REOPENING VS. REDETERMINATION

JOB AID

REOPENINGS

A Reopening is a process used to correct minor errors or omissions to a previously processed claim without using the formal appeals process.

CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes.
- Transposed procedure or diagnostic codes.
- Inaccurate data entry.
- Misapplication of a fee schedule.
- Computer errors.
- Incorrect data items, use of a modifier, or date of service.

A reopening must be requested within one year from the date of the initial determination. The contractor has discretion in determining what meets this definition and therefore, what could be corrected through a reopening.

- Reopening requests received with invalid or inaccurate information cannot be processed and will be returned to the provider.
- Inquiries are not reopenings and will be returned to the provider.
- Examples of “inquiries” include:
  - Asking for the status of claims or Reopening requests previously submitted.
  - Questions regarding denied and/or rejected (Return-to- Provider (RTP)) claims.
  - Questions on the amount paid on processed claims.
  - Requests to reprocess previously submitted claims without identifying specific error or changes needed.

  Inquiries are handled by the Customer Service Center. For options, please go to. https://www.cgsmedicare.com/partb/cs/index.html
- Do not submit duplicate requests.
- If erroneous Reopenings are submitted, do not resubmit corrections until the initial request is finalized.
- If correcting a recoupment claim for a clerical reopening send to the Overpayments and Recovery department.
  - Information is located at: https://www.cgsmedicare.com/partb/overpay/index.html
  - The Overpayment form is located at: https://www.cgsmedicare.com/forms/partb_overpayrecoveryform.pdf

If appealing a recoupment claim (which is not a recoupment clerical reopening, see above) send to the Redetermination department with supporting documentation.

HOW TO FILE A REOPENING REQUEST

myCGS Reopenings is the best vehicle for providers to submit their clerical reopening requests. Located at: https://www.cgsmedicare.com/partb/mycgs/index.html

Utilizing myCGS, our secure online Web portal, allows providers to have more control of your reopening to drive faster adjustments. Automation enables providers to submit required values which allow the claim to adjust without manual intervention. Job aids are available to assist in your submission.

Written Reopenings - A written reopening is a hard copy request.

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- We recommend accessing hard copy form online, type, and then downloading to print.
- Submit only one claim per request form.
- Written Reopenings may take up to 60 days to process. Do not send "second" and "third" requests.
- Check for accuracy PRIOR TO submitting the form to avoid errors.
- Reopening requests received with invalid or inaccurate information cannot be processed and will be returned to the provider.
- Forms located at: https://www.cgsmedicare.com/partb/forms/index.html#Reopenings and includes job aids.

General instructions on, *How to file a Clerical Reopening,* are located at:
https://www.cgsmedicare.com/partb/forms/gateways/when_to.html

REDETERMINATIONS

The Redetermination is the first level of appeals. A party who is dissatisfied with an initial determination and is afforded appeal rights may request a redetermination.

Redetermination requests must be submitted within 120 days from the initial claim determination. Refer to the Timeliness Calculator located at: https://www.cgsmedicare.com/medicare_dynamic/j15/partb_time_limit_calculator/partb_time_limit_calculator.aspx. If a request is received after 120 days and a "good cause" can be found for late filing, please indicate the "good cause" reason on the form. Good cause may be found when the record clearly shows:

- Incorrect or incomplete information about the subject claim and/ or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the provider, physician, or other supplier; or,
- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoidable circumstances encompasses situations that are beyond the provider, physician or supplier's control, such as major floods, fires, tornados, and other natural catastrophes.

WHEN TO FILE A REDETERMINATION

- Ambulance denials.

  Note: Run tickets should be included to support each trip.
- Charges denied as Part A because the patient was seen in the office prior to admission in the hospital.

  Note: Documentation should be included to support the office service.
- Shared care denied for global service already on file.

  Note: Documentation of the share care should be included to support the service billed.
- Claim denied as not medically necessary and the provider has supporting documentation to support the medical necessity.
- Procedures denied for exceeding Medically Unlikely Edits.

  Note: Documentation supporting medically reasonable and necessary units of service should be included with the request.
- If appealing a recoupment claim (which is not a recoupment clerical reopening) send to the Redetermination Department with **supporting documentation**.

Resources

- "What should I submit with my Appeal?" is located at: https://www.cgsmedicare.com/partb/appeals/pdf/msi_action_plan_part_b_check_list.pdf
- "When not to File an Appeal" is located at: https://www.cgsmedicare.com/partb/appeals/when_not_to_file.html

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HOW TO FILE A REDETERMINATION

Utilizing the **myCGS Web portal** is the preferred method for submitting your Redetermination. Providers who are registered users may complete and submit the form with required medical documentation. A job aid is located at: https://www.cgsmedicare.com/pdf/partb_mycgs_redeterminatin_request.pdf

Written request should be typed and submitted on the Medicare Part B Jurisdiction 15 Redetermination Request Form located at: https://www.cgsmedicare.com/pdf/partb_redeterminationform.pdf

- Redeterminations should be mailed to the address at the bottom of the form.
- Redeterminations do not accept faxed request.

Requirements for each redetermination request include:

- Beneficiary Name
- Medicare Identifier
- Service being appealed or the Internal Control Number (ICN)
- Requestor Name
- Date of Service

FIVE LEVELS OF APPEALS

https://www.cgsmedicare.com/partb/appeals/level_of_appeals.html

1. First Level of Appeals is a **Redetermination**
2. Second Level of Appeals is a **Reconsideration**

   Note: Second level Reconsideration should not be sent to CGS. The correct address is listed at the bottom of the form located at: https://www.cgsmedicare.com/partb/forms/pdf/partb_reconsideration_form.pdf
3. Third Level of Appeal is an **Administrative Law Judge Hearing**
4. Fourth Level of Appeal is an **Appeals Council Review**
5. Fifth Level of Appeal is a **Judicial Review in U.S District Court**

For additional information please visit, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf

Resources

- Internet Only Manual, Publication 100-04, Chapter 34 – Reopening and Revision of Claim Determinations and Decisions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c34.pdf
- Internet Only Manual Publication, Publication 100-04, Chapter 29 –Appeals of Claim Decisions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c29.pdf

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