
Additional Development Requests

Background

When a Medicare contractor cannot make a coverage or coding determination from the information that has been provided on a claim and its attachments, we may ask for additional documentation by issuing an Additional Development Request (ADR). We must request records related to the claim(s) being reviewed, and we may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition.

This job aid will assist providers with the process of ADRs that have been generated by NHIC, Corp. Please note that this process does not include requests generated by Recovery Audit Contractors (RAC), Quality Improvement Organizations (QIO), Comprehensive Error Rate Testing (CERT), and non-medicals such as National Provider Identifier (NPI) issues.

ADR Steps

1. A hardcopy ADR is sent and/or an electronic ADR is generated.
2. The Provider gathers the information to respond.
3. NHIC, Corp. makes decision based on the provider's response.

Step One

Additional Development Request is generated or sent to the provider

Providers set up for electronic ADRs:

The Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) functions allow all providers to view ADRs online. If you are set up to submit claim attachments electronically, **you must use the online system to identify claims and view the ADRs.** When an ADR is generated, the claim will be found in status/location S B6001. You will not receive hardcopy ADRs for claims pending in this location.

NHIC, Corp.

75 Sgt. William Terry Drive
Hingham, MA 02044
www.medicarenhic.com

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Providers set up for hardcopy ADRs:

Providers who cannot submit electronic attachments (those who are set up for hardcopy ADRs) will see **ALL** claims requiring medical documentation in status/location S B6001. Note that the FISS DDE functions allow all providers to view ADRs online.

Step Two

The Provider gathers the information to respond to the ADR

Documentation must be as complete as possible to allow medical reviewers to determine the appropriateness of the billed services. Providers should gather all requested information and submit the medical records by the due date on the ADR.

If all information requested in the ADR is not submitted, the claim could be denied. Submitting complete documentation will help decrease the number of denials because the “documentation needed to make a determination is missing,” and will help decrease the number of appeals which are a result of incomplete documentation. To determine what documentation is necessary, utilize the Local Coverage Determination/National Coverage Determination databases. Claims will be reviewed and processed based on the documentation submitted in response to an ADR.

Where to submit hardcopy ADR response

Responses are sent to one of the following addresses:

Claims Non-Medical ADR Replies NHIC, Corp.
PO Box 9201
Hingham, MA 02044

Medical Review Correspondence & Medical ADRs NHIC, Corp.
PO Box 9204
Hingham, MA 02044

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Step Three

NHIC, Corp. makes decision based on the provider's response

Documentation should be submitted as soon as possible, preferably within 30 days. By submitting the documentation as soon as possible, providers minimize the risk of the records not being received timely. If no response is received within 45 days of the ADR date, the system will **deny the claim** with reason code 56900 (failure to submit requested records within the designated time frame). Providers who do not respond in a timely manner will continue to have a high denial rate, and will be candidates for increased or continued medical review.

ADR Locations

Status/location S B6001:

- Providers set up for **only hardcopy ADRs** will see **all** claims in this location
- Providers set up for electronic ADRs will see claims for services other than ambulance and therapy in this location
- Providers set up for hardcopy ADRs **will receive** a yellow ADR for claims in this location
- Providers must submit **hardcopy** documentation

Note: Providers still have on-line capability to view claims in this location

Status/location S M5XXX:

Once medical records are received in response to an ADR, the claim will move to this location to await review of the medical records.

Common ADR Denials

Reason Code 56900:

- The claim is being denied due to failure to submit the requested medical documentation within the designated time frame.
- **The problem:** Medical records not received within 45 days of the ADR

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- **Prevention:**

1. Check the online system daily for claims pending with medical records
2. Route hardcopy medical requests to responsible party that will submit the medical records to NHIC, Corp.
3. Compile the documentation
4. Submit the medical records

Reason Code 56901

- This item or service was denied because information required to make payment was incorrect (Providers may find additional information on claim page 4).

- **The problem:**

1. Documentation was altered inappropriately
2. Illegible documentation

- **Prevention:**

1. Draw a single line through inaccurate information
2. Write correct information
3. Initial and date corrected entry
4. Make corrections as soon as possible
5. Medicare can not accept: using white out, blacking out with marker, writing over, scribbling out
6. Write legibly

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Key 7 in the upper right hand corner of any page or press F8 until page 7 is displayed.

MAP1711	M E D I C A R E A O N L I N E S Y S T E M	CLAIM PAGE 07
SC	UB92 CLAIM INQUIRY	SV:
HIC XXXXXXXXXXA	TOB 132 S/LOC S B6001 PROVIDER XXXXXX	UB-FORM

The ADR is displayed in a format very similar to the yellow hardcopy request form.

```
REPORT: 001                MEDICARE PART A 00308                PVDR NO : XXXXXX
DATE : 12/10/2003        ADDITIONAL DEVELOPMENT REQUEST        BILL TYPE: 132

                        XYZ HOSPITAL
                        400 S SALINA STREET
                        SYRACUSE                NY 13203

WE HAVE REVIEWED THIS CLAIM RECORD 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 AFFECTED CLAIM
RECORD (NEXT PAGE) FOR YOUR REVIEW. PLEASE REFER TO THE ACCOMPANYING LIST FOR
EXPLANATION OF THE ASSIGNED CODES. THE INTERMEDIARY NAMED BELOW NEEDS TO
RECEIVE THE REQUESTED INFORMATION BEFORE 01/05/2001 , ON WHICH DATE THE CLAIM
WILL BE DENIED FOR LACK OF RESPONSE. PLEASE SEND YOUR RESPONSE TO THE
ATTENTION OF:            KXXXXXXXXXXXXXXXXX
                        KXXXXXXXXXXXXXXXXX
                        KXXXXXXXXXXXXXXXXX

PATIENT CNTRL NBR: 1 A 2
MEDICAL REC NO: 5001XXXXX                DCN: 200XXXXXXXXX008
HIC: XXXXXXXXXXA                PATIENT NAME: TEST                CLAIM
FROM DATE: 11/01/2000        THRU DATE: 11/01/2000        OPR/MED ANALYST:
TOTAL CHARGES:                $190.97                ORIG REQ DT: 01/05/2001        CLM RCPT DT: 11/13/2000
```

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Press F8 to view the lower portion of the ADR, which identifies the documentation that must be submitted.

```
REASONS: 58799  
  
REASON CODE NARRATIVES FOR HIC/DCN: XXXXXXXXXXA 203XXXXXXXXXX04  
58799 ***** MEDICAL RECORD REQUEST *****  
* PLEASE SUBMIT THE FOLLOWING DOCUMENTATION FOR THE PHYSICAL THERAPY AND  
* THE CLINIC SERVICES (IF BILLED) ON THE CLAIM REFERENCED ABOVE:  
* - PHYSICIAN'S ORDER/REFERRAL FOR PHYSICAL THERAPY SERVICES  
* - DIAGNOSIS FOR PHYSICAL THERAPY SERVICES AND DATE OF ONSET  
* - INITIAL EVALUATION AND ALL RE-EVALUATIONS  
* - PLAN OF TREATMENT RELATIVE TO THIS CLAIM PERIOD  
* - PROGRESS NOTES AND ATTENDANCE RECORDS  
* - CLINIC PROGRESS NOTES  
* IF BILLING PULMONARY REHABILITATION SERVICES MUST INCLUDE:  
* - A SEPARATE PHYSICIAN'S EVALUATION - PERFORMED BY THE FACILITY  
* MD/DO OR THE MD/DO OVERSEEING THE PULMONARY REHABILITATION  
* SERVICES  
* - DAILY PROGRESS NOTES AND ATTENDANCE RECORDS  
* - PHYSICIAN'S SIGNED AND DATED MONTHLY PROGRESS REPORT  
* - DOCUMENTATION TO SUPPORT ALL RELATED SERVICES BILLED (IE. PFT'  
* PLEASE REFER TO MEDICARE NEWS UPDATE 2001-10  
*  
* PLEASE ATTACH THIS INFORMATION TO THIS FORM AND RETURN IT TO THE  
MEDICAL REVIEW UNIT (DEPT 424). IF THIS INFORMATION IS NOT RECEIVED
```

Providers also have the option of viewing the ADRs via the online reports view:

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Enter 04 in the Enter Menu Selection and press the enter key

```
MAP1701

                                MAIN MENU FOR REGION A62CQIN2

                                01    INQUIRIES
                                02    CLAIMS/ATTACHMENTS
                                03    CLAIMS CORRECTION
                                04    ONLINE REPORTS VIEW

ENTER MENU SELECTION: 04

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Enter R2 (View a Report) in the Enter Menu Selection field and press the enter key

```
MAP1705

                                ONLINE REPORTS MENU

                                R1    SUMMARY OF REPORTS
                                R2    VIEW A REPORT

ENTER MENU SELECTION: R2

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

On the screen below, press <Enter> to view a listing of the reports available

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```
MAP1671          M E D I C A R E  A  O N L I N E  S Y S T E M
                                O N L I N E  R E P O R T S  S E L E C T I O N
REPORT NO
SEL REPORT NO.  FREQUENCY  DESCRIPTION

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

Enter S in the select field for the 201 report and press the enter key

```
MAP1671          M E D I C A R E  A  O N L I N E  S Y S T E M
                                O N L I N E  R E P O R T S  S E L E C T I O N
REPORT NO
SEL REPORT NO.  FREQUENCY  DESCRIPTION

                201        WEEKLY        PEND, PROCESS, & RETURN CLAIMS
                316        DAILY         PROV SUBMISSION DAILY ERROR
                316        WEEKLY        PROV SUBMISSION WEEKLY ERROR
                316        MONTHLY       PROV SUBMISSION MONTHLY ERROR
                702        DAILY         ACS APPEALS RECEIVED

PROCESS COMPLETED --- NO MORE DATA THIS TYPE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT
```

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Electronic Additional Development Requests

REPORT: 201
CYCLE DATE: 7/06/01
BLUE CROSS CODE: XXXX

PAGE: 4
FREQUENCY: WEEKLY
PROVIDER NUMBER: 14XXXX

MEDICARE PART A - 00131
SUMMARY OF PENDED CLAIMS
OUTPATIENT

NAME	MED REC NUMBER	HIC NUMBER	RECD DATE	ADMIT DATE	FROM DATE	THRU DATE	ADJ IND	LAST TRAN	SUB IND	SUSP TYPE	TOTAL CHARGES
BENEFICIARY, IMA PAT CONTROL NBR: 11111111 ADS REASON CODES: 59302	00000001	111111111A	07/01/01	00/00/00	05/01/01	05/25/01	IND	07/02/01	A	SUSP	1080.00
CUSTOMER, IDA PAT CONTROL NBR: 22222222 ADS REASON CODES: 59302	00000002	222222222A	07/01/01	00/00/00	06/01/01	06/12/01	IND	07/02/01	A	SUSP	645.00
PATIENT, ISALAH PAT CONTROL NBR: 33333333 ADS REASON CODES: 59302	00000003	333333333A	07/02/01	00/00/00	05/15/01	05/31/01	IND	07/03/01	A	SUSP	912.00
SAMPLE, IMA PAT CONTROL NBR: 44444444 ADS REASON CODES: 59302	00000004	444444444A	07/01/01	00/00/00	05/12/01	05/29/01	IND	07/06/01	A	SUSP	30.00
TRYING, IDA PAT CONTROL NBR: 55555555 ADS REASON CODES: 59302	00000005	555555555A	06/22/01	00/00/00	05/29/01	05/31/01	IND	07/05/01	A	SUSP	8.00
WORKER, ISALAH PAT CONTROL NBR: 66666666 ADS REASON CODES: 59302	00000006	666666666A	07/03/01	00/00/00	06/15/01	06/15/01	IND	07/06/01	A	CWFD	335.25

The header information identifies that this is the pended claims section / outpatient subsection of the report.

These claims have ADRs requested. You can tell this by looking for the additional line item starting: ADS REASON CODES: 5XXXX
All of these claims should be found in the daily electronic files for that particular week's work.
The medical review ADR reason codes can be found on claims with a range in the 5XXXX series.

This line does not have an ADR that is attached to the claim. Therefore, you would not find an electronic ADR in the daily file.

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