Additional Development Request (ADR) Process

Send this page to a colleague

WHAT IS AN ADR? — When a claim is selected for medical review, an additional development request (ADR) is generated requesting medical documentation be submitted to ensure payment is appropriate. Documentation must be submitted timely to CGS for review and payment determination.

WHY AN ADR? — Any claim submitted to CGS may be selected for an additional development request (ADR). Claims may be selected when elements on the claim match the parameters of a pre-payment edit established by CGS. Additional information about the types of edits, and a current list of widespread edits, can be accessed from the "Overview of Medical Review" web page.

The information below will help ensure that necessary steps are taken to submit documentation timely, and avoid having claims denied as a result the ADR process.

CHECKING FOR ADRs — When a claim is selected for an ADR, the claim is moved to a Fiscal Intermediary Standard System (FISS) status/location S B6001. **Providers are encouraged to use FISS Option 12 (Claim Inquiry) to check for ADRs at least once per week**. You will not receive any other form of notification for an ADR.

Your agency should have an internal process established to monitor claims selected for an ADR, and to ensure the documentation is submitted within the required timeframe. If the requested documentation is not received timely by CGS, the claim will be automatically denied.

To check for ADRs using FISS Option 12, key your NPI number, the status/location 'S B6001', and press Enter. Claims selected for ADR will appear.

```
MAP1741                  CGS J15 MAC - HHH REGION        ACPFA052 MM/DD/YY
AB01CD    SC             CLAIM SUMMARY INQUIRY           C201245E HH:MM:SS
                              NPI 1234567890
       HIC                  PROVIDER                  S/LOC S B6001  TOB
  OPERATOR ID AB01CD        FROM DATE          TO DATE            DDE SORT
  MEDICAL REVIEW SELECT
       HIC              PROV/MRN    S/LOC       TOB    ADM DT FRM DT THRU DT  REC DT
 SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
   123123123A          XXXXXX       S B6001    XXX    0501YY 0501YY 0531YY   0615YY
     PATIEN              J      2042.72                                39700

   222444666A          XXXXXX       S B6001    XXX    0601YY 0601YY 0631YY   0701YY
     JONES               M      4234.78                                39700
```

FISS Pages 07 and 08 — Each claim that appears in S B6001 must be selected to identify the documentation that is being requested, as well as the timeframe by which the documentation must be received. This information is found on FISS Pages 07 and 08. These pages only appear when the claim is in status/location S B6001. **Screen print FISS pages 07 and 08 for your reference. CGS requires FISS Page 07 be returned with the ADR documentation.**

FISS page 07 includes the:

- HICN of the patient;
- dates of service on the claim;
- document control number (DCN) of the claim;
- mailing address to which your documentation must be sent;
- "Due Date", which is the 45th day. However, you are required by CMS (Pub. 100-08, Ch. 3 §3.2.3.2) to mail documentation by day 30 – 15 days **before** the "Due Date".

Example of FISS Page 07:

```
REPORT: 001                MEDICARE PART A 15004        PVDR NO  : XXXXXXXXXX
DATE  : MM/DD/CCYY   ADDITIONAL DEVELOPMENT REQUEST    BILL TYPE: XXX
CASE ID: 15004XXXXXXXXXXXXXXXR0PR
                  A GOOD AGENCY
                  123 MAIN ST

                  ANYTOWN            IA 50010 1234

WE HAVE REVIEWED THIS CLAIM AND FOUND THAT ADDITIONAL DEVELOPMENT
WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED.  TO ASSIST YOU IN
PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE
CLAIM RECORD FOR YOUR REVIEW. WE MUST RECEIVE THE REQUESTED INFORMATION
BEFORE THE DUE DATE LISTED BELOW OR THE CLAIM WILL BE DENIED DUE TO NO
RESPONSE. SEND YOUR RESPONSE TO THE ATTENTION OF:
                  CGS J15 MAC
                  J15 - HHH CORRESPONDENCE
                  P O BOX 20014
                  NASHVILLE            TN 37202
PATIENT CNTRL NBR:                          DUE DATE: MM/DD/CCYY
MEDICAL REC NO:                      DCN: XXXXXXXXXXXXXXXXR
HIC: 123123123A    PATIENT NAME: JOSEPHINE   PATIENT
FROM DATE: 05/01/20YY  THRU DATE: 05/31/20YY  OPR/MED ANALYST:
TOTAL CHARGES:   2042.72     ORIG REQ DT: 06/16/20YY  CLM RCPT DT: 06/15/20YY


     PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

FISS Page 08 is a list of the documentation being requested. This may include initial assessments, the plan of care, physician's orders, visit notes, the certification of terminal illness and election statement (hospice), and OASIS assessments (home health). You may need to press F6 to view the complete list of requested documentation. In addition to the listed documentation, **you should send any other documentation that supports payment of the services billed, even if the documentation is before or after the dates of service on the claim,** but relevant to the services provided.

Example of FISS Page 08:

```
REASONS: 5057T

REASON CODE NARRATIVES FOR HIC/DCN: 123123123A   XXXXXXXXXXXXXXR

5057T MEDICARE NEEDS TO RECEIVE THE RETURNED ADR INFORMATION BY THE 30TH DAY.
      THIS ALLOWS FOR MAIL TIME AND FOR US TO MOVE THE CLAIM INTO THE MEDICAL
      REVIEW STATUS/LOCATION SM50MR BY DAY 45 OR IT WILL BE DENIED WITH REASON
      CODE 56900 ON THE 46TH DAY.  SEND THE FOLLOWING  INFORMATION TO SUPPORT
      THE TERMINAL ILLNESS AND ALL DAYS/SERVICES BILLED:
      *INITIAL ASSESSMENT AND VISIT NOTES FOR ALL SERVICES PROVIDED THIS BILLIN
       PERIOD.
      *PLAN OF CARE /UPDATES AND INTERDISCIPLINARY GROUP NOTES TO COVER ALL DAY
       IN THIS BILLING PERIOD, WHICH MAY INCLUDE THE LATEST UPDATE PRIOR TO
       THIS BILLING PERIOD.
      *PHYSICIAN ORDERS AND VISIT NOTES
      *HOSPITAL DISCHARGE AND/OR PHYSICIAN SUMMARIES
      *HISTORY AND PHYSICAL EXAM, LAB, X-RAY, AND/OR SURGICAL REPORTS
      *SIGNED/DATED: CERTIFICATION OF TERMINAL ILLNESS, AND REVOCATION (IF
       APPLICABLE)
      *ANY PERTINENT INFORMATION PRIOR TO/AFTER THIS BILLING PERIOD
      *DATES AND TIMES OF SERVICE CHANGES, WHEN BILLING MULTIPLE LEVELS OF CARE
      *THE BENEFICIARY SIGNED AND DATED HOSPICE ELECTION STATEMENT
      *SIGNED AND DATED HHABN OR NOTICE OF NON-COVERAGE IF ONE WAS ISSUED TO
```

PREPARING and MAILING ADRs — Attach a copy of FISS Page 07 as the top page of your documentation to ensure the documentation is matched to the appropriate patient and claim. **Mail documentation to CGS by day 30** (15 days before the "Due Date"). This 30-day timeline allows for ample mail time, and processing of the documentation when received, preventing the claim from inadvertently denying. Mail to the address that appears on FISS Page 07:

CGS J15 MAC
J15 – HHH Correspondence
PO Box 20014
Nashville, TN 37202

NOTE: CGS does not recommend sending your documentation overnight via Fed Ex or UPS. If prompt mailing of your documentation is necessary to meet the due date, CGS recommends overnight delivery via the US Postal Service to the address above.

The Electronic Submission of Medical Documentation (esMD) process may be used as an alternative to mailing your documentation. For more information on the esMD process, refer to the CGS "Electronic Submission of Medical Documentation" web page.

If you are responding to multiple ADR requests, clearly separate the documentation for each claim. Due to CGS's process for imaging documentation, the use of rubber bands or binder clips, or mailing documentation for each claim in separate envelopes, is recommended. Multiple responses sent together, but not separated, may result in the documentation being imaged as one claim. Do not staple documentation.

Providers may include an outline or cover letter with their documentation. This can be used by CGS Medical Review staff as a roadmap, and prove very helpful to highlight key dates or documentation that supports payment of the claim. However, the cover letter cannot be used as documentation, and the documentation must support the contents of the cover letter in order to be useful.

In addition, **providers may use brackets, such as [ ] or { }, asterisks (*) or underlined text in the documentation** to draw the reviewer's attention to important information. However, notations should not alter, or give the appearance of altering, the documentation. The use of a highlighter is not recommended.

RECEIPT OF DOCUMENTATION — When your documentation has been received by CGS, the claim is moved from status/location S B6001 to S M50MR for review. Upon completion, the claim is moved to S M5CLM for additional processing. Providers can monitor the S M50MR status/location in FISS, to verify that their documentation has been received by CGS.

REVIEW OF DOCUMENTATION — A CGS nurse reviewer will examine the medical records submitted to ensure the technical components (OASIS, certifications, election statement, etc.) are met, and that medical necessity is supported. CGS has 60 days from the date the documentation is received to review the documentation, and make a payment determination.

A hierarchy is used to review documentation. This means that documentation is first reviewed for administrative documentation, and then medical documentation. At any point in the review process, if documentation is found to be missing, incomplete or insufficient, the review process ceases, and any remaining documentation is not reviewed. For example, if an error is found with the technical components of the documentation (i.e. FTF), the review stops, and the documentation is not reviewed for medical necessity (i.e. terminal prognosis).

Hospice Hierarchy	Home Health Hierarchy
Valid election statement	Technical components: OASIS

	Start	submission, certification/orders, FTF
Technical components: certification statement, FTF is 3rd or later benefit period		Homebound documentation
POC updated every 15 days		Intermittent skilled nursing or therapies
Disease acuity or trajectory supports 6 month prognosis – Hospice LCD: "Determining Terminal Status"		Reasonable and medically necessary skilled service
Non-routine care supported	Finish	Use "Physical Therapy – Home Health" LCD for guidance (when applicable)
Physician visits		OASIS and coding

During the review, if a signature is found to be missing or illegible, or an electronic signature cannot be authenticated, the claim will be re-ADRd to you in status/location S B6001. Page 08 will show with edit 5ADR2 with a narrative indicating that additional documentation is required to support the signatures. Page 04 (Remarks) will specify the documentation being requested. The additional signature documentation must be sent to CGS within 15 days of the request. A screenprint of Page 07 should be attached to the top of the additional documentation and returned to CGS.

ADR OUTCOMES — Possible outcomes of the ADR include payment in full (P B9997), partial payment (P B9997), or a full denial (D B9997). Providers are notified of the payment determination via the FISS status/location, as well as their remittance advice. Any denial for which the provider disagrees may be appealed using the Medicare Appeals Process.

ADR RESOURCES

- CGS "Additional Development Request Quick Resource Tool"
- Additional Development Request (ADR)/Medical Review Frequently Asked Questions (FAQs)
- CGS FISS Guide, Chapter 3: Inquiry Menu
- CMS Medicare Program Integrity Manual (PIM), CMS Publication 100-08, Chapter 3, Section 3.2.3, "Requesting Additional Documentation During Prepayment and Postpayment Review"
- Program Comparison: Medical Review, CERT and Recovery Audit

Updated: 04.17.13


CMS
CENTERS for MEDICARE & MEDICAID SERVICES