

Chapter 8: Reopenings and Appeals

Reopenings for Minor Errors and Omissions

If a supplier has made a minor error or omission when filing a claim, which results in a denial of the claim, the supplier must not request a redetermination. Minor errors or omissions on an initial determination may be corrected only through the contractor's Reopenings process. A reopening can be initiated via the telephone, in writing, or by fax.

Verbally by Telephone

A reopening can be done verbally by telephone through the Reopenings Telephone Line found in Chapter 1 of this manual.

When requesting a reopening by telephone, be sure to have the following information available:

- Beneficiary's name
- Medicare Health Insurance Claim Number
- Caller's name
- Caller's telephone number
- Supplier's name
- Supplier's PTAN number
- Claim Control Number
- Date of service
- Reason for the request

The telephone reopening process can be used to resolve minor errors or omissions involving:

- Units of service;
- Service dates;
- Healthcare Common Procedure Coding System (HCPCS) issues;
- Diagnosis codes and diagnosis reference;
- Modifiers;
- Place of service; and
- Claims incorrectly denied as duplicate charges
- Certain Medicare Secondary Payer (MSP) issues. **Note:** *This only applies in situations where the system records have been updated to indicate a change in the beneficiary's MSP status and the claim needs to be reprocessed as Medicare primary. If system records have not yet been updated, the claim cannot be reopened.*

Suppliers **should not** call the telephone reopening line without receipt of a Medicare Remittance Advice. No action can be taken until a final claim determination has been issued.

Suppliers should consult the *DME MAC Jurisdiction A Supplier Manual* and applicable medical policy guidelines before contacting the telephone reopening number to ensure the claim was filed per established requirements.

To effectively service all suppliers, each call will be limited to three claim issues.

Reopening requests for break in service issues, Certificate of Medical Necessity (CMN) or DME Information Form (DIF) issues, and other CMN/DIF changes are not permitted. These types of requests usually require a supplier to submit copies of CMNs/DIFs, delivery and pick-up information, and other documentation before a final determination can be made; therefore, these must be submitted in writing through the Appeals process.

If a previous reopening decision has been issued, a redetermination must be made in writing. If a previous redetermination decision has been issued, a reconsideration must be filed.

The following issues **cannot** be handled by the telephone reopening representative:

- Redetermination requests, which must be submitted via the Appeals process
- Untimely filing
- Unprocessable/Returned claims
- Most Medicare Secondary Payer (MSP) issues - Reopenings only apply in situations where the system records have been updated to indicate a change in the beneficiary's MSP status and the claim needs to be reprocessed as Medicare primary. If system records have not yet been updated, the claim cannot be reopened.
- Any claim that requires additional documentation
- Limitation on liability issues (inquiries regarding a missing GA modifier)
- Inquiries on the status of a claim(s)
- Inquiries related to denial of payment based on entitlement
- Questions that are general in nature and not claim specific
- Reopenings requests for break in service issues
- CMN or DIF issues or changes

Because some issues are more complicated than others it may be necessary to require more research time or consultation with medical staff. If this should occur, the DME MAC A reserves the right to decline the telephone reopening and may request that the supplier submit a written redetermination request.

In Writing via Fax

A reopening can also be requested in writing via fax by using the Claim Reopenings Fax number found in Chapter 1.

Be sure to use the *Reopening Fax Cover Sheet* which is available on the DME MAC A Web site at: http://www.medicarenhic.com/dme/dme_forms.shtml#Forms

In Writing via Mail

Lastly, a reopening can also be requested in writing via mail by using the ADS Responses Post Office Box found in Chapter 1.

Note: *Suppliers should wait to initiate a reopening request until after they have received their Remittance Advice. No action can be taken until a final claim determination is issued.*

CMS has determined that it is neither cost efficient or necessary for contractors to correct clerical errors through the appeals process. 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.

Minor errors or omissions can include, however are not limited to:

- Mathematical or computational mistakes
- Transposed procedure or diagnostic codes
- Inaccurate data entry, such as units of service, place of service, modifiers
- Misapplication of a fee schedule
- Computer errors
- Denial of claims as duplicates which the supplier believes were incorrectly identified as a duplicate
- Incorrect data items, such as provider number, use of modifier, or date of service

Contact Customer Service if you are unsure if your reason for requesting a reopening is valid. You can also refer to Chapter 34 of Pub. 100-4, *Medicare Claims Processing Manual*, at <http://www.cms.hhs.gov/manuals/downloads/clm104c34.pdf> on the CMS Web site for further information regarding Reopenings and revisions of claim determinations and decisions.

The Appeals Process

The Medicare program offers beneficiaries or their authorized representatives, providers and suppliers the right to appeal a claim if they are dissatisfied with an initial determination and/or appeal determination/decision made by the contractor.

The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a request for payment does not meet the requirements for a Medicare claim shall not be considered an initial determination. (Refer to Sections 200(B) and 200(C) of Chapter 29 of Pub. 100-4, *Medicare Claims Processing Manual*, at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf> on the CMS Web site for further information regarding initial determinations.)

The Part B appeals process consists of five levels. All appeal requests must be made in writing. The appellant must begin the appeal process at the first level after receiving an initial determination. Each level, after the initial determination, has procedural steps the appellant must take before appealing to the next level. If the appellant meets the procedural steps at a specific level, the appellant is then afforded the right to appeal any determination or decision to the next level in the process. The appellant may exercise the right to appeal any determination or decision to the next higher level, until appeal rights are exhausted.

Note: *Duplicate items and services are not afforded appeal rights, unless the supplier is appealing whether or not the service was, in fact, a duplicate.*

In the chart on the following page, levels one through five are part of the Administrative Appeals Process. If an appellant has completed all of the first four (4) steps and is still dissatisfied, the appellant may appeal to the federal courts, provided the appellant satisfies the requirements for obtaining judicial review.

Note: *Each level must be completed for each claim at issue prior to proceeding to the next level of appeal.*

Appeal Level	Time Limit for Filing Request	Monetary Threshold to be Met	Where to File an Appeal
<p><i>Level One</i></p> <p>Redetermination</p>	<p>Within <u>120</u> days from date of the receipt of the initial claim determination (allow an additional 5 days for mail delivery)</p>	<p>None</p>	<p>DME - Redeterminations P.O. Box 9150 Hingham, MA 02043-9150</p> <p>Overnight mailings: NHIC DME MAC Jurisdiction A Appeals 75 William Terry Drive Hingham, MA 02044</p>
<p><i>Level Two</i></p> <p>Reconsideration by a QIC</p>	<p>Within <u>180</u> days of receipt of the redetermination</p>	<p>None</p>	<p>RiverTrust Solutions, Inc. P.O. Box 180208 Chattanooga, TN 37401-7208</p> <p>Overnight mailings: RiverTrust Solutions, Inc. 801 Pine Street Chattanooga, TN 37402</p>
<p><i>Level Three</i></p> <p>Administrative Law Judge (ALJ) Hearing</p>	<p>Within <u>60</u> days of receipt of the reconsideration</p>	<p>At least \$120 remains in controversy*</p>	<p>HHS OMHA Mid-West Field Office BP Tower, Suite 1300 200 Public Square Cleveland, OH 44114-2316</p>
<p><i>Level Four</i></p> <p>Appeals Council Review / Departmental Appeals Board (DAB) Review</p>	<p>Within <u>60</u> days of receipt of ALJ hearing decision</p>	<p>None</p>	<p>DAB or ALJ Hearing Office</p>
<p><i>Level Five</i></p> <p>Judicial Review in U.S. District Court</p>	<p>Filed within <u>60</u> days of receipt of the Appeals Council's decision</p>	<p>At least \$1,220 remains in controversy*</p>	

*Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10. (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4152.pdf>)

Requests for Redetermination

A party must file a request for redetermination within 120 days of the date of receipt of the notice of initial determination (i.e., remittance advice (RA) for providers/suppliers or Medicare summary notice (MSN) for beneficiaries). For written requests for redetermination, DME MAC A provides a link to the *CMS Medicare Redetermination Request Form* at http://www.medicarehlc.com/dme/dme_forms.shtml. Parties are encouraged to use this form when submitting requests to DME MAC A.

The date of filing requests filed in writing is defined as the date received by the contractor in the corporate mailroom. If the party has filed the request in person with the contractor, the filing date is the date of filing at such office, as evidenced by the receiving office's date stamp on the request. If the party has mailed the request for redetermination to CMS, the Social Security Administration (SSA), a Railroad Retirement Board (RRB) office, or another government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired, the contractor considers good cause for late filing. Likewise, if the request is filed with CMS, SSA, RRB, or another government agency in person, the contractor considers good cause for late filing. The time limit for filing a request for redetermination may be extended in certain situations. Generally, physicians or other suppliers are expected to file appeal requests on a timely basis.

The contractor may extend the period for filing if it finds the party had good cause for not requesting the redetermination timely. In order for good cause to be considered, the appeal request **must** be in writing. If the carrier finds that the party did not have good cause for not requesting a redetermination on time, it may, at its discretion, consider reopening.

Good Cause

The contractor resolves the issue of whether good cause exists **before** taking any other action on the appeal.

Note: A finding by the contractor that good cause exists for late filing for the redetermination does **not** mean that the party is then excused from the timely filing rules for the reconsideration.

Refer to the following sections of Chapter 29 of Pub. 100-4, *Medicare Claims Processing Manual*, at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf> on the CMS Web site for further information regarding good cause:

- 240.2 - General Procedure to Establish Good Cause
- 240.3 - Conditions and Examples That May Establish Good Cause for Late Filing by Beneficiaries
- 240.4 - Conditions and Examples That May Establish Good Cause for Late Filing by Providers, Physicians or Other Suppliers
- 240.5 - Good Cause Not Found for Beneficiary, or for Providers, Physician, or Other Supplier

Amount in Controversy Requirements

The amount in controversy requirements **only** apply to the ALJ and Federal District Court levels. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an ALJ hearing or Federal District Court review.

Parties to an Appeal

Any of the persons/entities listed below are parties to an appeal of a claim for items or services payable under Part A or Part B and, therefore, may appeal the initial claim determination and any subsequent administrative appeal determinations or decisions made on all claims for items or services (assuming other requirements, such as filing within prescribed time limits are met).

Who may Appeal

A person with a right to appeal an initial determination is referred to as a “party.” These include:

- A beneficiary
- An institutional provider
- A participating provider or physician or other supplier (i.e., one who has agreed to take assignment on all items or services payable on behalf of a Medicare beneficiary.)
- A nonparticipating physician has the same rights to appeal the contractor’s determination in an unassigned claim for physicians’ services if the contractor denies or reduces payment on the basis of Section 1862(a)(1) of the Social Security Act (the Act) as a nonparticipating or participating physician has in assigned claims.
- A nonparticipating supplier has the same rights to appeal the contractor’s determination in an unassigned claim for medical equipment and supplies if the contractor denies or reduces payment on the basis of Sections 1862(a)(1), 1834(a)(17)(B), 1834(j)(1), or 1834(a)(15) of the Act as a nonparticipating or participating supplier has in assigned claims.
- A supplier of medical equipment and supplies furnishing items or services to a beneficiary not on an assigned basis and responsible for making a refund to the beneficiary under Section 1834(j)(4) of the Act has party status for that claim
- A provider or supplier who otherwise does not have the right to appeal may appeal when the beneficiary dies and there is no other party available to appeal
- A Medicaid state agency or party authorized to act on behalf of the state
- Any individual whose rights with respect to the particular claim being reviewed may be affected by such review and any other individual whose rights with respect to supplementary medical insurance benefits may be prejudiced by the decision (e.g., an individual or entity liable for payments under 42 CFR Subpart E 424.60 in the case of a deceased beneficiary)

(Refer to Section 210.1 of Chapter 29 of Pub. 100-4, *Medicare Claims Processing Manual*, at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf> on the CMS Web site for information regarding appeals when the beneficiary is deceased.)

The provider of the item or service denied may represent the individual, **but may not impose any financial liability on the individual in connection with such representation.** If limitation on liability is involved, the provider of the item or service may represent the individual **only** if the provider waives any rights for payment from the individual with respect to the services or items involved in the appeal.

Note: While a representative may request an appeal on behalf of the party that the representative represents, the representative is **not** a party to the appeal solely by virtue of being a representative. (Refer to Section 270 of Chapter 29 of Pub. 100-4, *Medicare Claims Processing Manual*, at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf> on the CMS Web site for the rights and responsibilities of a representative.)

For additional information on appeals of claims decisions, refer to Chapter 29 of Pub. 100-4, *Medicare Claims Processing Manual*, at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf> on the CMS Web site.