DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

NEW product from the Medicare Learning Network® (MLN)

- "**Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 4]**", Educational Tool, ICN 909012, downloadable

MLN Matters® Number: MM8581 Revised **Related Change Request (CR) #: CR 8581**

Related CR Release Date: March 16, 2015 **Effective Date: Claims received on or after October 1, 2015**

Related CR Transmittal #: R3219CP **Implementation Date: October 5, 2015**

Note: This article was revised on March 17, 2015 to reflect the revisions to CR8581 issued on March 16, 2015, That revision changed the ":" and "/" in BR8481.12 to a "-" (page 2 below). It was previously revised in February 2015 to provide clarifications regarding the relationship of reopenings to timely filing and also to certain denied claims lines and to clarify the need for a "Remarks" field code for certain reopenings. All other information remains the same.

Automation of the Request for Reopening Claims Process

Note: To assist providers with coding a request to reopen claims that are beyond the filing timeframes a Special Edition Article, SE1426, has been developed. That article contains some additional information on this process as well as condition codes and billing scenarios. The article may be reviewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf on the CMS website.

Provider Types Affected

This MLN Matters® Article is intended for providers, including home health and hospice providers, and suppliers submitting institutional claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8581 which informs A/MACs about changes that will allow providers and their vendors to electronically request reopenings of claims. Make sure your

billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a "new" bill type frequency code to be used by providers indicating a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. These institutional reopenings must be submitted with a "Q" frequency code to identify them as a Reopening.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause). Reopenings are only allowed after normal timely filing period has expired.

If the normal timely filing period has not expired, the MAC will return the reopening to the provider and request the provider submit an adjustment claim not a reopening.

Also, MACs interrogate the remarks field for good cause on reopenings that have an adjustment reason code of R2 or R3 and they will return the reopening to the provider when the remarks field is not annotated with one of the following 15 character remarks:

- GOOD_CAUSE-**_C-A** (underline indicates a space)
- GOOD_CAUSE-**_NME** (underline indicates a space)
- GOOD_CAUSE-**_F-E** (underline indicates a space)

Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal decision is pending or in process.

MACs will not allow claim lines that have been denied through a Medicare Review process (for example, MR, RAC, CERT, OIG, QIO, etc.) to be reopened, however, other claim lines that were not denied through a Medicare Review process shall be allowed to be reopened.

Also, MACs will not allow Direct Data Entry (DDE) claims that have been fully denied to be reopened. Providers must appeal these claims.

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC's decision to reopen a claim determination, or refusal to reopen a claim determination, is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will Return To Provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action. In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered by the refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor's refusal to reopen. However, when an A/MAC reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills or reopening requests in response to claim denials resulting from review of medical records (including failure to submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials.

Additionally, many A/MACs allow reopenings to be submitted hardcopy (by mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about other ways reopenings may be submitted.

Additional Information

The official instruction, CR 8581, issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3219CP.pdf** on the CMS website.

For additional information regarding the distinction between adjustment bills, which are subject to normal claims processing timely filing limits, and reopenings, which may be requested beyond timely filing limitations, review Chapter 1, Section 70.5 of the "Medicare Claims Processing Manual" (IOM 100-4). That manual chapter is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf** on the CMS website.

For additional information regarding the processing of appeals, review Chapter 29 in the "Medicare Claims Processing Manual" at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf** on the CMS website.

For additional information regarding the processing of requests for reopening, review Chapter 34 in the "Medicare Claims Processing Manual" at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf** on the CMS website.

Attachment 1 will assist providers with coding claim's request for reopening.

Attachment 1 - Coding Requirements:

These claims must be submitted with a "Q" in the 4th position of the Type of Bill (TOB xxxQ) to identify them as a Reopening.

Condition Code Definitions for Reopening

Condition Code	Title	Definition
R1	Request for Reopening Reason Code - Mathematical or Computational Mistakes	Mathematical or computational mistakes
R2	Request for Reopening Reason Code - Inaccurate Data Entry	Inaccurate data entry, e.g., mis-keyed or transposed provider number, referring NPI, date of service, procedure code, etc.
R3	Request for Reopening Reason Code - Misapplication of a Fee Schedule.	Misapplication of a fee schedule
R4	Request for Reopening Reason Code - Computer Errors	Computer errors.
R5	Request for Reopening Reason Code - Incorrectly Identified Duplicate	Claim Claims denied as duplicates which the party believes were incorrectly identified as a duplicate.
R6	Request for Reopening Reason Code - Other Clerical Errors or Minor Errors and Omissions not Specified in R1-R5 above	Other clerical errors or minor errors and omissions not specified in R1-R5 above.
R7	Request for Reopening Reason Code - Corrections other than Clerical Errors	Claim corrections other than clerical errors within one year of the date of initial determination.
R8	Request for Reopening Reason Code - New and Material Evidence	A reopening for good cause (one to four years from the date of the initial determination) due to new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.
R9	Request for Reopening Reason Code - Faulty Evidence	A reopening for good cause (one to four years from the date of the initial determination) because the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.