

**TO: ALL PROVIDERS**

**FROM: CAREFIRST OF MARYLAND INC., MEDICARE PART A**

**DATE: SEPTEMBER 20, 2004**

**SUBJECT: PROCEDURES FOR ADDITIONAL DEVELOPMENT REQUESTS (ADRs) RELATED TO CLAIMS IN MEDICAL REVIEW**

The purpose of this bulletin is to assist providers in identifying claims suspended for additional development by Medical Review and clarifying the process for submitting the requested documentation to Medical Review to ensure accurate and timely accounting of claims received. Following the recommended procedures below will assist Medical Review in adjudicating your claims through the system as quickly as possible.

### **Identifying ADR Claims**

Claims will be suspended to status location SB6000 within one or two days of submission for additional development. The claim then moves to status location SB6001 and providers with Direct Data Entry (DDE) capabilities can access the ADR on line. To access the ADR:

- Go to the claim inquiry screen
- Place an "S" or "U" outside the claim in question and access the claim
- Locate the reason code beginning with a 5 (lower left corner)
- Place the cursor over the reason code and key F1 to view the ADR

If the provider does not have DDE capabilities, a hard copy ADR will be mailed to the provider two to five days after the day the claim went to SB6001. The ADR will identify the specific information that is needed to review the claim.

The claims will remain in the SB6001 status location to allow the provider 45 days to submit the documentation.

When documentation is received the claim will then be moved to status location SM5013. The claim will remain in the SM5013 location until it is adjudicated.

Providers have 30 days from the date that the ADR was generated to respond with medical records. In accordance with CMS instructions, if no documentation is received within 45 days, the claim will automatically deny with reason code – 56900 (failure to submit requested documentation). This denial will count against the provider's overall error rate and could result in a more intensive level of medical review.

It is the provider's responsibility to check the status of the claim to ensure that records were received and logged into the system. For further consideration of payment, the claim will have to go through the appeals process.

The appeals process will delay payment to the provider. We urge providers to **submit ALL requested documentation in a timely manner.**

### **What Can Providers Do To Help Claims Process Promptly**

- Check status location SB6001 on a regular (daily) basis for applicable ADRs.
- Respond timely to all ADRs.
- Ensure all information that was requested on the ADR is included. Documentation requests are specific to individual reason codes (5XXXX).
- Attach a copy of the ADR to each individual set of medical records.
- If responding to multiple ADRs for the same beneficiary, **separate each response and attach a copy of the ADR to each individual set of medical records.**
- **Documentation for each claim should be separately identified.**
- **Multiple sets of documentation should not be bundled as one unit unless a cover sheet is attached indicating the number of claims enclosed in the packet.**
- Send documentation to:  
  
CareFirst of MD, Inc.  
Medicare Part A Medical Review  
1946 Greenspring Drive  
Timonium, MD 21093-4141
- Allow five working days mail time for posting and then check the SM5013 status location to ensure receipt of the information (this step is critical in the process). Notify Melanie Maxwell, Supervisor – Medical Review immediately at 410-561-4108 if your records have not been logged in as received (SM5013) so they will not auto deny with 56900.
- Regularly check the remittance advice for denied and paid claims.
- If a claim denies you will have to file an appeal.

The above steps will allow us to properly match information with each claim and to process claims promptly.

### **How Long Does It Take For Claims to Pay**

- Claims are reviewed based on receipt of the requested documentation.

- Normal inventory averages 30 days of work on hand and therefore takes approximately 30 days for medical review to process after receipt of all information.
- Actual payment will be made on the next Tuesday after the claim is processed, due to the weekly payment requirement.

Note: Claims are received by medical review after passing all consistency edits. After medical review has performed their review, claims are subject to Medicare Secondary Payer (MSP) and Common Working File (CWF) (cable) edits. Claims that suspend for edits other than medical review will take additional time to process.

If you have any questions you can contact our Provider Service line at 1-866-488-0545.

**THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE AT NO-COST FROM OUR WEBSITE AT [www.marylandmedicare.com](http://www.marylandmedicare.com)**