DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: *"Automation of the Request for Reopening Claims Process"*

Note: This article was revised on May 7, 2015, to make changes to keep the information consistent with the related article, MM8581. The table on page 4 was added, and the effective date and implementation date were also changed. The CR release date, transmittal number and link to the CR also changed to the revised CR for MM8581. All other information remains the same.

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 intended to provide additional information, coding instructions and scenarios for requesting a reopening of a claim that is beyond the filing timeframe. It is a companion article to MLN Matters® Article MM8581 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8581.pdf) on the CMS website. MM8581 is based on Change Request (CR) 8581 which informs A MACs about changes that will allow providers and their vendors to electronically request reopening claims. Make sure your billing staffs are aware of 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. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after January 1, 2016 (based on an October 1, 2015 implementation of ICD-10, see bold below).

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 the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause). Note that while the reopening period associated with ARC R1 is one year from the RA date, providers must submit an adjustment bill (TOB xxx7) when the claim correction is submitted within the claims timely filing period (that is, within one year of the date of service or claim through date). The reopening request (TOB xxxQ) should only be utilized when the submission falls outside of the period to submit an adjustment bill.

The following table presents some scenarios of reopening and adjustment timeline scenarios.

Claim "Through" Date	Remittance Advice (RA) Date	Adjustment Period (based on "Through" date)	Reopening Period – Adjustment Reason Code (ARC)= R1 (Based on RA date after Adjustment Period has lapsed)	Reopening Period – ARC=R2 (Based on RA date)	Reopening Period – ARC=R3 (Based on RA date)
Timely Filing Period – Use TOB xxx7			**Beyond Timely Filing Period – Use TOB xxxQ**		
10-01-2014	11-01-2014	10-01-2014 Thru 09-30-2015	10-01-2015 Thru 10-31-2015	11-01-2015 Thru 10-31-2018	11-01-2018 and beyond
10-01-2014	03-31-2015	04-01-2015 Thru 09-30-2015	10-01-2015 Thru 03-30-2016	3-31-2016 Thru 3-30-2019	3-31-2019 and beyond
10-01-2014	9-30-2015	N/A – Timely Filing Period has lapsed	10-01-2015 Thru 09-30-2016	10-1-2016 Thru 9-29-2019	09-30-2019 and beyond

Note that there is a special congressionally mandated time frame for adjustments/reopenings that are for higher weighted DRGs. These must be filed within 60 days from the initial claim determination.

Note that clerical errors or minor errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services (for example, late charges).

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

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 the filing timeframes to request an appeal (which are based on the original initial determination on the RA) are not extended and do not "reset" 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 (TOB xxx7) or reopening requests (TOB xxxQ) 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.

Also, due to ICD-10 implementation, currently scheduled for October 2015, the NUBC is going to delay implementation of the new bill type and condition codes until January 1, 2016. CMS will implement system changes in October, as scheduled, but will not allow the Front End Edits to accept these coding changes until January 2016. If there is a change in the ICD-10 implementation dates, we will re-issue this communication and provide the acceptance of the reopenings as scheduled with system changes in October 2015.

Finally, clarification was requested regarding the congressional exception to the adjustment and reopening process. As is currently the situation with adjustment and reopening processes, a provider cannot use the automation of the reopening process to reopen a claim to a higher weighted DRG after 60 days from the initial claim processing. The automation of the reopening process does not change this long standing congressional exception.

Definitions:

Timely Filing = 12 Calendar months from the date of service
(IOM 100-04, Chapter 1, Section 70.1 - Determining Start Date of Timely Filing Period -- Date of Service)
"For institutional claims (Form CMS-1450, the UB-04 and now the 837 I or its paper equivalent) that include span dates of service (that is, a "From" and "Through" date span on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness."

Initial Claim Determinations = the date of the initial determination via an electronic or paper remittance advice (RA) (that is, A.K.A. the date on the 835) – see CFR 42 §405.921.

Additional Information

The related CR 8581 may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3060CP.pdf** on the CMS website.

To assist providers with claims coding a request for reopening, the following attachment was prepared with condition codes that may be used and scenarios using Adjustment Reason Codes, R1, R2 and R3.

Attachment

Coding Requirements

(1) Type of Bill xxxQ

(2) An applicable Condition Code R1-R9

R1=Mathematical or computational mistake
R2=Inaccurate data entry
R3=Misapplication of a fee schedule
R4=Computer Errors
R5=Incorrectly Identified Duplicate
R6=Other Clerical Error or Minor Error or Omission (Failure to bill for services is not consider a considered a minor error
R7=Correction other than Clerical Error
R8=New and material evidence is available
R9=Faulty evidence (Initial determination was based on faulty evidence)

(3) A Condition Code to identify what was changed (if appropriate):

D0=Changes in service date
D1= Changes to charges
D2=Changes in Revenue Code/HCPCS/HIPPS Rate Codes
D4=Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
D9=Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Provider ID, Modifiers and other changes
E0=Change in patient status

(4) A Condition Code W2=Duplicate of an original bill. When a provider uses this code they are attesting that they are reopening a bill already sent to the Medicare program and that there is no Appeal in Process. A provider cannot reopen a bill and appeal the same bill simultaneously.

(5) (For DDE claims only) An "Adjustment Reason Code" from the reopening subset below on claim page 3 (MAP1713)

R1 = < 1 yr Initial Determination (from Remittance Advice date)
R2 = 1 - 4 yr Initial Determination (from Remittance Advice date)
R3 = > 4 yr Initial Determination (from Remittance Advice date)

(6) Reopenings that require "Good Cause" to be documented must have a Remark/Note from the provider. Remarks/notes should be formatted as shown below **without the parenthetical**

explanation (this is not an exhaustive list) and a narrative explanation after the word "because". If the change or addition affects a line item (shown as bold) instead of a claim item, please indicate which lines are being changed in the remark/note. The first fifteen (15) characters of the remark/note must match exactly as shown below.

GOOD CAUSE- C-A CC (CHANGED OR ADDED CONDITION CODE) BECAUSE…

GOOD CAUSE- C-A OC (CHANGED OR ADDED OCCURRENCE CODE) BECAUSE…

GOOD CAUSE- C-A OSC (CHANGED OR ADDED OCCURRENCE SPAN CODE) BECAUSE…

GOOD CAUSE- C-A VC (CHANGED OR ADDED VALUE CODE) BECAUSE…

GOOD CAUSE- C-A DX (CHANGED OR ADDED DIAGNOSIS CODE) BECAUSE…

GOOD CAUSE- C-A **MOD** (CHANGED OR ADDED MODIFIER) BECAUSE…

GOOD CAUSE- C-A PX (CHANGED OR ADDED PROCEDURE CODE) BECAUSE…

GOOD CAUSE- C-A **LIDOS** (CHANGED OR ADDED LINE ITEM DATES OF SERVICE) BECAUSE…

GOOD CAUSE- C-A PSC (CHANGED OR ADDED PATIENT STATUS CODE) BECAUSE…

GOOD CAUSE- C-A **HCPCS**

GOOD CAUSE- C-A **HIPPS**

GOOD CAUSE- C-A OTHER BECAUSE…

GOOD CAUSE- NME (NEW AND MATERIAL EVIDENCE) BECAUSE…

GOOD CAUSE- F-E (FAULTY EVIDENCE) BECAUSE…

(7) To assist in quickly processing a reopening, any reopening request that contains changes or additions from the original claim should contain a remark/note explaining what has been changed. If the change or addition affects a line item instead of a claim item, please indicate which lines are being changed in the remark/note.

Reopening Request Scenarios (Examples are not all-inclusive)

Scenario A – Adjustment Reason Code R1

Claim 1: Clerical Error – Minor Error – New Pricer/New Fee-Scheduled, Revised MCE, Revised IOCE, Revised NCD edits, Revised MUE edits

TOB	xxxQ	
Reopening Condition Code	R1	**Mathematical or computational mistakes**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 2: Clerical Error – Minor Error – Keying Error

TOB	xxxQ	
Reopening Condition Code	R2	**Inaccurate data entry (inverted code)**
Adjustment Condition Code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 3: Clerical Error – Minor Error – Wrong Locality or Wrong payment system used to Price the claim (Claim paid using the wrong locality or the locality wasn't loaded; or claim paid at CLFS and should have been paid cost or OPPS) Provider file not set up correctly.

TOB	xxxQ	
Reopening Condition Code	R3	**Misapplication of a fee schedule**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 4: Clerical Error – Minor Error – (that is, Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

TOB	xxxQ	
Reopening Condition Code	R4	**Computer errors**
Adjustment Condition Code	D1 D2 D4 D9 E0	Changes to charges Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 5: Clerical Error – Minor Error – Incorrectly Identified Duplicate

TOB	xxxQ	
Reopening Condition Code	R5	**Incorrectly Identified Duplicate**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 6a: Other Clerical Errors – Minor Errors – Coding Error (that is, incorrect data items such as discharge status, modifier or date of service.)

TOB	xxxQ	
Reopening Condition Code	R6	**Incorrect data entry (used wrong code completely)**
Adjustment Condition Code	D0	Changes in service date
	D1	Changes to charges
	D2	Changes in Revenue Code/HCPCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
	E0	Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 6b: Other Clerical Errors – Omissions (that is, incorrect data items such as modifier or clinical information.)

TOB	xxxQ	
Reopening Condition Code	R6	**Incorrect data entry (left off the code from billing)**
Adjustment Condition Code	D2 D4 D9	Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 7: Corrections Other than Clerical Errors – Computer System Omissions (that is, Off-site provider zip code, condition code, Occurrence Code, Occurrence Span Code, Value Code, Modifier)

TOB	xxxQ	
Reopening Condition Code	R7	**Computer System Omission**
Adjustment Condition Code	D2 D4 D9	Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Value Codes or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 4: Clerical Error – Minor Error – (that is, Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

TOB	xxxQ	
Reopening Condition Code	R4	**Computer errors**
Adjustment Condition Code	D1 D2 D4 D9 E0	Changes to charges Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 5: Clerical Error – Minor Error – Incorrectly Identified Duplicate

TOB	xxxQ	
Reopening Condition Code	R5	**Incorrectly Identified Duplicate**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 6a: Other Clerical Errors – Minor Errors – Coding Error (that is, incorrect data items such as discharge status, modifier or date of service.)

TOB	xxxQ	
Reopening Condition Code	R6	**Incorrect data entry (used wrong code completely)**
Adjustment Condition Code	D0	Changes in service date
	D1	Changes to charges
	D2	Changes in Revenue Code/HCPCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
	E0	Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 6b: Other Clerical Errors – Omissions (that is, incorrect data items such as modifier or clinical information.)

TOB	xxxQ	
Reopening Condition Code	R6	**Incorrect data entry (left off the code from billing)**
Adjustment Condition Code	D2	Changes in Revenue Code/HCPCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 7: Corrections Other than Clerical Errors – Computer System Omissions (that is, Off-site provider zip code, condition code, Occurrence Code, Occurrence Span Code, Value Code, Modifier)

TOB	xxxQ	
Reopening Condition Code	R7	**Computer System Omission**
Adjustment Condition Code	D2 D4 D9	Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Value Codes or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 8: Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	
Reopening Condition Code	R8	**New and Material Evidence**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 9: Corrections Other than Clerical Errors – Faulty Evidence

TOB	xxxQ	
Reopening Condition Code	R9	**Faulty Evidence**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Scenario C – Adjustment Reason Code R3

Claim 1: Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	
Reopening Condition Code	R8	**New and Material Evidence**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code	R3	>4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 2: Corrections Other than Clerical Errors – Faulty Evidence

TOB	xxxQ	
Reopening Condition Code	R9	**Faulty Evidence**
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code	R3	>4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	