



AUC CLAIMS DD TAG AGENDA

February 4, 2015

9:00 a.m. – 10:30 a.m.

Teleconference line: 1-857-232-0300

Participant passcode: 337213

WebEx instructions:

1. To start the WebEx session, go to: <https://health-state-mn-ustraining.webex.com>
2. Under "Attend a Session," click "Live Sessions"
3. Click on the session for "AUC Claims DD TAG"
4. Provide your name, email address, and the following password: Cdd2010! (Note: The exclamation mark at the end is part of the password.)
5. Click "Join now"

Meeting Objectives:

- Worker's Comp
- Determine if Reopening Claims Frequency Type Code Q should be included in 837 Companion Guide or should Best Practice be developed
- Determine if need for ICD-10 workgroup

Agenda items

1. Meeting to order – Sue Lee
2. Anti-trust statement (<http://www.health.state.mn.us/auc/antitrust.pdf>)
3. Introductions - Please e-mail your attendance to susan.lee@allina.com
4. Discussion
 - a. Worker's Comp
 - b. ICD-10
 - c. Reopening Claims Frequency Type Code (837I)
5. Other Business

Next Meeting –

9:00 a.m. – 10:30 a.m.

Teleconference / WebEx only

AUC Claims DD TAG

2-3-2014

Teleconference

9:00 a.m. – 10:30 a.m.

Workers Comp Key Issues/Challenges

- Key issues/challenges
 - Claim event number
 - Lack of transparency, tracking
 - Attachments, lack of standard for attachments
 - Payer IDs (not standard, can't find, changing)
 - Lack of acknowledgments and/or using them incorrectly
 - 835s not: correct, detailed enough, used correctly
 - Compliance (need consistent levels of accountability and enforcement)

Next Steps

- How do we improve process for Work Comp and MVA?

Next Steps

- How do we get payers, clearinghouse and providers to work better together?

Next Steps

- Eligibility checks? How we can validate patient information with Clearinghouse and Payers?

Next Steps

- How many different type of attachment are sent?
Tiff files, PDF files etc..

ICD-10

- Any issues to be considered by CDD (At December meeting, it was suggested to have ICD-10 as a placeholder for 2015 discussion)?

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



REVISED product from the Medicare Learning Network® (MLN)

- [“The Basics of Internet-based PECOS for DMEPOS Suppliers”](#) Fact Sheet, ICN 904283, Downloadable

MLN Matters® Number: SE1426

Related Change Request (CR) #: CR 8581

Related CR Release Date: August 8, 2014

Effective Date: Claims received on or after April 1, 2015

Related CR Transmittal #: R3060CP

Implementation Date: July 6, 2015

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 September 3, 2014, to reflect a new Change Request (CR). The revised CR corrected the effective date to “Claims received on or after April 1, 2015,” and spread the implementation across four quarterly releases. In this article the CR release date, transmittal number and link to the CR also changed. 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

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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 April 1, 2015.

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 (i.e., 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 (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause).

Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal 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 appeal filing timeframes on the original initial determination are not extended following a contractor’s refusal to reopen. However, when an A/MAC

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reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

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

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

Additional Information

The 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.

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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 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=Attestation that there is no Appeal in Process

(5) For DDE claims only) An Adjustment Reason Code on page

R1 = < 1 yr Initial Determination

R2 = 1-4 yr Initial Determination

R3 = > 4 yr Initial Determination

(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...

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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.

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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 |
| Adjustment Reason Code | 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 |
| Adjustment Reason Code | R1 | < 1 yr Initial Determination |
| Remarks – (Good Cause) | Not Required | May be added to provide additional information for claims processing. |

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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 |
| Adjustment Reason Code | 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 – (i.e., 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 |
| Adjustment Reason Code | R1 | < 1 yr Initial Determination |
| Remarks – (Good Cause) | Not Required | May be added to provide additional information for claims processing. |

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

| | | |
|---------------------------|--------------|---|
| TOB | xxxQ | |
| Reopening Condition Code | R5 | Incorrectly Identified Duplicate |
| Adjustment Condition Code | D9 | Other |
| Adjustment Reason Code | 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 (i.e., 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 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 |
| Adjustment Reason Code | R1 | < 1 yr Initial Determination |
| Remarks – (Good Cause) | Not Required | May be added to provide additional information for claims processing. |

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Claim 6b: Other Clerical Errors – Omissions (i.e., 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 |
| Adjustment Reason Code | 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 (i.e., 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 | 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, Value Codes or Modifiers |
| Adjustment Reason Code | R1 | < 1 yr Initial Determination |
| Remarks – (Good Cause) | Not Required | May be added to provide additional information for claims processing. |

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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 |
| Adjustment Reason Code | r1 | < 1 yr Initial Determination |
| Remarks – (Good Cause) | Not Required | May be added to provide additional information for claims processing. |

Claim 9: Corrections Other than Clerical Errors – Faulty Evidence

| | | |
|---------------------------|--------------|---|
| TOB | xxxQ | |
| Reopening Condition Code | R9 | Faulty Evidence |
| Adjustment Condition Code | D9 | Other |
| Adjustment Reason Code | R1 | < 1 yr Initial Determination |
| Remarks – (Good Cause) | Not Required | May be added to provide additional information for claims processing. |

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Scenario B – Adjustment Reason Code R2

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 |
| Adjustment Reason Code | R2 | 1 -4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

Claim 2: Clerical Error – Minor Error – Keying Error

| | | |
|---------------------------|------|--|
| TOB | xxxQ | |
| Reopening Condition Code | R2 | Inaccurate data entry (inverted code) |
| 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 |
| Adjustment Reason Code | R2 | 1 -4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

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 |
| Adjustment Reason Code | R2 | 1 -4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

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Claim 4: Clerical Error – Minor Error – (i.e., 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 | 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 |
| Adjustment Reason Code | 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 |
| Adjustment Reason Code | R2 | 1 -4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

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Claim 6a: Other Clerical Errors – Minor Errors – Coding Error (i.e., 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 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 |
| Adjustment Reason Code | R2 | 1 -4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

Claim 6b: Other Clerical Errors – Omissions (i.e., 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 |
| Adjustment Reason Code | R2 | 1 -4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

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Claim 7: Corrections Other than Clerical Errors – Computer System Omissions (i.e., 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 |
| Adjustment Reason Code | 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 |
| Adjustment Reason Code | 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 |
| Adjustment Reason Code | R2 | 1 -4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

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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 |
| 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 |
| Adjustment Reason Code | R3 | >4 yrs from Initial Determination |
| Remarks – (Good Cause) | Yes | |

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NEW product from the Medicare Learning Network® (MLN)

- “[Medicare Quarterly Provider Compliance Newsletter \[Volume 4, Issue 4\]](#)”, Educational Tool, ICN 909012, downloadable

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

Related CR Release Date: September 3, 2014 Effective Date: Claims received on or after April 1, 2015

Related CR Transmittal #: R3060CP Implementation Date: July 6, 2015

Note: This article was revised on September 3, 2014, to reflect a new Change Request (CR). The revised CR corrected the effective date to “Claims received on or after April 1, 2015,” and spread the implementation across four quarterly releases. In this article the CR release date, transmittal number and link to the CR also changed. All other information remains the same.

Automation of the Request for Reopening Claims Process

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

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a “new” bill type frequency code to be used by providers indicating a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. These institutional reopenings must be submitted with a “Q” frequency code to identify them as a Reopening. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after April 1, 2015.

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 (i.e., 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 (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause). Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal 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 appeal filing timeframes on the original initial determination are not extended following a contractor’s refusal to reopen. However, when an A/MAC

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reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

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

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

Additional Information

The official instruction, CR 8581, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3060CP.pdf> on the CMS website.

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

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

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

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

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Coding Requirements:

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

Condition Code Definitions for Reopening

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

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