CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3154	**Date: December 19, 2014**
	Change Request 8581

Transmittal 3060, dated September 3, 2014, is being rescinded and replaced by Transmittal 3154, dated December 19, 2014, 201x, to add "a condition code W2, and a condition code D0, D1, D2, D4, D9, or E0" to Business Requirement 8185.2, to clarify Business Requirement 8185.5 creates a system report that is used by A/MACs to complete CMS reporting, to add "for each of the adjustment reason codes R1-R3 for a total of 3 reason codes" to Business Requirement 8185.8 and to add new Business Requirements 8185.3.1, 8185.3.2, 8185.12 8185.12.1, 8185.13, and 8185.14 that were missed during analysis. All other information remains the same.

SUBJECT: Automation of the Request for Reopening Claims Process

I. SUMMARY OF CHANGES: This will implement NUBC approved bill type and condition codes for a request for reopening.

EFFECTIVE DATE: October 1, 2014 - Analysis and Design (CWF, FISS and FISS USERS); Claims received on or after April 1, 2015 - (CWF, FISS and FISS USERS)

IMPLEMENTATION DATE: October 6, 2014 - Analysis and Design (CWF, FISS and FISS USERS); January 5, 2015 – Coding and April 6, 2015; July 6, 2015 – Full Implementation (CWF, FISS and FISS USERS)

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/70.5/Application to Special Claim Types

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3154	Date: December 19, 2014	Change Request: 8581

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I. GENERAL INFORMATION

A. Background: Many A/MAC contractors have various forms and instructions for a provider to request a Reopening of a claim. Often Providers and vendors have multiple A/MAC contractors that they conduct business with as a part of normal operations. Faced with the difficulty of a non-standard approach of requesting Reopening of claims, they have to maintain several procedures and policies for each of the separate A/MACs. CMS, in an effort to streamline and standardize the requesting process has petitioned the National Uniform Billing Committee (NUBC) for a "new" bill type frequency code that can be used by providers to indicate a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. Upon adoption of these NUBC changes, CMS can move forward with implementation of necessary system changes to accommodate this process.

B. Policy: 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. Re-openings are separate and distinct from the appeals process. Re-openings are a discretionary action on the part of the contractor. A contractor's decision to reopen a claim determination is not an initial determination and is therefore not appealable. Requesting a reopening does not toll the timeframe to request an appeal. When a contractor reopens and revises or adjusts an initial determination, that revised determination is a new determination with new appeal rights. If a contractor refuses to reopen a claim, 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 a refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor's refusal to reopen. See, Pub 100-04 Medicare Claims Processing Manual, chapter 1, §70.5 for the distinction between adjustment bills that are handled as new claims and timely filing rules, and those that are handled under the reopening rules regarding administrative finality. See also, Pub 100-04 Medicare Claims Processing Manual, chapter 34 for additional information regarding the processing of requests for reopening.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8581.1	Medicare Contractors shall accept new bill type frequency code “Q” for all institutional claim bill types and adjust any shared system reason codes as necessary.	X		X		X			X	COBA, HIGLAS
8581.2	Medicare Contractors shall accept and develop edits that require a condition code in the R1-R9 series, a condition code W2, and a condition code D0, D1, D2, D4, D9, or E0 if the bill type frequency code is “Q”.	X		X		X				COBA
8581.3	Medicare contractors shall bypass timely filing edits 39011 and 39012 on any claim with a bill type frequency code "Q".					X				
8581.3.1	Medicare contractors shall create a new edit that compares bill type frequency code "Q" reopening with timely filing parameters to ensure that normal claims timely filing has expired and set this edit to a RTP status if normal claims timely filing has not expired.	X		X		X				
8581.3.2	Reopenings are only allowed after normal timely filing period has expired. If the normal timely filing period has not expired, the reopening shall be RTP’d to the provider requesting the provider submit an adjustment claim not a reopening.	X		X						
8581.4	Medicare Contractors shall develop internal processes for handling the routing and processing of the Automation of Reopening Claims Receipts.	X		X						
8581.5	Medicare Contractors shall create a system report with reopenings identified with a bill type frequency code “Q” to allow A/MACs the ability to report workload to CMS based on future CMS direction.	X		X		X				CROWD, HIGLAS, MAS
8581.6	Medicare Contractors shall create standard system adjustment reason codes to identify reopenings performed within 1 year of the date of the initial determination, greater than 1 year and up to 4 years from the date of the initial determination, and greater than 4 years of the date of the initial determination.					X				HIGLAS
8581.6.1	Medicare System Maintainer Contractor shall append					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the corresponding adjustment reason code to all ANSI 837I claims received based on the criteria found in the above business requirement.									
8581.7	Medicare Contractors shall edit Direct Data Entry (DDE) claims with reopening adjustment reason codes to ensure the time-frame parameters of the adjustment reason codes created in BR 8581.6 are being met. Claims not meeting the time-frame parameters shall be RTP'd to the provider.					X				
8581.8	Medicare System Maintainer Contractor shall create a new edit for each of the adjustment reason codes R1-R3 for a total of 3 Reason Codes to suspend claims with new bill type frequency code "Q" for all institutional claim bill types to allow A/MAC contractors control over workload acceptance.					X				
8581.8.1	MACs shall create an ECPS event to accept or RTP suspended claims with new bill type frequency code "Q" for all institutional claim bill types.	X		X						
8581.9	Medicare contractors shall create/update reason codes for the disposition of the reopening bill type/claim – e.g., refusal to reopen, reopen for coverage, reopen for change in denial reason, etc. and ensure that MSNs and Remittance Advices are correctly annotated.					X				
8581.10	Medicare Contractors shall attend up to 6 conference calls with the CMS to discuss the automation of the request for reopening claims process requirements and design.	X		X		X			X	
8581.11	Medicare Contractors shall develop a requirements document for implementing automation of the request for reopening claims process by July 11, 2014.					X			X	
8581.12	Medicare Contractors shall create an edit which interrogates the remarks field for good cause on reopenings that have an adjustment reason code of R2 or R3 and this edit is to fire and RTP the reopening when the remarks field is not annotated with a correct standard 15 character remark. The 15 Character remark will be 1 of the following 3 choices: GOOD_CAUSE:_C/A (underline indicates a space) GOOD_CAUSE:_NME (underline indicates a space)					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	GOOD_CAUSE:_F/E (underline indicates a space)									
8581.12.1	If the standard 15 character remark code is missing or formatted incorrectly on a reopening that requires good cause, the reopening shall be RTP'd to the provider requesting the provider submit the standard 15 character remark and reason.	X		X						
8581.13	Medicare Contractors shall not allow DDE claims that have been fully denied to be reopened. These must be appealed by the provider.	X		X		X				
8581.14	Medicare Contractors shall not allow claim lines that have been denied through a Medicare Review process (i.e., 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.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8581.15	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 the contractor's 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.	X		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, 404-562-7205 or fred.rooke@cms.hhs.gov (For Institutional claims processing), David Danek, 617-565-2682 or david.danek@cms.hhs.gov (For Policy)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: (1)

Attachment

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.

70.5 - Application to Special Claim Types

(Rev.3154; Issued: 12-19-14; Effective: October 1, 2014 - Analysis and Design (CWF, FISS and FISS USERS); Claims received on or after April 1, 2015 - (CWF, FISS and FISS USERS)- Implementation October 6, 2014 - Analysis and Design (CWF, FISS and FISS USERS); January 5, 2015 – Coding and April 6, 2015; July 6, 2015 – Full Implementation (CWF, FISS and FISS USERS)

- Adjustments - If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

  However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see Chapter 34 on Re-openings). *These claims must be submitted with a "Q" in the 4th position of the Type of Bill to identify them as a Reopening.*

- Emergency Hospital Services and Services Outside the United States - The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §70.1 above.) The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any intermediary within the time limit.

- Home health Requests for Anticipated Payment (RAPs) - Since by regulation RAPs are not claims for purposes of Title 18 of the Social Security Act, timely filing enforcement will be bypassed for any RAP for which the associated home health prospective payment system (HH PPS) claim could still be timely. RAPs for which the associated HH PPS claim could not still be timely will continue to be rejected, to prevent payment of RAP amounts that would be subject to recovery later.