

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



**MLN Matters® Number: MM9639**

**Related Change Request (CR) #: CR 9639**

**Related CR Release Date: July 29, 2016**

**Effective Date: September 30, 2016**

**Related CR Transmittal #: R3568CP**

**Implementation Date: September 30, 2016**

## Reopenings Update – Changes to Chapter 34

### Provider Types Affected

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

### Provider Action Needed

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Change Request (CR) 9639 provides updates to Chapter 34, Section 10 of the “Medicare Claims Processing Manual” to remove outdated contractor terminology, clarify remittance advice code reference and to add hyperlinks for regulation and statutory obligations. The updates enhance and clarify operating instructions and language in accordance with regulation and statute. CR9639 includes no policy changes. Make sure that your billing staffs are aware of these updates.

### Background

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A reopening is a remedial action taken to change a binding 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 1 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

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within 1 year of the date of the initial determination for any reason, or within 1 to 4 years of the date of the initial determination upon a showing of good cause).

The main clarification in CR9639 is to note that where Medicare medical review staff request documentation from a provider/supplier for a claim, but did not receive it, and issued a denial based on no documentation, the codes used for the denial are as follows:

- Group Code: CO – Contractual Obligation
- Claim Adjustment Reason Code (CARC) 50 – these are non-covered services because this is not deemed a ‘medical necessity’ by the payer
- Remittance Advice Remark Code (RARC) M127 – Missing patient medical record for this service).

### Additional Information

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The official instruction, CR9639 issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3568CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html>.

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