**Overview of MDS 2023 Updates Toolkit-**

**MDS 2023 Changes and the Additional Determination Request (ADR)**

**Additional Development/Documentation Request (ADR)**

**Introduction**

The Centers for Medicare & Medicaid Services (CMS) indicates, “Medical reviews involve the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing, and medical necessity requirements.”1

**Definition**

An Additional Documentation Request (ADR) (also known as an Additional Documentation Request) is, “An additional documentation request (ADR) is generated when documentation is necessary to support a Medicare claim. This request is for medical record documentation to support payment of an item(s) or service(s) reported on the claim to ensure compliance with Medicare's coverage, coding, payment and billing policies.”1

**Additional Development/Documentation Request and the MDS**

An Additional Development Request is issued for the purpose of reviewing documentation for specific issues as determined by the Centers for Medicare and Medicaid Services (CMS) or other governing agencies of the federal government. In essence, it is the beginning of a claim’s denial process. ADRs reviews can be either prepayment or post payment in nature. There are different reviewers in the ADR process including [MACs, UPICs, or RACs](https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/medical-review-and-education/additional-documentation-request) .

Data for the billing claim (UB04) is derived from the MDS and supporting claim documentation. Per the Medicare Benefits Policy Manual, the resident must require skilled services on a daily basis and one of the following must be met – qualifying hospital stay, rehabilitation (PT/OT/ST) at least five days per week, skilled nursing at least seven days per week or restorative nursing at least six days per week.

MDS Coordinators and IDT members are integral to the success of the Medicare claims process. Accurate MDS coding along with supporting assessments and claims documentation are the foundation for successful ADR outcomes.

The MDS 2023 changes bring about a new set of data trends that will be reviewed by contractors to support Medicare claims. It is recommended that leaders access the appropriate training for MDS Coordinators, IDT members and billing team members, hold them accountable for their assigned portions of the MDS/RAI process, and review trends or potential performance gaps while determining the necessary actions for performance improvement.

**Understand the Additional Documentation Request (ADR)**

* The contractor may not be able to make a determination about improper payment based solely on claims data. The contractor will send an ADR letter to the provider.
* Any contractor can submit an ADR to the facility.
* Read carefully.
* The letter specifies the documents to send.
* Documents must be sent by the date specified in the letter or the claim will be denied.
* Beneficiaries cannot be held liable for funds denied or recouped.

**Key Knowledge Points**

* Some ADRs are randomly selected.
* The Medical Review section of your MAC website has useful information about TPE, ADR, etc.
* Read ARD letters very carefully.
  + Note the deadline and adhere to it.
    - Deadlines vary by contractor.
  + Provide a copy of the documents that are requested.
    - The ADR letter will contain specific instructions for packaging and sending the documents.
  + Number or letter the pages for reference in the facility’s cover letter.
  + Write a cover letter with the list of documents included in the package.
  + Have a designated reviewer to validate that all required documents are there.
  + Keep a copy of all documents sent with the ADR.
  + You can consider adding documents that support compliance. Describe them in your cover letter along with the critical information you want reviewed on those documents.
  + Review ADRs with the Quality Assurance Performance Improvement Committee.

**References and Resources**

Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities: <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

Centers for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual. Version 1.18.11, October 2023: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual>

Centers for Medicare & Medicaid Services. Additional Documentation Request. <https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/medical-review-and-education/additional-documentation-request>