CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3568	**Date: July 29, 2016**
	Change Request 9639

SUBJECT: Reopenings Update - Changes to Chapter 34

I. SUMMARY OF CHANGES: The purpose of this change request is to provide updates to Pub. 100-4, chapter 34, to remove outdated contractor terminology, clarify remittance advice code reference and to add hyperlinks for regulation and statutory citations. The updates enhance and clarify operating instructions and language in accordance with regulation and statute.

EFFECTIVE DATE: September 30, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 30, 2016

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	34/Table of Contents
R	34/10/Reopenings and Revisions of Claim Determinations and Decisions – General
R	34/10.1/Authority to Conduct a Reopening
R	34/10.4/Reopenings Based on Clerical or Minor Errors and Omissions
R	34/10.5/Telephone Reopenings - Required for A/B MACs (B) Only
R	34/10.5.1/Informing the Provider Communities About the Telephone Reopenings Process
R	34/10.5.3/Conducting the Telephone Reopening
R	34/10.5.5/Monitoring the Telephone Reopening
R	34/10.6/Timeframes to Reopen Claim Determinations
R	34/10.6.1/Timeframes for Contractor Initiated Reopenings
R	34/10.6.2/Timeframes for Party Requested Reopenings
R	34/10.6.3/Timeframes for Adjudicator to Reopen
R	34/10.6.4/Timeframes When a Party Requests an Adjudicator Reopen Their Decision
R	34/10.11/Good Cause for Reopening

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	34/10.12/Change in Substantive Law or Interpretative Policy

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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3568	Date: July 29, 2016	Change Request: 9639

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I. GENERAL INFORMATION

A. Background: A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (that is, filed within 1 year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within 1 year of the date of the initial determination for any reason, or within 1 to 4 years of the date of the initial determination upon a showing of good cause).

B. Policy: No change in policy.

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	
9639.1	Contractors shall observe the updated medical review reopening exception CARC/RARC code combination.	X	X	X	X					RRB-SMAC
9639.2	Contractors shall observe updated changes to contractor references "MAC" or "DME MAC," where applicable, throughout chapter.	X	X	X	X					RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
9639.3	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 5 business days after receipt of the notification from CMS announcing the availability of the 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	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): Rosemary McCann, 410-786-2182 or Rosemary.McCann@cms.hhs.gov , Katherine Hosna, 410-786-4993 or Katherine.Hosna@cms.hhs.gov

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: 0

Medicare Claims Processing Manual
Chapter 34 - Reopening and Revision of Claim Determinations and Decisions

Table of Contents
(Rev. 3568, Issued: 07-29-16)

Transmittals for Chapter 34

10 - Reopenings and Revisions of Claim Determinations and Decisions - General

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A reopening is a remedial action taken to change a *binding* determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process. Reopenings 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. If the reopening action results in a revised determination, then new appeal rights would be offered on that revised determination. Under certain circumstances a party may request a reopening even if the timeframe to request an appeal has not expired.

Historically, contractors have employed a variety of informal procedures under the general heading of "reopenings," "re-reviews," "informal redeterminations," etc.

Providers, physicians and suppliers may have come to view these as appeal rights. However, as stated above, reopenings are separate and distinct from the appeals process. They are not a party's right. Contractors shall not use them to provide an appeal when a formal appeal is not available. Contractors should also note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) recovery claims where the debtor is the beneficiary or provider/supplier are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim because the provider/supplier failed to file a proper claim as defined in *42 CFR Part 411*. Aside from this one exception, MSP recovery claims involve recovery of the insurance funds at issue, not recovery of the payment previously made by Medicare. Consequently, the recovery action does not involve the reopening of Medicare's payment determination. The MSP recovery demand letter is an "initial determination" as defined in *42 CFR 405.924*, not a reopening and revision of Medicare's initial claims payment determination.

10.1 - Authority to Conduct a Reopening

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

Reopenings can be conducted by a contractor to revise an initial determination, revised initial determination or redetermination; a Qualified Independent Contractor (QIC) to revise a reconsideration; an Administrative Law Judge (ALJ) to revise a

hearing decision, and the Appeals Council (AC) to revise an ALJ decision or their own review decision.

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. 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 (MR) requested documentation, did not receive it, and issued a denial based on no documentation (i.e., *Group Code: CO - Contractual Obligation; Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a "medical necessity" by the payer; and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service*). Subsequently, if the party requests an appeal and submits the requested documentation with that appeal, it shall be treated as a reopening; and

- Clerical errors (which includes minor errors and omissions) shall be treated as reopenings.

If a contractor receives a valid and timely request for redetermination and begins processing the request as a reopening (clerical error or otherwise) and later determines that a reopening cannot be performed, or the determination cannot be changed, the contractor shall not issue a refusal to reopen notice. Rather, the contractor shall process the request as a valid/timely redetermination (as originally requested by the party) in accordance with Pub. 100-04, *c*hapter 29.

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. For example, a party simultaneously requests a QIC reconsideration and a reopening with the contractor. The contractor can no longer reopen that redetermination decision now that the party has filed a valid request for QIC reconsideration. This does not preclude contractors from accepting and processing remands from the QIC.

As stated previously, it is within the contractor's discretion to accept reopening requests, but once accepted, they must be processed in accordance with the above instruction.

10.4 - Reopenings Based on Clerical or Minor Errors and Omissions

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

Section 937 of the Medicare Modernization Act *(MMA)* required CMS to establish a process, separate from appeals, whereby providers, physicians and suppliers could correct minor errors or omissions. We equate the MMA's minor error or omission to fall under our definition of clerical error, located in *42 CFR 405.980(a)(3)*. We believe that it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeal process. Thus, *42 CFR 405.927* and *405.980(a)(3)* require that clerical errors be processed as reopenings rather than appeals. 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; or,
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate.
- Incorrect data items, such as provider number, use of a modifier or date of service.

Note that clerical errors or minor errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. A contractor shall not grant a reopening to add items or services that were not previously billed, with the exception of a few limited items that cannot be filed on a claim alone (e.g., G0369, G0370, G0371 and G0374). Third party payer errors do not constitute clerical errors.

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.

10.5 - Telephone Reopenings - Required for A/B MACs (B) Only

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

NOTE: Since most A/B MACs (A) and (HHH) never processed telephone redeterminations, CMS does not expect that A/B MACs (A) and (HHH) will process many telephone reopenings, if any. However, they are not precluded from doing so, should the telephone process prove effective. If A/B MACs (A) and (HHH) choose to process telephone reopenings, they will be held to the same standards.

The majority of appeals processed as telephone redeterminations consisted of minor or clerical errors that could be quickly corrected over the telephone. Section 937 of MMA required CMS to establish a process to correct such errors outside of the appeals process. Therefore, CMS has discontinued telephone redeterminations that were formerly processed by A/B MACs (B) and DME MACs and has implemented the telephone reopenings process. CMS believes that the vast majority of the work processed as telephone redeterminations can instead be processed as telephone reopenings. A small percentage of the work processed under telephone redeterminations will now fall under written redeterminations and stay within the purview of the appeals units.

A/B MACs (B) and DME MACs shall allocate costs of reopenings that would have formerly been processed as a telephone redetermination, but fall under the definition of a clerical error under the claims reopenings *Budget & Performance Requirements (*BPR*)* Code (11210). ADR reopenings that are shipped back to MR should be counted in the appropriate MR BPR code.

The following sections describe the procedures for accepting and processing reopenings over the telephone. CMS believes that most telephone reopenings will consist of clerical errors or omissions that can be corrected quickly and easily over the telephone. That does not preclude contractors from processing written requests for clerical error reopenings. They may handle such requests either by phone or in writing.

Whether a request for reopening is made by telephone or is conducted and completed as a telephone reopening depends on the issues at hand and the complexity of the matters involved.

Receiving reopening requests and conducting reopenings on the telephone should expedite and simplify the process. Requesting a reopening on the telephone provides quick and easy access to parties who wish to correct clerical errors or omissions.

The contractor shall ensure that the Privacy Act of 1974, *5 USC, §552a*, is applied to its telephone reopening process. All staff that perform telephone reopenings shall be trained on the Privacy Act requirements (see Pub. 100-01, *c*hapter 6, Disclosure of Information).

10.5.1 - Informing the Provider Communities About the Telephone Reopenings Process

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

The contractor shall inform providers, physicians, and other suppliers of its telephone reopenings process 30 days prior to initiation and annually thereafter or when making significant changes to its process. It shall provide information about its process through means such as Web sites, bulletins/newsletters, customer service/inquiry and provider relations departments, conduct seminars, etc.

Information it publishes about its telephone reopenings process should include:

- How to access the process (telephone number, hours of operation, etc.);
- Any limitations (such as certain issues, number of claims/issues per call, etc.);
- Specific instructions that the party should state that he/she is requesting a telephone reopening;
- Type of documentation that the party should have on hand when calling in to request a reopening;

- The types of issues the contractor might be able to handle over the telephone and the types of issues it will not handle over the telephone. Please see §10.5.2 below for further discussion of issues that are appropriate for telephone reopenings.

10.5.3 - Conducting the Telephone Reopening

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

Prior to conducting a telephone reopening, the caller must provide the following three items:

- Verify the provider's/physician's/supplier's name and identification number or National Supplier Clearinghouse number;
- Beneficiary last name, first initial; and
- Medicare *number or Medicare Health Insurance Claim Number (*HICN*)*.

Items must match exactly.

The contractor should also inform the caller that the call may be monitored for quality assurance.

The following items shall be obtained/recorded/confirmed during telephone reopening:

- Date of call;
- Name of caller;
- Phone number of the party;
- Name of provider/physician/supplier of item or service;
- Dates of service;
- Which items(s) or service(s) are at issue;
- Reason for the request;
- Any new information that is received during the telephone call;
- Rationale for not processing the request, if applicable;
- Any appeal rights, if applicable*;*
- Name of *the* reviewer;
- Confirmation number, if applicable; and
- Inform the caller that *the* call may be monitored.

10.5.5 - Monitoring the Telephone Reopening

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

CMS may review this function at any time so the contractor may want to develop *and maintain records on* a monitoring/quality assurance process.

10.6 - Timeframes to Reopen Claim Determinations

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

Our regulations establish timeframes that restrict the ability of the contractor to reopen claim determinations. See *42 CFR 405.980(b) and (c)* for the timeframes for reopenings. The specific timeframes for contractor-initiated and party-requested reopenings are detailed below.

10.6.1 - Timeframes for Contractor Initiated Reopenings

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A contractor may reopen and revise its initial determination or redetermination on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or

- Within 4 years from the date of the initial determination or redetermination for good cause as defined in §10.11; or

- At any time if:

    - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in *42 CFR 405.902*; or

    - The initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error as defined in §10.4; or,

- At any time to effectuate a coverage decision issued under *42 CFR 426.460(b)(1)(i)*, *426.488(b) and (c)* or *426.560 (b)(1)(i)* appeals process.

10.6.2 - Timeframes for Party Requested Reopenings

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A party may request a contractor reopen and revise its initial determination or redetermination under the following conditions:

- Within 1 year from the date of the initial determination or redetermination for any reason; or

- Within 4 years from the date of the initial determination or redetermination for good cause as defined in §10.11; or,

- At any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error as defined in §10.4.

While a contractor can reopen at any time under the limited criterion set forth above to correct an unfavorable determination, CMS does not expect that a contractor would regularly grant these requests, especially for older claims where the claims history is not readily available. Both the contractor and the provider/physician/supplier have a reasonable expectation to administrative finality in the processing of their claims. Additionally, administrative efficiency and the ability of a Medicare contractor to continue vital functions (i.e., process Medicare claims and process appeal requests) require that contractors grant such requests rarely.

10.6.3 - Timeframes for Adjudicator to Reopen

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)A

QIC, ALJ or the AC may reopen and revise its reconsideration, hearing decision or review, respectively, under the following conditions:

- Within 180 days from the date of its decision for good cause in accordance with *42 CFR 405.986*; or,

- At any time if the reconsideration, hearing decision or review was procured by fraud or similar fault.

10.6.4 - Timeframes When a Party Requests an Adjudicator Reopen Their Decision

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A party may request a QIC, ALJ or the AC reopen and revise its reconsideration, hearing decision or review within 180 days from the date of the reconsideration, hearing decision or review, as applicable, for good cause in accordance with *42 CFR 405.986*.

10.11 - Good Cause for Reopening

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

On its own initiative or at the request of party (see IOM Pub. 100-4, *c*hapter 29, §110 for the definition of a party), a contractor may reopen an initial determination or redetermination within 4 years from the date of the initial determination or redetermination when good cause exists. However, good cause is not required for reopening of claims for up to 1 year from the date of the initial determination or redetermination. Under *42 CFR 405.986*, good cause exists when:

- There is 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; or

- The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

A contractor's decision to reopen based on the existence of good cause, or refusal to reopen after determining good cause does not exist, is not subject to appeal. See *42 CFR 405.926(l), and 405.980(a)(5)*.

NOTE: Third party payer error in making a primary payment determination does not constitute good cause for the purposes of reopening an initial determination or redetermination when Medicare processed the claim in accordance with the information in its system of records or on the claim form. Contractors may only reopen for third party payer error under the "within one year for any reason" standard. This is true for both contractor initiated reopenings as well as reopenings requested by a party. All providers and suppliers have a legal obligation to determine the correct primary payer when billing Medicare. Failure to do so, regardless of third party payer error, does not constitute "good cause" that will permit reopening beyond one year. Information regarding such error does not constitute "new and material evidence."

10.12 - Change in Substantive Law or Interpretative Policy

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A change of legal interpretation or policy by CMS in a regulation, CMS ruling or CMS general instruction, or a change in legal interpretation or policy by SSA in a regulation, SSA ruling or SSA general instruction in entitlement appeals, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or decision under this section. This provision does not preclude contractors from conducting reopenings to effectuate coverage decisions issued under 42 CFR *42 CFR §426.460(b)(1)(i)*, *426.488 (b) and (c)*, or *426.560(b)(1)(i)* appeals process.