

Provider Education

New England Medicare Part B



HOW TO DETERMINE THE DIFFERENCE BETWEEN A REOPENING, A REDETERMINATION, and A WRITTEN INQUIRY

A **Reopening** is limited to resolving minor issues and correcting errors. It can be performed by telephone or in writing. These typically include clerical errors by the provider or the Medicare contractor.

Examples of reopening issues include:

- Mathematical/computational errors (e.g., obvious errors of miscoding the allowed amount as \$10.00 vs. \$100.00)
- Transposed diagnosis and procedure codes
- Inaccurate data entry (e.g., scanner errors, billed amounts, dates of service, place of service)
- Carrier Errors
- Addition of an add-on procedure code (e.g., codes with global days of ZZZ)
- Misapplication of fee schedule (generally due to changes in the fee schedule amounts)
- Inaccurate duplicate denial (not a true duplicate)
- Incorrect performing provider identification number in Item 24K (Missing performing provider PIN's are rejected, and must be resubmitted)
- Ambulance (correct transposed zip code; correct origin/destination modifiers for obvious errors such as HS)
- Modifier additions: limited to modifiers 24, 25, 26, 57, 78, 79, TC, KX, GV, GW, QW, QB, QU, AR, AQ, AT, SG.
- The addition of 54 and 59 modifiers can be reopened as a Written request only.
- Correction to a CLIA number can be reopened as a Written request only.

To request a reopening, we strongly recommend the use of the Medicare [Reopening/Redetermination Request Form](#).

A **Redetermination** is the first level of appeal. It applies after an initial determination has been made on a claim. This is a second review of the claim and any supporting documentation when the claimant is not satisfied with the initial payment decision (denial).

Examples of redetermination issues include:

- Not covered for the diagnosis reported – Request may be to change the diagnosis
- Non-covered service/procedure
- Diagnosis inconsistent with procedure code - Request may be to change the diagnosis
- Diagnosis inconsistent with the age of the patient
- This many services for the reported condition
- Information does not support this length of service
- Treatment not rendered in the appropriate facility
- Not medically necessary
- The information submitted does not support this many services
- Coverage guidelines were not met or were exceeded

Provider Education

New England Medicare Part B



- Non-covered services because this is a routine exam or screening procedure in conjunction with a routine exam
- Procedure not deemed proven to be effective
- Routine services
- The info does not support medical need for similar proc by two MD's (i.e., concurrent care, cosurgery).
- Component part of another at the same time (Correct Coding Initiative) if the denied service already processed with the 59 modifier
- Screening mammogram covered once every year
- Screening mammogram for beneficiary under age 35
- Benefit Maximum Reached for This Time Period
- Cosmetic surgery and related supplies
- Transportation is only allowed to the closest facility
- Ambulance not medically indicated
- Two flu shots, same season
- National Coverage Determination non-covered service
- Medicare does not pay for this investigational device
- Duplicate charge 76/77 modifier requests
- Services by household member or relative
- Disputing an overpayment
- Disputing the allowed amount
- Modifiers being added 22, 50, 51, 55, 56, 58, 62, 66, 76, LT, RT
- Clinical Laboratory Improvement Amendment (CLIA) with CLIA number not certified

The time frame for submitting a request for a redetermination is 120 days from the date on denial on your initial remittance determination notice. To avoid a dismissal of this type, we strongly recommend the use of the Medicare [Reopening/Redetermination Request Form](#).

Please ensure that the Redetermination request includes a signature because it cannot be processed without one. Attach any additional documentation you would like Medicare to consider.

Provider Education

New England Medicare Part B



A **Written Inquiry** is a question or questions submitted via written request. These requests should be submitted to the contractor on practice or business letterhead.

Examples of Written Inquiries include:

- Administrative billing issues
- Coding issues
- Eligibility and entitlement issues
- Not paid separately when patient is inpatient should be billed through Part A
- Additional Development Response (ADS) requested information was not provided or was incomplete
- Provider is not eligible
- Assumed and relinquished date information

Please Note: claims rejected with reason code **MA130** do not qualify for a Redetermination and can not be processed as a reopening. A corrected claim must be resubmitted.

12/15/08

Correction to link for form: 092109