive review of ADR management, medical review structures, common denial drivers, successful appeal strategies, and compliance readiness practices designed to support accuracy at every step.

Background

Documentation drives every aspect of skilled nursing reimbursement. Claims are paid based on the accuracy and completeness of the supporting clinical record, which must reflect medical necessity, the services delivered, and the resident's response to care.

Payers have intensified their medical review efforts, relying on targeted probes, stratified claim sampling, and advanced analytics to identify unusual billing patterns or inconsistencies. As a result, providers must remain prepared for a variety of review types, each with unique timelines and documentation expectations.

With multiple oversight entities involved (Medicare administrative Contractors, recovery audit contractors, comprehensive error rate testing, unified program integrity contractors, and commercial payers) facilities need a clear understanding of what each program evaluates and how to respond effectively.

"Triple Check is essential for preventing errors before claims are submitted."

Understanding ADRs

An Additional Documentation Request is a formal request for records issued when a payer requires more information to support a claim. ADRs may be triggered before or after payment and represent a crucial part of the medical review process.

Common reasons for ADRs include:
- Missing, inconsistent, or incomplete documentation
- Coding discrepancies
- Medical necessity concerns
- Unusual billing patterns
- Duplicate or overlapping services

Responding to an ADR fully and on time is essential. Failure to submit complete documentation by the deadline results in an automatic claim denial, regardless of whether the services were appropriate or medically necessary.

An effective ADR packet includes:
- The ADR letter as the first page
- Hospital admission and discharge summaries (for Part A stays)
- The SNF certification and recertification
- All orders for the dates of service under review
- Physician, nursing, dietary, and therapy notes
- MDS assessments and supporting documentation
- MARs and TARs
- Therapy service logs and encounter notes

Documentation should always reflect the residents' condition on the dates under review and support all services billed.

> *Failure to submit complete documentation by the deadline results in an automatic claim denial, regardless of whether the services were appropriate or medically necessary.*

Responding to ADRs Effectively

Responding to ADRs requires four essential components: timeliness, completeness, organization, and accuracy.

Timeliness:
Each ADR includes a due date or response window. For Medicare contractors, this is typically 30 to 45 days. Managed care timelines vary and may be shorter. Missing the deadline results in a denial, requiring an appeal.

Completeness:
All required medical records must be included. Omissions such as unsigned therapy plans of care, missing progress notes, or incomplete physician certifications can trigger denials.

Organization:
Records should be submitted in a clear, logical, and labeled order to help reviewers locate information quickly.

Accuracy:
Documentation must support each billed code, time entry, or service. Therapy evaluations must match MDS coding, and all Section GG performance values require supporting evidence.

A strong ADR response reduces the need for appeals and demonstrates attention to compliance, accuracy, and quality of care.

Medical Review Programs

CMS and commercial payers utilize several medical review mechanisms. Understanding each program helps facilities prepare responses and reduce risk.

Targeted Probe and Educate (TPE):

Designed to identify error patterns and provide one-on-one education. Providers undergo rounds of reviews until error rates fall below thresholds.

Comprehensive Error Rate Testing (CERT):

Random sampling of claims across Medicare Fee-for-Service used to calculate national improper payment rates.

Supplemental Medical Review Contractor (SMRC):

Conducts focused reviews on service categories identified as high risk or vulnerable to improper payment.

Unified Program Integrity Contractor (UPIC):

Reviews potential fraud, waste, and abuse across Medicare and Medicaid claims using analytics, investigations, and extrapolation.

Recovery Audit Contractor (RAC):

Reviews claims for improper payments and recoups overpayments. RAC reviews may be automated or complex and can extend several years back.

These programs highlight the need for strong documentation practices and daily compliance readiness.

Understanding Denials

Denials occur when submitted claims fail to meet payer requirements. They fall into two primary categories: technical denials and clinical denials.

Technical Denials:

These stem from administrative or billing errors, including:

- Missing therapy diagnoses on the UB-04
- Incorrect or missing modifiers
- Missing or unsigned plans of care
- Missing certifications or recertifications
- Failure to respond to ADR requests

Clinical Denials:

These occur when medical necessity is not supported by documentation. Examples include:

- Encounter notes that do not support therapy intensity or frequency
- Inconsistencies between therapy evaluations and MDS coding
- Lack of documentation for conditions such as dysphagia, falls, or functional decline

Understanding the root cause of denials helps prevent recurrence and strengthens compliance.

Functional Pathways has achieved a *100%* win rate for claims denials for *22 consecutive quarters*

Denial Management Strategies

Proactive denial management reduces administrative burden and protects revenue.

Prevention:

Regular staff training, robust documentation expectations, and interdisciplinary communication reduce the likelihood of errors.

Root Cause Analysis:

Analyzing denial trends identifies where processes break down. This may include inconsistent documentation, delayed certifications, or incorrect coding practices.

Triple Check:

This interdisciplinary process verifies MDS accuracy, therapy minutes, diagnoses, and billing elements before claim submission. Triple Check is one of the most effective tools for preventing denials.

Workflow Optimization:

Clear workflows ensure documentation is completed in a timely and organized manner. Teams should have defined responsibilities and escalation pathways.

The Appeals Process

Appeals provide an opportunity to overturn claim denials. Understanding the steps and timelines is essential.

Medicare has five levels of appeal:

1. Redetermination
2. Reconsideration
3. Administrative Law Judge Hearing
4. Appeals Council Review
5. Judicial Review

Commercial payers may offer fewer levels and have variable timelines.

A strong appeal letter should include:

- A clear issue statement
- Explanation of the residents' condition
- Clinical rationale supporting medical necessity
- Policy references
- All supporting documentation

Successful appeals tell a clear, logical story backed by clinical evidence and regulatory citations.

Compliance Preparedness

Compliance requires continual attention to detail. Effective programs prioritize:

Accurate Documentation:
Record medical necessity clearly and use standardized assessments. Staff should understand payer-specific documentation expectations.

Coding Specificity:
Use the most detailed ICD-10, CPT, or HCPCS codes supported by documentation. Avoid generic or unspecified codes.

Eligibility and Coverage Verification:
Verify benefits on admission and communicate requirements across disciplines.

Audit Preparedness:
Be audit-ready through regular reviews of claims, documentation, MDS coding, and therapy logs. Create logs by denial type to identify trends.

Triple Check and Interdisciplinary Collaboration:
Triple Check remains a cornerstone of compliance, linking clinical and financial data while ensuring accuracy before claims are submitted.

Conclusion

Winning the ADR, denial, and appeal battle requires a proactive and disciplined approach. Documentation must be complete, timely, and defensible. Strong processes, interdisciplinary collaboration, and continuous staff education help organizations navigate payer scrutiny with confidence.

By focusing on prevention, accuracy, and audit-readiness, skilled nursing providers can reduce risk, strengthen compliance, and support high-quality resident care.

Celebrating 30 years of service, Functional Pathways is a therapist-founded, -owned, and -led company continually reinventing the therapy market. Spanning the full continuum of care, the company provides its hospital rehab and contract therapy clients with enhanced operational efficiencies, improved patient outcomes, and optimized revenue streams that position them as a leader in their market. Through its 2,500+ therapists caring for close to 7,000 patients a day, Functional Pathways continues to make a difference in every life they touch.

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