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## How to Request a Reopening

The Medicare program offers to providers, physicians, and suppliers the right to request a revision to an initial determination or redetermination. All providers have the right to appeal claim determinations if they do not agree with the original decision made on the claim. The providers must send all requests for redeterminations in writing within 120 days of receipt of the notice of initial determination.

The Clerical Error Reopening process is not a part of the formal appeals process, but it allows providers to make a minor change to a previously filed claim, if the original claim has been denied or reduced. The reopening activities conducted by carriers are governed by instructions from the Centers for Medicare & Medicaid Services (CMS).

Clerical Error Reopenings can be done on the phone or in writing, and for provider minor errors, clerical errors, or omissions. The Carrier reserves the right to refuse to adjust a claim as requested if it appears that such an adjustment would risk incorrect payment or any claims that are not clearly identified for correction.

A provider, physician, or supplier may request a reopening up to one year from the receipt of the initial Remittance Notice. If the provider, physician, or supplier would like to request a reopening after the one-year time limit has expired, they may request the reopening in writing. Documentation supporting good cause to waive the timeliness requirement must be included.

Section 937 of the Medicare Modernization Act (MMA) required CMS to establish a process whereby providers, physicians, and suppliers could correct minor error or omissions outside of the appeals process. CMS issued interim final regulations, which state that clerical errors (which CMS likens to MMA's minor errors or omissions), defined 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 error; or,
- Denial of claims as duplicates which are denied as a result of a clerical error or minor omission and require a change on the face of the claim (i.e. adding or removing a modifier) in order for the claim to be reopened. **(Exception: We will reopen claims that denied as a duplicate when multiple services have been billed and some are denied due to a separate claim submission; i.e., when three radiology services have been paid on one claim and a fourth one denied as a duplicate due to a separate claim submission and a request is made to allow a total of four services. A reopening can be performed even though the claim was submitted correctly and no change is being made.)**
- Incorrect data items, such as provider number, use of a modifier or date of service.

THE BASIS OF A CLERICAL ERROR OR MINOR OMISSION REOPENING IS TO CORRECT THE MINOR CLERICAL OR MINOR OMISSION THAT RESULTED IN AN INITIAL CLAIM DENIAL OR REDUCTION.

***Types of Issues that can be performed as clerical error or minor omission reopenings (if the change will allow additional payment):***

- Increase number of services or units (without an increase in the billed amount)
- Add/Change/Delete modifiers such as 24, 25, 54, 58, 59, 76, 78, 79, or GA (**Exception: Modifiers 54 and 78 are reduction modifiers and cannot be added to a paid claim as this would create an overpayment.**)
- Transposed procedure codes only
- Change place of service, if the change will allow an additional payment
- Add or change a diagnosis on a denied service
- Billed amounts
- Provider numbers (except when an overpayment is involved)
- Date of service. The date of service change must be within the same year.

***Types of Issues that cannot be performed as clerical error or minor omission reopenings.***  
***For these issues providers must submit a redetermination request in writing:***

- Any action that would create an overpayment (**Exception: When requesting a procedure code change, a reopening claim adjustment will be done to remove the incorrect service(s). The reopening representative will simultaneously initiate a request for refund of the incorrect service. The provider will receive a remittance notice within 5 to 10 days showing the adjusted claim with the incorrect service denied. The provider must submit a new claim with the correct code once the adjusted claim finalizes. An overpayment demand letter will be sent to recover the payment for the initial claim. This letter will notify the provider of the amount due.**)
- Appeal on established overpayment
- CERT (Comprehensive Error Rate Testing)
- Provider Enrollment issues
- Wrong payee
- Adding services that were not previously billed (i.e. increase number of services with an increase in the billed amount)
- Complex claim situations (such as ambulance, anesthesia, Not Otherwise Classified codes, claims with modifiers 22, 55, 62, 66, or GY or any other claim which requires analysis of documentation).
- CMS input (e.g. services after date of death)
- If there is a pending or finalized redetermination or a higher level appeal request
- If there are multiple surgeries on multiple claims for the date of service in question

IF THE ORIGINAL DENIAL IS REJECTED AS UNPROCESSABLE, SUBMIT A NEW CLAIM.

IF THE CLAIM IN QUESTION IS IN PROCESS, YOU MUST WAIT UNTIL AFTER THE CLAIM HAS PROCESSED BEFORE REQUESTING A REOPENING.

IF THERE HAS BEEN NO CLAIM SUBMITTED, SUBMIT A NEW CLAIM.

LEVEL/TYPE	TIME LIMIT	AMOUNT IN CONTROVERSY REQUIRED (after deductible and co- insurance)
Telephone Reopening	Within 1 year of receipt of the notice of initial determination.	No minimum
Written Reopening	Within 1 year of receipt of the notice of initial determination but within 4 years after the date of the initial determination, may be reopened for good cause.	No minimum