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

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**Transmittals for Chapter 34**

## *10 - Reopenings and Revisions of Claims Determinations and Decisions - General*

***(Rev. 1069, Issued:09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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 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 adverse 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. 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. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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., N102 or 56900). 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 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.*

## *10.2 - Refusal to Reopen Is Not an Initial Determination*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*A finding that a prior determination or decision will not be reopened is not an "initial determination or decision." A contractor's choice not to reopen is not appealable. Accordingly, the contractor shall not include a statement concerning the right to an appeal in the notice informing the party that their reopening request cannot be processed. A party may however request an appeal on the original claim denial, but must do so within the required timeframes. If a contractor receives a reopening request and does not believe they can change the determination, they should not process the request.*

## *10.3 - Reopenings of Denials Based on an Unanswered Additional Documentation Request (ADR)*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*If a claim is suspended for medical review, an ADR may be issued to obtain information needed to make a determination. Providers, physicians, and suppliers are responsible for providing the information needed to adjudicate their claims. If no response is received to the ADR within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on a lack of documentation.*

*If such a denial is appealed, the Medical Review department at the contractor shall perform a reopening instead of an appeal if all of the following conditions are met:*

*1) A provider failed to timely submit documentation requested through an ADR;*

*2) The claim was denied because the requested documentation was not received timely;*

*3) The requested documentation is received after the 45 day period with or without a request for redetermination or reopening; AND,*

*4) The request is filed within 120 days of the date of receipt of the initial determination.*

*If all 4 criteria are not present, the request is for a redetermination and it is submitted within 120 days of the date of receipt of the initial determination, handle it as an appeal and do not ship the case back to MR. In this instance, the request must meet the criteria for a valid request for redetermination (see Pub. 100-04, Chapter 29, §310.1) in order for the appeals unit to accept the request.*

*The CMS is handling these requests outside of the appeals process because CMS wants to encourage providers, physicians and suppliers to submit documentation when requested in order to prevent unnecessary appeals. Contractors should note that this requirement does not extend the time frame for filing an appeal. Therefore, only those appeal requests that are submitted within 120 days of the date of receipt of the initial determination and meet all of the criteria above should be shipped back to MR for a reopening. When the appeals unit ships cases back to the MR unit, MR must reopen those cases.*

*If the request is submitted after 120 days, contractors may grant a regular reopening at their discretion or dismiss the request if no good cause explanation is provided for the late filing.*

*If the ADR reopening results in an affirmation of the original denial or an adverse decision, the provider will retain their right to a redetermination. The date of the MR decision will be the date used to calculate the 120 days to request a redetermination.*

## *10.4 - Reopenings Based on Clerical or Minor Errors and Omissions*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*Section 937 of the Medicare Modernization Act 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 §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, § 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.*

## *10.4.1 - Providers Submitting Adjustments*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*Part A providers that are able to submit an adjusted or corrected claim to correct an error or omission may continue to do so and are not required to request a reopening. Additionally, we encourage FIs who were handling the corrections of such errors by advising providers to submit adjusted claims to instruct providers that submitting adjusted claims continues to be the most efficient way to correct simple errors.*

## *10.5 - Telephone Reopenings - Required for Carriers Only*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

***NOTE:** Since most FIs never processed telephone redeterminations, CMS does not expect that FIs will process many telephone reopenings, if any. However, they are not precluded from doing so, should the telephone process prove effective. If FIs 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 carriers 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.*

*Carriers and DMERCs 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 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, Chapter 6, Disclosure of Information).*

## *10.5.1 - Informing the Provider Communities About the Telephone Reopenings Process*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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, newspaper articles; maintain 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.*

## *10.5.2 - Issues for Telephone Reopenings*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*Telephone reopenings shall be limited to resolving minor issues and correcting errors as defined in §10.4. As necessary, the contractor may ask the provider, physician, or supplier to fax in documentation to support changes and error correction. If it appears extensive documentation is required for review, please inform the requestor that they should file a written request for reopening or file a request for an appeal, if applicable.*

*Telephone reopenings are* ***generally inappropriate*** *for the following issues:*

- *Limitation on liability;*

- *Medical necessity denials and reductions; or*

- *Analysis of documents such as operative reports and clinical summaries.*

*Contractors are not precluded from conducting a reopening on the issues listed above. However, CMS believes that the issues above are usually too complex to be handled appropriately over the phone in most instances.*

*In all cases, telephone reopenings are* ***inappropriate*** *for the following issues: Claims requiring the input of medical staff or other entities outside of the reopenings department and "big box" cases.*

### *A. Issues That Can Not be Resolved During the Telephone Reopening*

*There may be instances where an issue cannot be resolved during the telephone reopening. An issue may not be resolvable on the telephone because: (1) the issue becomes too complex to be handled over the telephone and/or it is in the best interest of*

*the party to have a more in-depth review performed; or (2) there is a need for additional medical documentation from the provider, physician, or other supplier.*

*If the issue cannot be resolved due to one of the preceding reasons, the contractor advises the party that the reopening cannot be handled over the telephone. The contractor shall instruct the party to either file a written request for reopening or file a written request for appeal. Instruct the party that appeal requests must be filed within 120 days from the date of the initial determination.*

## *10.5.3 - Conducting the Telephone Reopening*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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 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 reviewer;*
- *Confirmation number, if applicable; and*
- *Inform the caller that call may be monitored.*

## *10.5.4 - Documenting the Telephone Reopening*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*The information received during the telephone reopening (especially the date of the call) must be either: (1) documented on a reopening documentation form; or (2) logged into the contractor's computer system.*

*All documentation must be assigned a control number. Any additional documentation received must be recorded into the contractor system or attached to the form. The telephone reopening control number is recorded on all documents received that are associated with the telephone reopening, if applicable. The documents are included in the file.*

*Although documentation should rarely be necessary during a telephone reopening, the documentation must be made a part of the file and be available if an appeal is requested based on any revised determination issued as a result of the reopening. All documentation should be maintained in a manner that allows for future audits.*

## *10.5.5 - Monitoring the Telephone Reopening*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

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

## *10.6 - Timeframes to Reopen Claim Determinations*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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 CR §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 Party Request an Adjudicator Reopen Their Decisions*
***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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.*

## *10.7 - Timeframes to Complete a Reopening Requested by a Party*
***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*There are no timeframes established in statute or regulation governing the timeframes for a contractor to complete a reopening action. However, a party to an initial determination has a reasonable expectation to the administrative finality of a determination issued by Medicare. Therefore, this section sets out timeframes to complete the reopening action once the reopening has been initiated. These timeframes apply only to those reopening requests that are requested by the party to the initial determination. These timeframes do not apply to contractor initiated reopenings.*

*For those reopenings requested by a party that the contractor agrees to reopen, the contractor shall complete the reopening action 60 days from the date of receipt of the party's reopening request in the corporate mailroom or receipt of the telephone request. This does not apply to "big box cases" as defined in Pub. 100-04, Chapter 29, §60.19.3(B).*

## *10.8 - Notice of a Revised Determination or Decision*
***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*If the reopening action results in a revised determination or decision that results in payment to a provider, physician, or supplier, a revised electronic or paper remittance advice notice must be issued by the Medicare contractor and will satisfy the notice requirements. If applicable, a revised Medicare Summary Notice will suffice for notice to the beneficiary in the above instances. If the reopening action results in an adverse revised determination or decision the contractor shall mail a letter that states the*

*rationale and basis for the reopening and revision and any right to appeal. The timeframe to request the appeal would be based on the date of the contractor's revised determination. If the contractor cannot change the original determination or chooses to not accept the request, the contractor should inform the requestor that the contractor cannot process their reopening request. If the request is over the telephone, the contractor can verbally inform the caller that they cannot process their request. If it is a written reopening request, the contractor should send a brief letter informing the requestor that they cannot process the request. The contractor should state that their decision to not reopen a claim determination is not an initial determination and is therefore not appealable.*

## *10.9 - Revised Determination or Decision*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*A revised determination or decision is one in which:*

- *The end result is changed (e.g., a service previously found to be covered is now found not to be covered or the allowable charge for the service is determined to be incorrect); or*

- *The end result is not changed, but a party might be disadvantaged by the revision (e.g., a request for payment on a claim previously disallowed because the services were not medically necessary and therefore subject to the limitation on liability provisions, is now to be disallowed on a basis that precludes consideration of limitation on liability).*

## *10.10 - Effect of a Revised Determination or Decision*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*The revision of an initial determination is binding on all parties unless a party files a written request for a redetermination of the revised determination that is accepted and processed. The request for a redetermination must be filed within 120 days from the date of the revised initial determination. The revision of a redetermination is binding on all parties unless a party files a written request for a QIC reconsideration that is accepted and processed.*

## *10.11 - Good Cause for Reopening*

***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*The contractor may reopen a claim or claims within 4 years from the date of the initial determination if good cause is established. Good cause may be established 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.*

***NOTE:*** *Third party payer error does not constitute good cause. Contractors may only reopen for third party payer error under the "within one year for any reason" standard. This is true for both a contractor own motion reopenings as well as reopenings requested by a party.*

## *10.11.1 - What Constitutes New and Material Evidence*
***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*New and material evidence includes any evidence which was not considered when the previous determination or decision was made and which shows facts not available and that may result in a conclusion different from that reached in the determination or decision. Thus, the submittal of any additional evidence is not a basis for reopening. The information must be "new," i.e., not readily available or known to exist at the time of the initial determination.*

*The evidence may justify or even require further development before a proper revised determination or decision is made. If the reopening is requested by a provider, physician, or other supplier, any additional development is to be done by the party. If the party cannot complete the development, the contractor assists to the extent it can.*

***NOTE:*** *Third party payer error does not constitute new and material evidence; it does not constitute good cause. Contractors may only open for third party payer error under the "within one year for any reason" standard. All providers, physicians, and other 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." Information regarding such error does not constitute "new and material evidence." A provider, physician or supplier's representation that CMS information concerning the primary payer is inaccurate or that the primary payer made an error does not constitute "new and material evidence."*

## *10.11.2 - What Constitutes Error on the Face of the Evidence*
***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***
*Error on the face of the evidence exists if it is clear that the determination or decision was incorrect based on all evidence in file on which the determination or decision was based, or any evidence of record anywhere in the contractor's Medicare file or in CMS files at the time such determination or decision was made.*

## *10.12 - Change in Substantive Law or Interpretative Policy*
***(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)***

*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 §426.460(b)(1)(i), §426.488 (b) and (c), or §426.560(b)(1)(i) appeals process.*

## Transmittals Issued for this Chapter

| Rev # | Issue Date | Subject | Impl Date | CR# |
|---|---|---|---|---|
| R1069CP | 09/29/2006 | Initial Release of Chapter-Reopenings and Revisions of Claim Determinations and Decisions | 11/29/2006 | 4147 |