FAQ FOR CMS IOM 100-04 CHAPTER 34 REOPENINGS
ORIGINAL CHANGE REQUEST: CR 4147
EFFECTIVE DATE NOVEMBER 29, 2006

The following pages contain a collection of questions and responses to the most frequently received inquiries concerning the clerical error reopening process.

This document lists the items by IOM section number. For instance, to find an item concerning telephone reopenings, which is Section 10.5, you can either scroll down to that area of the document, or you can search by section number (10.5) or keyword (telephone). To search, use the "Search" feature in Adobe, or, while holding down the "Control" key, hit the "F" key and a search box will come on screen and you can enter your search information in there.

Additional updates may be made to this document, as new issues are identified.

Reopenings and Revisions of Claims Determinations and Decisions - General

Section 10 Question 1: Is there any limit to the number of times a carrier will reopen a claim or redetermination?

Section 10 RESPONSE 1: There is no limit beyond the time limits to reopen claims, but CMS does NOT anticipate that contractors would be reopening the same claim multiple times.

Section 10 Question 2: Are reopenings done per claim or detail line?

Section 10 Response 2 : Contractors should reopen what is requested by the provider or supplier.

Section 10 Question 3: *Requesting a reopening does not toll the timeframe to request an appeal*. This statement is confusing and it would be beneficial to clarify it.

Section 10 Response 3: If you request a reopening while you still have appeal rights, waiting on the contractor's decision as to whether or not they will reopen does not stop the clock with respect to filing a timely request for an appeal. For example, a provider has until April 30th to request a redetermination and on April 15th they request a reopening. Then on April 29th they find out that the reopening request has not been accepted. The provider still has to file their redetermination request by April 30th. CMS does not want providers to mistakenly think if they request a reopening, the 120-day clock to request a redetermination has stopped ticking. If providers are unsure that an issue should be handled as a reopening, they can avoid missing the appeal deadline by filing a request for a redetermination. If the contractor determines the issue should be handled as a reopening, they will perform a reopening, if not, they will process it as a redetermination.

Section 10 Question 4: CMS' use of the word "toll" seems unclear. Is the word "alter" more appropriate in this case? If yes, will a revised final CR and MLN article be issued? If not, are contractors free to use the word "alter" instead of the word "toll" in the posting/publishing of the MLN article?

Section 10 Response 4: No revision will be made as to the use of the word "toll." Contractors may use a clarifying word if they think the current wording will be confusing.

Section 10 Question 5: Would a request received via fax be considered a request made in writing?

Section 10 Response 5: Yes.

Section 10 Question 6: *Contractors shall not use reopenings as an appeal when a formal appeal is not available.* Does this mean that reopenings cannot be performed in lieu of an appeal if the time limit (120 days) has expired?

Section 10 Response 6: **No, a party may request or a contractor may reopen and revise the initial determination or redetermination within 1 year from the date of the initial determination or redetermination for any reason or within 4 years for good cause.**

Authority to Conduct a Reopening:

Section 10.1 Question 1: Is it expected that the appeals area will initially receive all requests for reopenings, and if the denial code was N102 or 56900, the appeals unit will forward to the Medical Review (MR) unit or Medical Review Program Safeguard Contractor (MR PSC) responsible for medical review of that claim?

Section 10.1 Response 1: **We are not specifying how requests are routed from the mail room. Ultimately, requests of this type must be forwarded to the medical review unit for processing.**

Section 10.1 Question 2: *If a party has filed a valid request for an appeal, the adjudicator at the lower levels of the appeals process loses jurisdiction to reopen the claim on the issues in question*…Does this mean that if there is a clerical error, but the party has requested a valid redetermination, that the redetermination must be completed?

Section 10.1 Response 2: **No, both of those requests would still be at the contractor and at the first level of appeal. If a contractor receives a valid redetermination request and determines that the only issue is a minor error or omission, then the contractor will process the request as a reopening. This provision is meant to cover a situation where you receive a request for reopening and the Qualified Independent Contractor (QIC) receives a request for reconsideration. You would then lose jurisdiction to reopen and would need to let the appeal proceed and not process the reopening request.**

Section 10.1 Question 3: Instruction indicates that if a valid request for appeal is received, the adjudicator at the lower level loses jurisdiction. However, each appeal level is more costly than the previous level. If something meets the criteria for an appeal, but it could quickly and easily be resolved through a prior level reopening, it would be more cost efficient to proceed and resolve it through the reopening rather than having to go to the appeal level. Do you truly want us to process as appeals any that are valid requests for appeal even if they can be more quickly and easily remedied by a reopening?

Section 10.1 Response 3: **Contractors should contact the appellant and let them know that they can resolve the issue through a reopening, but that you need them to withdraw their appeal request. If providers request a reopening on the initial**

determination in addition to an appeal at the next level, then their reopening request will essentially be null and void, as the lower level adjudicator will lose authority to reopen.

SECTION 10.1 Question 4: The last sentence on Section 10.1 is confusing. The interpretation is: the contractor can accept the reopening request, but has to process it as the next level of appeal. Is this what is meant?

Section 10.1 Response 4: No. Accepting the request is discretionary, but once it has been accepted as a reopening, you must process it in accordance with the reopening procedures.

Section 10.1 Question 5: *Reopenings are generally not conducted until a party's appeal rights have been exhausted or the timeframe to file a request for an appeal has expired.* Will the provider be required to specifically request a redetermination or a reopening? The appeal rights have not been exhausted on most provider clerical errors. Should we interpret this statement to mean that we should not perform a reopening until the appeal timeframe has been exhausted (which contradicts BR 4147.1)?

Section 10.1 Response 5: There are two exceptions that allow a reopening to be conducted when appeal rights have not been exhausted or the timeframe to request an appeal has not expired. These exceptions are:

- **Cases where Medical Review requested documentation, did not receive it, and issued a denial based on no documentation (i.e. N102 or 56900). Subsequently, if the party requests an appeal and submits the requested documentation with the appeal, it shall be treated as a reopening; and**
- **Clerical errors (which include minor errors and omissions) shall be treated as reopenings.**

Contractors should educate providers on what constitutes clerical error versus issues that should be appealed. Until the provider and supplier community is confident of what will be processed by the contractor as a reopening and what needs to be submitted through the appeals system, the provider and supplier community may continue to believe that their only or best recourse is to request an appeal. Regardless of whether the provider requests an appeal or a reopening, the contractor must process clerical errors through the reopening process.

Section 10.1 Question 6: When the request is considered a request for reconsideration, how will the case be handled?

- Will the case be forwarded to the QIC? Most often the case is 20+ days old when this is identified.
- Will a letter be sent to the provider explain that this is a duplicate request to a QIC case?

Section 10.1 Response 6: **Since you lose jurisdiction to reopen when a valid request for reconsideration is made, you would not accept the reopening request or if you felt you could change it and pay, then you would need to tell the party to withdraw their request for reconsideration.**

Section 10.1 Question 7: If a valid request for redetermination is received and a provider clerical error is identified, will this be considered a redetermination or reopening?

Section 10.1 Response 7: **Reopening. If a party submits a valid request for a redetermination and it is discovered that the issue is a clerical error, the contractor must transfer the appeal request to the reopenings unit for processing. Otherwise, the request would go through as a redetermination. If the contractor receives a valid request for a reopening but disagrees that the issue is a clerical error, then the contractor must advise the party that their reopening request could not be processed and that an appeal of the initial claim determination may be pursued, if the time frames for an appeal have not expired.**

Section 10.1 Question 8: Will this process affect beneficiary redetermination workload? The CR refers to provider and never mentions the beneficiary workload.

Section 10.1 Response 8: **No, the process will not affect beneficiary redeterminations. CMS believes that the reopenings process will most likely be utilized by physicians, suppliers and providers, but that does not preclude beneficiaries from requesting a reopening.**

Section 10.1 Question 9: Are you indicating that the beneficiary cannot have a reopening due to carrier error/omission? By indicating that beneficiary redeterminations are not impacted, means that the reopening CR will not apply to the beneficiary and therefore, beneficiaries cannot have a reopening performed that will be reported on the 2592. What about the error/omissions identified by the Call Center? CR 3944 stated that ALL redeterminations must be in writing and did not break it down between beneficiary and provider.

Section 10.1 Response 9: **A beneficiary can certainly request a reopening, but we think most beneficiaries will request an appeal since they may not be familiar with the reopenings process. If the issue involves a clerical error, contractors should process the request as a reopening. Redetermination requests must be in writing, but reopening requests may be by telephone or in writing.**

Section 10.1 Question 10: Should claims denied due to lack of documentation (FISS edit 56900) receive American National Standards Institute (ANSI) Remarks Code MA01? What MSN code should be applied, as beneficiaries can appeal?

Section 10.1 Response 10: **Use the same codes and language you always used. Do not change your process.**

Section 10.1 Question 11: Please address reopening requests that impact a different claim. For example, a provider requests a reopening to add a modifier that was omitted from a paid service. The addition of the modifier now supports payment on a different claim in history that had been denied. Is the provider required to request a separate reopening on the denied history claim, or can the related history claim be adjusted for payment based on the original reopening request?

Section 10.1 Response 11: **This would be at the contractor's discretion. The contractor has the authority to reopen, so there does not need to be a request by the provider or beneficiary in order to correct the claims history or make the adjustment on a related claim.**

Section 10.1 Question 12: Regarding impact on costs and appeals: Under the new reopening rules, facilities that submit Additional Documentation Request (ADR) records within 120 days of the 45th day will be treated exactly the same (in practical terms) as those that submit records within the requested 45 day timeframe; there are no significant consequences to noncompliance. This effectively nullifies contractor initiatives to convince providers to submit records timely, exactly the opposite of a stated goal of this change. As providers learn that there are no adverse consequences to taking up to 165 days to respond to an ADR, the number of initial non-responses should steadily increase. Since the appeals period will now be 120 days beyond the revised determination, won't the longer period marginally increase the number of appeals?

Section 10.1 Response 12: **It was often thought that providers waited until they got into the appeals process to submit documentation - this process would encourage them to submit on time, since they will be unable to bypass the MR reviewer. It also encourages timely submission because it will delay their ability to enter the appeals process.**

Refusal to Reopen Is Not an Initial Determination:

Section 10.2 Question 1: In this section, it is stated that the contractor shall not include a statement concerning the right to appeal in any notice that their reopening request cannot be processed. However, in Section 10.5.2A, concerning telephone reopenings that cannot be processed, the contractor is instructed to inform the appellant of any appeal rights, if applicable. Shouldn't both sections refer to the giving of any applicable appeal rights?

Section 10.2 Response 1: **You are confusing the right to appeal an initial determination and the fact that a contractor's refusal to reopen a claim is not an initial determination and therefore not appealable. In Sec. 10.2, we are addressing only those cases where the contractor has decided not to reopen and is not processing the reopening request. Therefore, there is no reason to include any statement about appeal rights on the reopening issue since there are none in such**

cases. In Section 10.5.2A, we address the need to inform the party of their appeal rights on the original claim denial. If a contractor was responding to a written request for reopening that they are not going to process, they could include language in their letter stating, "We can not process your request for a reopening. This decision is not an initial determination and can not be appealed. However, if you would like to appeal the original denial on the claims in question, you may request an appeal within 120 days from the date of Medicare's initial determination."

Section 10.2 Question 2: Who will be responsible for sending the notice that a reopening request cannot be processed?

Section 10.2 Response 2: The department that would normally process the reopening request should send the letter that states that the contractor cannot process the reopening request. However, if contractors have a more efficient set-up that another unit would send the letter that is acceptable.

Section 10.2 Question 3: If the original decision is upheld, then a reopening cannot be performed. Indicating that the decision is being upheld implies that a response is being made to the inquirer. How will this be done if no Remittance Advice (RA) is generated?

Section 10.2 Response 3: Contractors will not "dismiss" the request (since providers and beneficiaries could mistakenly believe appeal rights attach to the action). Instead, inform the requester that you can not process their reopening request. If the reopening request came in over the telephone, simply inform the caller that you cannot process the request and no letter is needed. However, if the reopening request was written, the contractor should write a brief letter explaining that the reopening request will not be processed and that a contractor's refusal to reopen is not an initial determination and is therefore not appealable.

Section 10.2 Question 4: Rather than dismissing a request for reopening that the carrier determines may not be reopened, you are indicating to simply "not process" a reopening if the contractor does not believe they can change the determination. From a technical standpoint, in the MCS a case must be closed...somehow. We are directed to do a letter explaining that the reopening will not be processed. In the MCS, in order to produce a tacs letter, it must be produced via a case control number. After you complete your letter, that case must be closed out of the system. You can't just delete it or back it out. What kind of closing is the decision "not to process" a reopening? Are you considering this an inquiry? or should it still be a dismissal?

Section 10.2 Response 4: In section 10.8 we are no longer using the word "dismissal" in the reopening process. If the contractor cannot change the original determination or chooses to not accept the request, the contractor must inform the requester that they cannot process the reopening request. Contractors may close this as an inquiry. In instances where workload must be assigned, contractors should use the following guide: if a redetermination was conducted, then it is closed out as a redetermination; if a reopening was conducted, it is closed out as a

reopening; and if an inquiry was conducted (such as recording a telephone call received where no action was taken) it may be closed out as an inquiry.

<u>Reopening of Denials Based on an Unanswered Additional Documentation Requests:</u>

Section 10.3 Question 1: States claims that have been denied by MR for lack of documentation should be reopened. The BR 4147.2 does not state whether the Appeal reopening staff or MR staff should perform the reopening. The Internet Only Manual (IOM) 100-4 Chapter 34, Section 10.3 states if the five requirements listed are not met handle as an appeal and do not ship the case to MR. CR 4203 has not yet been issued, but the CR refers to claims denied for no response to additional documentation request by MR. CR 4203 states ship the cases to the MR unit as opposed to the Appeals unit. Please clarify which area should reopen these claims, and if they should report under the MR workload or as reopening workload by non-MR staff. Does it depend on which CR is finalized first, or will the two directives be synchronized? We would prefer to have the claims reopened by our Appeal unit reopening staff as that area will likely receive the initial request, researched the issue, and identify that the initial claim was denied by MR. It would be a duplication of work to route the claim back to MR at that point.

Section 10.3 Response 1: The language in CR 4203 which, as of November 29, 2006, was replaced by CR 5252, has been updated to match the language in CR 4147.

Section 10.3 Question 2: (4th Paragraph) **-** As part of the Comprehensive Error Rate Testing (CERT) process, we do not limit MR's review of late documentation to 120 days.

Section 10.3 Response 2: If additional documentation is received as part of an appeal request and the claim/service being appealed was the subject of a Medical Review ADR, the appeals unit will forward such cases to MR for reopening if the appeal was filed timely (i.e., within 120 days from the date of the initial determination). Untimely appeal requests will be dismissed absent good cause.

If additional documentation related to a CERT case is received by the MR unit and is not included as part of an appeal request, the MR unit should follow its standard procedures for such cases.

Section 10.3 Question 3: (last paragraph) **-** Please clarify; we believe all reopenings receive the right to a redetermination. Is this statement simply clarifying that in cases where a letter is sent you must spell out the right to a redetermination and when the claim is paid, the appeal rights will be on the Medicare Summary Notice (MSN)?

Section 10.3 Response 3: In the previous release, there was confusion about what level of appeal a claim or claims would go to if they were shipped back to MR for a reopening. The last paragraph in section 10.3 was inserted to confirm that that after the MR reopening, the appeal would be a redetermination.

Section 10.3 Question 4: Section 10.3 refers only to unanswered ADR requests. Could you please include instruction for all documentation requests (including telephone) where the redetermination request is untimely? Can good cause be found because the service is now proven to be documented?

Section 10.3 Response 4: No, this does not in itself constitute good cause to accept a late filed appeal. However, contractors may reopen initial determinations for any reason within one year of the initial determination.

Section 10.3 Question 5: Contractors will not be able to work unanswered ADR requests as reopenings because they are outside of the timeliness standard that would allow a reopening.

Section 10.3 Response 5: You can reopen within one year for any reason.

Section 10.3 Question 6: The current denial for non-response to MR development generates a message on the MSN and remittance advice about appeal rights. If what would otherwise be a valid appeals request (i.e., is submitted within the allowed timeframe) is now not going to be handled as an appeal, should the right to appeal the denial still be stated in the notices to the beneficiary and provider?

Section 10.3 Response 6: Yes, it should remain the same. Do not change the remark codes or language.

Section 10.3 Question 7: Please clarify the 3 possible MR decision scenarios in response to a 56900 reopening decision. They are:

- When the decision is to pay the 56900 reopening request, will a revised electronic remittance advice satisfy the notice requirements?
- When MR makes a decision on a 56900 reopening, and now the decision is to still deny the claim, holding the provider liable, will the electronic remittance advice notice noting the new decision suffice to meet this requirement? Presently we include MSN 31.1 on MR adjustment claims, along with the specific denial reason for the case.
- If the MR decision would be to now hold the beneficiary liable, is it correct that a letter would need to be sent, stating the rationale and basis for the reopening decision?

Section 10.3 Response 7: When the MR decision is to pay the 56900 reopening request, a revised electronic remittance advice would satisfy the notice requirements.

When MR makes a decision on a 56900 reopening request, and the decision is to continue to deny the claim, holding the provider liable, an electronic remittance advice notice noting the new decision will suffice to meet this requirement. You can continue to include MSN 31.1 on MR adjustment claims, along with the specific denial reason for the case.

If the MR decision is now going to hold the beneficiary liable, send a letter that states the rationale and basis for the reopening and revision and any right to appeal.

Reopenings Based on Clerical or Minor Errors and Omissions:

Section 10.4 Question 1: In this section, it is shown that missing data items, such as a provider number or dates of service may qualify as clerical error/omission issues. It is our understanding that if these items were missing on the initial claim, the claim would be rejected and not adjudicated as a Return to Provider (RTP). Are contractors to perform clerical or minor error reopenings on unprocessable claims? Current instructions are that providers must correct the claim and resubmit. How would this then be a clerical error/omission issue?

Section 10.4 Response 1: If it's an RTP, then it would not be subject to reopening, as no initial determination would have been made. We will correct this section to avoid confusion.

Section 10.4 Question 2: Shouldn't providers have the ability to submit an adjustment, or request a reopening if applicable, to add items or services if it's submitted within the claim filing time limit?

Section 10.4 Response 2: Providers can submit an adjustment claim, but they cannot request a reopening. If the item was never previously billed, then Medicare never made an initial determination on the item or service. If there is no initial determination, then there can be no reopening.

Section 10.4 Question 3: Ordinarily a reopening would result in a revised initial determination. What happens if there was never an initial determination (e.g. if a claim was initially rejected as a duplicate)? What is issued as a result of a reopening of this type of issue? Are there appeal rights that would attach if the party didn't like the reopening decision?

Section 10.4 Response 3: Duplicates are most often denied, not rejected. Denials as duplicates where they don't believe it is a duplicate should be handled as a reopening. Claims that have been rejected can be resubmitted subject to the timeliness requirements for claims processing.

Yes, if the reopening results in a revised determination which is unfavorable to the appellant, then appeal rights will be offered. However, if a contractor decides to not reopen and upholds the original denial, no new appeal rights will extend from that decision, as the party was already offered appeal rights on the original claim denial.

Section 10.4 Question 4: Includes "omissions." Should "omissions" be included in the business requirement?

Section 10.4 Response 4: **CMS definition of clerical errors includes minor errors and omissions. Omissions do not include failure to bill for certain items or services. If an item or service is not billed on the original claim, there is no initial determination to reopen with respect to that item or service. The provider or supplier must submit a new claim.**

Section 10.4 Question 5: Multiple sections of draft refer to third party payer errors. We are not certain what is being discussed with these issues. Could an example be provided?

Section 10.4 Response 5: **If a third party payer of health benefits (for example, a group health plan) originally makes a payment which is primary to Medicare but later alleges that Medicare should have been the primary payer and itself a secondary payer, such error on the part of the third party payer does not constitute clerical error or good cause for reopening. A third party payer's error in making a primary payment determination when Medicare processes a claim in accordance with the information in its system of records or on the claim form does not constitute good cause. This is true regardless of whether the reopening is requested by the provider, physician or other supplier or the third party payer.**

Section 10.4 Question 6: *Third party payer error does not constitute clerical error*. How is third party payer error processed? What if the clerical error results in an overpayment?

Section 10.4 Response 6: A third party payer error resulting in an underpayment may be processed as a reopening under the authority to reopen for any reason within 1 year standard. Where a third party payer error results in an overpayment, CMS' Medicare Secondary Payer (MSP) recovery claim is an "initial determination" as defined in 42 CFR §405.924, not a reopening and revision of an initial determination.

Section 10.4 Question 7: The law provides that reopenings may be done to correct minor errors or omissions, that is, clerical errors. The contractor has discretion in determining what meets this definition, and therefore, what could be corrected through a reopening. Please explain how the reopening can be the discretion of the contractor. The business requirements state "shall." The IOM section (10, 3rd paragraph) states that the reopenings "may" be done to correct minor errors or omissions.

Section 10.4 Response 7: **Please see BR4147.1.1 which clearly states that contractors "may" reopen. Also see BR4147.3 which states "if contractor accepts the request". These clearly indicate that the reopening action is discretionary. However, once the contractor accepts the request, there are processes that the contractor must follow.**

Section 10.4 Question 8: We are requesting clarification on any instance where duplicates could be subject to the reopening process.

Section 10.4 Response 8: **If the duplicate claim was denied and not rejected or RTP'd, then an initial determination was made and it is subject to the reopening process. However, if the claim rejected, then no initial determination was made and there is nothing to reopen.**

Section 10.4 Question 9: It is recommended that release of this draft CR be coordinated with the release/rescission of draft CRs 4203 and 4345.

Section 10.4 Response 9: **We are coordinating with the authors of those CRs to ensure the language is consistent.**

<u>Providers Submitting Adjustments:</u>

Section 10.4.1 Question 1: Will there be an allowance within Fiscal Intermediary Shared System (FISS) to permit providers to submit adjustments for a denied item on a claim which had a clerical error on a non-denied item? At present providers can not submit an adjustment if a non-denied item contained a clerical error and a denied item is present on the claim.

Section 10.4.1 Response 1: **No changes are being made to FISS or any standard system with this CR.**

<u>Telephone Reopenings:</u>

Section 10.5 Question 1: The criteria for the new 2592 report will have to change as all clerical error reopenings were going to be reported as such on that report. Will carriers need to devise a way to manually separate out those completed in writing vs. those completed over the telephone? This will add FTE time to the process.

Section 10.5 Response 1: **In the first draft version of CR 4147, CMS asked contractors to report written and telephone reopenings under two separate Budget & Performance Requirement (BPR) codes. Due to a high level of confusion, CMS now requires all clerical error reopenings to be counted under BPR 11210. As for counting workload, CMS does not expect contractors to manually separate the reopenings workload for the 2592. Report workload associated with 11210 in the 2592 fields for clerical error reopenings.**

Section 10.5 Question 2: This section is tagged for carriers only, however, the first paragraph states that Fiscal Intermediaries (FIs) are not precluded from conducting telephone reopenings. With this in mind, should we remove "carriers only" from the title of this section? Also, if FIs perform telephone reopenings, where would they report this activity? (Response can change the responsible parties under business requirement 4147.9.)

Section 10.5 Response 2: **FIs may, but are not required to, perform telephone reopenings. Clerical error reopenings, as well as any reopening previously counted under 11210 will be counted in the 11210. Report workload associated with 11210 in the 2592 fields for clerical error reopenings.**

Section 10.5 Question 3: Does this indicate that the FI may choose to not perform telephone reopenings? If so, will 10.5.1 through 10.5.5 apply only to the Carrier?

Section 10.5 Response 3: **Yes.**

Section 10.5 Question 4: Overpayments are currently counted as reopenings. Do you mean to change the way we count the overpayments?

Section 10.5 Response 4: **Please continue to count overpayments the way you have historically.**

Section 10.5 Question 5: In the second full paragraph excluding the Note, the last sentence states: "ADR reopenings that are shipped back to MR, should be counted in the appropriate MR BPR code." If shipping the cases to MR is determined to be too labor intensive, can they be worked in the reopening area?

Section 10.5 Response 5: **No.**

Section 10.5 Question 6: Will CMS create a reopening form (similar to the 20027 for redeterminations) or can the carrier create their own form for providers to request clerical or minor error reopenings?

Section 10.5 Response 6: **Carriers can create their own form, however CMS assumes that most requests will be received over the telephone.**

Section 10.5 Question 7: It is time-consuming to receive call after call from a provider changing something on the claim until payment can finally be made. Will this be considered workload or closed as a no count? A redetermination - or reopening? Also, written reopening requests which are not reopened require a letter. If this is workload, where does this get reported on the 2590? on the 2592? There does not appear to be a spot to report this workload; however, performing this function without including it as part of the carrier's workload does not seem fair to the carriers. Also, I would have to assume that at some point CMS will want figures and statistics on this function. This, too, is time-consuming and labor intensive.

Section 10.5 Response 7: **Reopenings are discretionary. If a provider is repeatedly calling to change the same claim, contractors should not accept or process the reopening request and CMS would not expect contractors to do so. In addition, should a contractor note a provider is shopping for a payable diagnosis code, the contractor has discretion to require medical documentation to support the diagnosis code provided. As stated in Section 10.2, Response 4 – if the issue is processed in**

any manner, that is the workload area it will be reported in, likewise, if the request is not processed as workload, it should be closed out accordingly. All redetermination requests must be in writing.

Informing the Provider Communities About the Telephone Reopening Process:

Section 10.5.1 Question 1: 3rd bullet states, "Specific instructions that the party must state that he/she is requesting a telephone reopening." CR 4019 IOM section 200.D states, "Since it is neither cost efficient or necessary for contractors to correct clerical errors through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed as reopenings. In situations where a provider, supplier, or beneficiary requests an appeal and the issue involves a minor error or omission, irrespective of the request for an appeal, contractors shall treat the request as a request for reopening." Considering both directives, how strict should contractors be in following this requirement? For example, a request is received that asks to have the date of service changed for one line due to a clerical error. The date error may have caused another service on the claim to be denied and the provider asks for a review of the second service. Should contractors handle the entire case as a redetermination, or as a clerical or minor error reopening? Or split the case and process one service on the claim as a redetermination and the other as a reopening? It would require the least amount of contractor effort to handle both issues as a reopening.

Section 10.5.1 Response 1: Handle both issues as a reopening.

Section 10.5.1 Question 2: 3rd Bullet indicates that the caller must state that they are requesting a telephone reopening. If they do not state that, do we prompt them? It would be extremely poor customer service to not assist a caller simply because they may either use the wrong terminology or forget to utter that specific statement.

Section 10.5.1 Response 2: Yes, you can prompt them. Contractors should continue to educate the provider community of the types of issues to be handled and specific instructions on how to request telephone reopenings until the provider community is more familiar with the process.

Section 10.5.1 Question 3: Contractors are to inform providers of the telephone reopenings process 30 days prior to its initiation, however, since the target implementation date for this CR is just 30 days after issuance, that would not allow enough time to adequately create and post web articles or other materials informing the providers of this process.

Section 10.5.1 Response 3: CMS is extending the timeframe to 60 days to accommodate this.

Section 10.5.1 Question 4: BR 4147.22: The fourth sentence in this BR states that, "In addition, the provider education article shall be…incorporated into any educational

events on this topic." If no educational events are planned in the immediate future, will contractors be required to hold an event specifically for this CR?

Section 10.5.1 Response 4: Below is the revised language that we have created for the provider education business requirements. We completely removed all reference to "any educational activities that they may have planned."

A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.

Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

Issues for Telephone Reopenings:

Section 10.5.2 Question 1: *Telephone reopenings are generally inappropriate for the following issues: Medical necessity denials and reductions*. Does the term "reductions" refer to downcoding that may have been done at the claims level or downcoding that may have been done at the CERT or appeal level? Downcoding at the CERT or appeal level often results in an overpayment being discovered. For example the provider was paid for a 99215 originally and the code is changed to a 99212; an overpayment will result. Should these situations be required to be put in writing rather than taken as a telephone clerical or minor error reopening? This situation may not require documentation if the provider/supplier is stating they billed the wrong code on the initial claim. Another example is an ambulance service billed at a level A0434 and paid. The supplier calls and states they should have billed A0426. This would also result in an overpayment. Can these situations of downcoding (reductions) be taken as a telephone clerical or minor error reopening or should the provider be required to place this type of request in writing?

Section 10.5.2 Response 1: If the issue is minor and does not ordinarily require documentation to review, then it is acceptable for the contractor to handle it over the telephone. Contractors should use their discretion. If the issue is handled over the telephone and the downcoding results in an overpayment, the contractor must ensure that the reopening action is adequately documented. If the issue is more complex, or requires more than a page or two of documentation to be submitted and reviewed, it would not be appropriate to handle this issue over the phone.

Section 10.5.2 Question 2: *Telephone reopenings shall be limited to resolving minor issues and correcting errors as defined in §10.4. As necessary, the contractor may ask the provider, physician, or supplier to fax in the proof to support changes and error correction.* When would the contractor be required to ask the provider or supplier to fax in proof to support changes and error corrections? Generally, when the provider is asked to provide proof to support changes the result is a redetermination and not a reopening. Wouldn't asking for proof to support the changes make the request a complex issue and therefore it could not be done as a clerical or minor error reopening?

Section 10.5.2 Response 2: When developing this CR, our contractor workgroup stated that they sometimes do request documentation, even for simple issues that are handled over the phone. They stated that the documentation is usually only a page or two long and did not want these issues to be prohibited from being handled over the telephone, simply because some short documentation was requested. CMS agreed. If larger amounts of documentation are required, the issue is definitely too complex to be handled over the telephone.

Section 10.5.2 Question 3: *As necessary, the contractor may ask the provider…to fax in documentation to support changes…* "As necessary" should be defined.

Section 10.5.2 Response 3: Since we cannot define every situation where documentation may be required, we are continuing our longstanding process of giving contractors discretion to develop for documentation when necessary.

Section 10.5.2 Question 4: It is mentioned 'big box' cases may be inappropriate for telephone reopenings. Would the provider be required to request the reopening in writing? How are big box cases defined in this work type? Over 40 claims or beneficiaries?

Section 10.5.2 Response 4: Yes, these requests should be in writing, although CMS believes most overpayments will be appealed. Please see Pub. 100-04, Chapter 29, §60.19.3(B) for the definition of a big box case.

Issues That Can Not be Resolved During the Telephone Reopening

Section 10.5.2.A Question 1: In the last paragraph, the instruction to advise the party that a reopening cannot be done and provide appeal rights negates 10.2 where it indicates that a contractor's refusal to reopen is not appealable.

Section 10.5.2.A Response 1: The contractor's refusal to reopen is not appealable, however the timeframe to request an appeal of the original claim denial may not have expired yet. In that case, the party could request an appeal of the original claim denial.

Conducting the Telephone Reopening

Section 10.5.3 Question 1: The name of the reviewer is to be recorded during the call. Would a reviewer ID number be sufficient?

Section 10.5.3 Response 1: As long as you track that back to a person.

Section 10.5.3 Question 2: Is the date of birth no longer required since these are not telephone appeals or eligibility requests? The only item found in the DDR that requires the date of birth to be verified was eligibility questions. The IOM section for redeterminations previously required the date of birth to be verified, however, since telephone redeterminations no longer exist, we believe the date of birth should not be required.

Section 10.5.3 Response 2: CMS changed the language to make it consistent with the requirements in the Disclosure of Information Manual, Publication 100-6.

Section 10.5.3 Question 3: This section seems to lean towards the caller being a provider. Can the beneficiaries also call in for a telephone clerical error reopening?

Section 10.5.3 Response 3: CMS believes that this process will most likely be used by providers, suppliers and physicians, but beneficiaries are not excluded from requesting a reopening if they spot an error.

Documenting the Telephone Reopening

Section 10.5.4 Question 1: Recording the control number on all documents related to a case is a costly action. If all items were placed in a folder labeled with the control number would this not serve the same purpose and save time and money?

Section 10.5.4 Response 1: Most telephone reopenings will be conducted without any documentation and be handled within the system, so there wouldn't be any documents for you to number. If anything is submitted it should be minimal, maybe a page or two. Therefore, CMS disagrees this will be costly.

Section 10.5.4 Question 2: If the additional documentation the carrier receives is verbal, would an on-line question or documentation on a telephone record form meet this requirement?

Section 10.5.4 Response 2: Yes.

Monitoring the Telephone Reopening

Section 10.5.5 Question 1: Only refers to monitoring the telephone reopenings, could there not be a requirement for quality assurance on written reopenings?

Section 10.5.5 Response 1: There is no requirement for a formal quality assurance process for reopenings at this time.

Timeframes for Contractor Initiated Reopenings

Section 10.6.1 Question 1: The last bullet is to effectuate a decision issued under the appeals process, but wouldn't that workload/timeliness instead be more appropriately reported under the workload that is being effectuated?

Section 10.6.1 Response 1: This bullet has nothing to do with reporting workload, it is simply stating that if a party is successful in bringing a *coverage* appeal, that you, the contractor may reopen the claim to effectuate that coverage appeals decision.

Section 10.6.1 Question 2: BR 4147.16 – *A contractor may reopen and revise its initial determination or redetermination on its own motion if one of the following conditions is met:*

3. *At any time if:*
   - *There exists reliable evidence as defined in §405.902 that the initial determination was procured by fraud or similar fault as defined in §405.902; or…*

First bullet – Please define "similar fault." Are we correct to assume that this includes Benefit Integrity investigation overpayment cases that typically cover multiple years? Our experience shows that attorneys argue that the claim should not be reopened if it is over a year old. We would like to suggest that this bullet state: …*similar fault, such as a Benefit Integrity investigation.*

Section 10.6.1 Response 2: CMS provides the exact citation to the federal regulation defining similar fault in this section and no additional language will be added to this. For clarification, the Interim Final Rule for Changes to the Medicare Claims Appeal Procedures (42 CFR parts 401 and 405) page 11450 states: "Similar fault is intended to cover instances where Medicare payment is obtained by those with no legal rights to the funds, but where law enforcement is not proceeding with a recovery based on fraud. This includes instances where a provider has been paid twice for the same claim where the contractor erroneously pays for codes that should not have been paid, but there is no evidence that the provider intentionally failed to refund the money; or where there is the manipulation of legitimate codes to obtain a higher reimbursement."

Timeframes for Party Requested Reopenings

Section 10.6.2 Question 1: Can the last paragraph be modified to state "the timeframe for reopenings would expire when the claims are not readily available"? We recognize the timeframes are not a new element but the correction of clerical errors made by the provider is a new concept. We believe that provider initiated requests based on self audits will increase based on this new concept and contractors will find it difficult to defend a position to not reopen.

Section 10.6.2 Response 1: There is already language in section 10.6.2 that states that when claims history is not readily available, CMS would not expect contractors to accept reopening requests. Typically, contractors have 18 months of claims history online and additional claims history archived. We want to clarify that archived claims history qualifies as "readily available."

Section 10.6.2 Question 2: Requesters are being given one full year to request a reopening under normal circumstances. The telephone redetermination process only allowed them 120 days to call in. By allowing so much more time, we will see an increase in receipts of calls. Further, the last bullet provides an option to request a reopening at any time. If we publish that, providers will take full advantage and attempt to submit requests for extremely aged items. Our instruction is to grant such requests rarely, but that will not limit the attempts made by providers to get them granted – resulting in increased workload and FTE time.

Section 10.6.2 Response 2: The ability to request a reopening for one year has always existed, it is not a new provision, and granting reopenings are at the discretion of the contractor. CMS does not expect contractors to grant reopenings for extremely aged claims.

Timeframes to Complete a Reopening Requested by a Party

Section 10.7 Question 1: Timeliness does not apply for big box cases. Please define what makes a case a big box case, and if there will be an alternate timeliness requirement for those cases or if they are completely outside the scope of the timeliness measure.

Section 10.7 Response 1: No timeframe for big box cases, the definition of big box is provided in Pub. 100-04, Chapter 29, §60.19.3(B).

Section 10.7 Question 2: Last paragraph states "*For those reopenings requested by a party that the contractor agrees to reopen, the contractor should complete the reopening action 60 days from the date of the party's reopening request. This does not apply to "big box cases"*." With appeal budget constraints, we do not believe the 60 day time frame should be mandated for reopening workload. Timeframes for completion of reopenings are not outlined in the CFR. We recognize that we need to respond as soon as

possible to the requests but do not believe contractors should be measured against this parameter.

Section 10.7 Response 2: The vast majority of reopenings in the appeals unit will be telephone reopenings. Telephone reopenings are going to be done over the phone while on the call. We believe the 60-day requirement for party-initiated reopenings should not be a problem.

Section 10.7 Question 3: Contractors shall complete a reopening action within 60 days with an exception for big box cases. How are contractors to report small and big box cases when the 2592 is implemented? Also the current 2590 has no mechanisms to report time frames for reopenings. How are contractors to report cases processed in less than 60 days versus big box cases processed over 60 days?

Section 10.7 Response 3: If the 2590 does not capture this information, then you can't report it. The 2592 has fields for cases processed within 1-30 days and 31-60 days, but does not have a field to capture case information beyond 60 days.

Section 10.7 Question 4: The contractor shall complete a reopening action within 60 days from the date of a party initiated reopening request. This does not apply to big box cases. Does CMS intend this requirement to mean that contractors would have 60 days to initiate the reopening or 60 days to initiate and fully complete the reopening?

Section 10.7 Response 4: 60 days to fully complete for party-initiated reopenings that are not big box cases.

Notice of a Revised Determination or Decision

Section 10.8 Question 1: References a "notice of revised determination." Is this inclusive of a revised MSN/RA, or will a letter always be required?

Section 10.8 Response 1: It is inclusive of the MSN/RA, a letter is not always required.

Section 10.8 Question 2: Requires parties to be informed of appeal rights if the result of the reopening is a revised determination and the decision is not fully favorable. The remittance and MSN generates the appeal rights verbiage on all claim reopenings. Is this an acceptable method of communicating the appeal rights?

Section 10.8 Response 2: No. For unfavorable decisions, you must send a letter. If you are upholding the original denial, no letter is required, just simply inform the caller that you can not accept their request for a reopening.

Section 10.8 Question 3: We find this wording confusing. Our understanding is as follows:

- Revise determination for payment – MSN/RA
- Adverse determination - letter offer new right to a redetermination
- Upholding original decision i.e. no change reopening – letter

For the third situation, what appeal rights are offered (i.e. the appeal right with the initial determination or are new appeal rights offered in the letter i.e. a new 120 day period)?

Section 10.8 Response 3: If your decision is favorable then a revised MSN or RA will suffice as notice of your decision. If there is a change in payment, a revised MSN or RA would also be generated, but if any part of this change is unfavorable, then a letter should be sent explaining the rationale for your decision and information regarding the party's appeal rights.

If you can not change the determination then the contractor should inform the party than you can not process their reopening request. If the request is over the telephone the contractor can simply inform the caller that they can not process their request. If it is received in writing, the contractor should send a brief written letter explaining that their request will not be processed and that not reopening a claim is not an initial determination and is therefore not appealable. However, the party could request an appeal on the original claim denial, provided the request is filed within 120 days from the date of the initial determination.

Section 10.8 Question 4: In the last sentence *"The contractor should state that their decision to not reopen a claim determination is not an initial determination and is therefore not appealable."* - The Standard Part B System MSN/RA generates a new 120 day period with each claim or adjustment that's on the statement. The way the IOM is currently worded it would require contractors to generate a letter for this situation. In the previous Q&A, it stated that a letter would not be required in this situation.

Section 10.8 Response 4: If you do not think you can change the claim determination and the reopening would result in you upholding the original denial, you should not conduct the reopening. New appeal rights would not flow from that as a refusal to reopen is not an initial determination and is not appealable. Only if you reopen and change the initial determination would new appeal rights be offered to the party. Appeal rights then flow from the revised determination issued after the claim is reopened.

Section 10.8 Question 5: In this section, it is stated that if the revised decision results in payment, a revised RA and if applicable a revised MSN will suffice for notice requirements. In cases of partially favorable decisions where there is some payment and some noncoverage remaining, does the contractor need to send any additional notice other than the revised RA or revised MSN, if applicable? Also, in cases where the reopening action results in a decision where the original denial is upheld, how does the

appellant know that the contractor even considered the reopening request as there is no notice sent? In addition, how would they be aware of any remaining appeal rights?

Section 10.8 Response 5: **Contractors should not accept the request if they do not believe that they can change the denial. In the case of written requests, a notice is sent informing the party of the contractor's final action. The letter should have general language informing the party that while the decision to not process the reopening request is not appealable, that the party can request an appeal of the original claim denial, provided that they file the request within 120 days from the date of the initial determination.**

If the reopening request is accepted and results in a partially or wholly unfavorable decision, contractors should send a letter explaining the rationale for their decision and providing information regarding appeal rights. For reopenings that result in a fully favorable decision, a revised MSN or RA will suffice.

When reopening requests are received over the telephone and the contractor can not accept the request, the contractor can simply inform the caller that they can not process their request, no letter is necessary. The contractor can inform the caller that an appeal may be filed, provided that it is filed within 120 days from the date of the initial determination on the claims in question.

For telephone reopening requests that are accepted, partially or wholly unfavorable decisions should be followed up with a decision letter, favorable decisions will only require a revised MSN or RA.

Section 10.8 Question 6: Only when the reopening results in a revised adverse determination will a letter be required. Upholding the original denial will not require a letter. Also, CMS doesn't anticipate many "adverse revised determinations" because the contractor will most likely not grant the reopening request if they don't believe they can make payment. Are you indicating that carriers can choose to not take overpayment requests on the reopening line?

Section 10.8 Response 6: **Reopenings are discretionary. We expect that providers and suppliers will file appeal requests on overpayment demands.**

Section 10.8 Question 7: We would need to respond to the requester in some way. If this was not a reopening and no letter would be sent and no SPR/MSN would be generated, how would this be handled?

Section 10.8 Response 7: **If you can not change the original claim determination, you should not process the request. If the reopening request came in over the telephone, simply inform the caller that you cannot process the request and no letter is needed. However, if the reopening request was written, the contractor should write a brief letter explaining that the reopening request will not be processed and**

that a contractor's refusal to reopen is not an initial determination and is therefore not appealable.

Section 10.8 Question 8: *If the reopening results in an adverse revised determination or decision the contractor shall mail a letter that states the rationale and basis for the reopening and revision and any right to appeal.* Our assumption is that an adverse revised decision would result in an overpayment. Does the demand letter for the overpayment satisfy this letter requirement or is there an additional letter that should be mailed? If there is an additional letter to be mailed, will a model letter copy be provided?

Section 10.8 Response 8: Not necessarily. The contractor may reopen a claim that was denied but end up denying for a different reason. There would be no overpayment in that case.

However, if the adverse revised determination does result in an overpayment, then the demand letter with appeal rights would satisfy this requirement, as long as it contains information explaining why the claim was denied. No additional letter would be necessary.

Section 10.8 Question 9: How will the appellant know of the decision on an adverse determination where the end result is unchanged? There will be no RA or letter of MSN on these cases for Part A.

Section 10.8 Response 9: If the request came in over the telephone you would simply inform the caller that you can not process their request for a reopening. If the request was written, the contractor would need to send a short response informing the requester that their request cannot be processed.

Section 10.8 Question 10: The majority of clerical error reopenings are to add information like a modifier or dx code etc. There are rare occasions where a representative, who is only able to do minimal research, would know immediately that the data being added or changed on the claim would <u>not</u> result in a change to the determination (for example, the addition of a HPSA modifier). So, in probably 99.9% of the cases, when a provider asks to add omitted data, we assume that the data may change the outcome of the claim, but until that claim reprocesses through all the system editing, we do not know absolutely if the outcome will be a change. In order to reprocess a claim in the MCS, a decision indicator (e.g., Full Reversal, Affirmation, Dismissal etc.) must be entered into the system before the transaction can be initiated. You cannot go back and undo the decision or choose to "not reopen" the claim at that point.

The majority of claims reprocessed with additional information do result in a change, which is usually an additional payment. However, in the cases where reprocessing does not result in a change, we send a letter to the appellant advising that the additional data did not change the original outcome and consider the case a reopening affirmation of the original decision.

Because of the workflow of the MCS, does CMS approve of how we resolve requests for clerical error reopenings that we do not identify initially as "no change" but then result in a "no change"? If you do not approve of our current procedure, what is the recommended procedure?

Section 10.8 Response 10: **Based on your explanation of the workflow of the MCS, we do not see a problem with you continuing with your current process of how you resolve requests for clerical error reopenings that you do not identify initially as "no change" but that actually result in a "no change."**

If the contractor cannot change the original determination or chooses to not accept the request, the contractor must inform the requester that they cannot process the reopening request. Contractors may close this as an inquiry. If a redetermination was conducted, then it is closed out as a redetermination; if a reopening was conducted, it is closed out as a reopening; and if an inquiry was conducted (such a recording a telephone call received that did not result in any action being taken) it may be closed out as an inquiry.

Good Cause for Reopening

Section 10.11 Question 1: States third party payer error does not constitute good cause for reopening. Does this refer to MSP or actual third party claims?

Section 10.11 Response 1: **The question is unclear. Additionally, CMS does not understand what is meant by the phrase "actual third party claims" as Medicare does not make payment to third parties such as insurers. Any MSP recovery claim where a beneficiary or provider/supplier is the debtor is not, with one exception (see 42 CFR 405.924(b)(15)), a "reopening" action. Consequently the reopening rules are not (with this one exception) a consideration when Medicare issues an MSP recovery demand letter. The recovery demand letter is an "initial determination", not a revised determination as the result of a reopening.**

What Constitutes New and Material Evidence

Section 10.11.1 Question 1: *There is new or material evidence that was not available or known at the time of the determination…* We have never found good cause for a provider if he cannot obtain records from a hospital. Should we change our guidelines?

Section 10.11.1 Response 1: **No. IOM 100-4 Ch. 29, Section 60.7.5 discusses good cause for late filing of an appeals request, this CR is discussing good cause for reopening a claim determination, the two are different situations. The criteria for allowing an appeal request to be filed AND accepted late are more stringent than requesting a reopening because reopenings are discretionary actions on the part of the contractor.**

<u>Change in Substantive Law or Interpretative Policy</u>

Section 10.12 Question 1: Please clarify the meaning of this section. If a beneficiary file is corrected, should carriers reopen claims to correct the beneficiary history?

Section 10.12 Response 1: **This paragraph is here to cover a situation where a coverage appeal was filed and the party receives a favorable decision on the coverage appeal, which would ultimately affect that same party's claim. This simply allows the contractor the ability to reopen the claim to effectuate a decision issued under the coverage appeals process. For example, Mary Jones filed a coverage appeal and is issued a favorable decision. You can reopen Mary Jones's claim associated with that specific coverage appeal and effectuate the decision on her claim.**