

# Understanding the Reopening and Appeals Process Open Forum

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**Closed Captioning:** *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

# Today's Presenters

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# Objective

Improving efficiency and reducing administrative burden by taking the NGS Medicare holistic approach prior to submitting claim, submitting reopenings or redeterminations.

During this Open Forum/Let's Chat session, subject matter experts will address appropriate workflows for reopenings and redeterminations.

Providers and office staff members will have the opportunity to ask questions and learn the reopening and redeterminations process.



# Agenda

- Holistic Approach
- Unprocessable, Reopening or Redetermination
- Reopenings
- Appeals (Redeterminations)
- Documentation Requirements

# Holistic Approach

# Best Practices: Holistic Approach

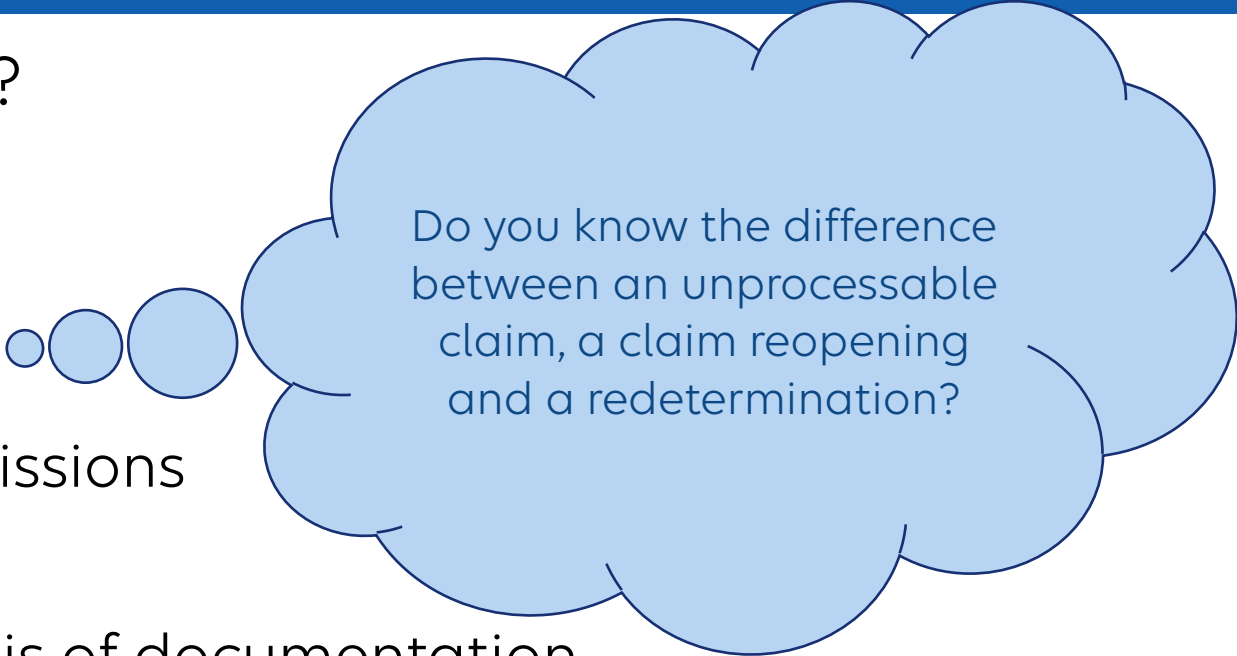
- Follow these steps before submitting claim(s), an appeal or a reopening to NGS Medicare Part B
  1. Is claim within CMS time limit regulations [CMS IOM Publication, 100-04, Medicare Claims Processing Manual, Chapter 1](#) or [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 29](#)?
  2. What is the [AMA CPT Current Procedural Terminology](#) or [List of CPT/HCPCS Code\(s\)](#)?
  3. Should a [Modifier\(s\)](#) be used with the code(s)?
  4. Do you know the difference between [Reopening versus Redetermination](#)?
  5. Have you visited the [NGS website](#) for [Fee Schedule Lookup](#)?
  6. Does the code have [Medicare NCCI Medically Unlikely Edits \(MUEs\)](#)?
  7. Are services distinct from other procedures [Medicare National Correct Coding Initiative \(NCCI\) Edits](#)?
- Once you have gone through all these steps, you may submit your claim or inquiry appropriately

# Unprocessable, Reopening or Redetermination



# Know Your Next Steps

- What are your next steps?
- Resubmit
  - Unprocessable
- Reopening
  - Minor clerical errors or omissions
- Redetermination
  - Claims that require analysis of documentation



Do you know the difference between an unprocessable claim, a claim reopening and a redetermination?



# Resubmission of Unprocessable Claims

- Claim rejections CO16, MA130
  - Claim lacks information or has submission billing error(s), which is needed for adjudication
  - Claims received containing incomplete or invalid information will be “rejected” and returned as unprocessable
- Unprocessable claims
  - No appeal rights
  - No reopening rights
- Resubmit a new claim with corrected information

The background is a solid dark blue color with several overlapping, semi-transparent geometric shapes in lighter shades of blue. These shapes include triangles, rectangles, and rounded forms, creating a layered, abstract effect. The shapes are positioned primarily on the right side of the frame, with some extending towards the center.

Reopenings

# Clerical Error Reopenings

- Reopening is reprocessing of claim to fix minor mistakes
  - Mathematical or computational mistake
  - Transposed procedure or diagnostic codes
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items



# Appeals (Redeterminations)

# Appeals Process: Levels One–Five

- Level One
  - [First Level of Appeal: Redetermination by a Medicare Contractor](#)
  - National Government Services
- Level Two
  - [Second Level of Appeal: Reconsideration by a Qualified Independent Contractor](#)
- Three
  - [Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals \(OMHA\)](#)
- Level Four
  - [Fourth Level of Appeal: Review by the Medicare Appeals Council](#)
- Level Five
  - [Fifth Level of Appeal: Judicial Review in Federal District Court](#)





# Redetermination First Level Appeal

- Redeterminations are more complex issues that require analysis of documentation
  - Coverage of furnished items and service
  - Medical necessity claim denials
  - Determination on limitation of liability provision
  - Overpayment determinations from NGS probe reviews
  - Post payment CERT, RAC and/or SMRC denials
  - Processed at MAC level

# Redeterminations

- First Level of Appeal
- Time Limit
  - 120 days from date of receipt of the initial determination notice
- Amount in Controversy
  - No minimum amount
- Decision made within 60 days of receipt
- Refrain from submitting duplicate appeal requests via paper or NGSConnex
- Duplicate submissions will not speed up the process
  - Will cause administrative delays and slow down processing of your appeal







# Redetermination Documentation

- Submitting unnecessary or excessive documentation may lead to a delay in processing appeal
  - Inpatient services
    - Submit only reports relevant to the denial on claim
    - Do not submit patient's entire hospital stay
  - Critical care
    - Submit notes for NP or specialty denied on claim
    - Total time spent by provider performing service
  - Anesthesia
    - Submit only those reports and records that apply to case
- [What Documents are Needed?](#)

# NGSConnex

- Providers who are registered to use NGSConnex, our secure web portal, shall submit reopening or redetermination requests electronically
- Quickest route to correct claim(s) that contained errors and faster way of receiving reimbursements for reopenings
- Able to check a redetermination status



# NGSConnex User Guide

The screenshot displays the NGSConnex interface for checking appeal status. On the left is a sidebar menu with the following items: Introduction, Registration, Log In, Navigation, Eligibility Lookup, Claims Status Inquiry, Part B Claim Submissions, Appeals (expanded), ADR, Inquiries, Resources, MBI Lookup, and Remittance. The 'Check Appeal Status' option is highlighted in the 'Appeals' section. The main content area is titled 'Check Appeal Status' and includes the following instructions:

1. Click the **Appeals** button from the NGSConnex homepage.
2. In the **Select a Provider** panel, click the **Select** button next to the applicable provider account.

The interface shows a dashboard with a search bar 'What would you like to do in NGSConnex?' and several action buttons: Eligibility Lookup, Claim Status Lookup, Part B Claim Submissions, Appeals (highlighted with an orange arrow), ADR, and Inquiries. Below these are buttons for Resources, MBI Lookup, Remittance, Prior Authorizations, Financials, and Manage Account. A vertical 'FEEDBACK' button is on the right. The 'Select a Provider' panel includes a search box, a 'Search' button, and a 'Reset Search' link. Below is a table with columns: PTAN, NPI, TIN, Provider/Supplier, City, State, and LOB. Two rows are visible, each with a 'Select' button (the second one is highlighted with an orange arrow).

# Reopening Versus Redetermination

- Reopening
  - Correct a claim(s) determination resulting from minor errors, you should use reopening process
  - Documentation cannot be submitted with reopening request when using [NGSConnex](#)
- Redetermination
  - Partially paid or denied claim(s) resulting from more complex issues that require analysis of documentation
  - Documentation shall be submitted with redetermination request when using [NGSConnex](#)

# Reopening Versus Redetermination (cont.)

**national government SERVICES** HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾

Resources > Claims and Appeals

## ABOUT APPEALS

About Appeals

- Reopening versus Redetermination**
- Who May File an Appeal?
- Levels of Appeals and Time Limits for Filing
- MSP Overpayments

### Reopening versus Redetermination

Understanding your next steps are very important for quick reimbursement and providers are required to know the difference between a reopening or a redetermination.

- **A reopening** is a reprocessing of a claim to fix minor mistakes.
- **A redetermination** is an examination of a claim that includes analysis of documentation.

**Helpful Resources**

- Log Into NGSConnex
- Appeals Timeline Calculator
- YouTube Video: Holistic Approach to Avoiding Administrative Burden

**Form(s) you'll need:**

- Appeal Forms

# Documentation Requirements



# Missing Documentation

- Examples of documentation that is required when submitting claims
- N706: Missing documentation
  - Information requested was not provided or not provided timely or was insufficient/incomplete
- Common error among providers is submitting claims without documentation
  - Modifiers: AS, 22, 52, 53, 62, 66, 80, NOC and unlisted codes

# Electronic Attachments Program

- Increase revenue, decrease administrative burden by using
- Electronic attachments
  - ANSI 275: [Benefits of Electronic Attachments](#)
  - 275: [How To Get Started – Five Easy Steps](#)
  - ANSI 277: [Benefits of the 277 RFI](#)
  - 277: [How To Get Started – Five Easy Steps](#)
- Information and data that comes together to process claims





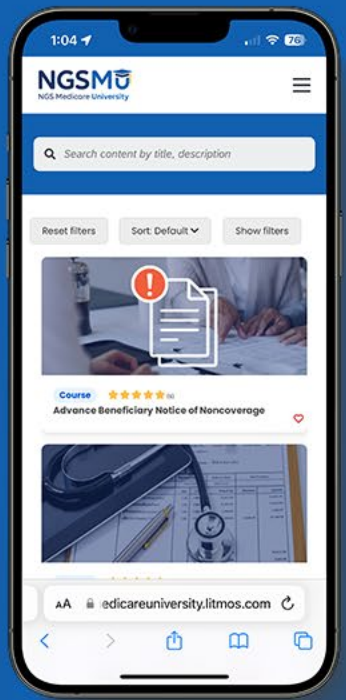
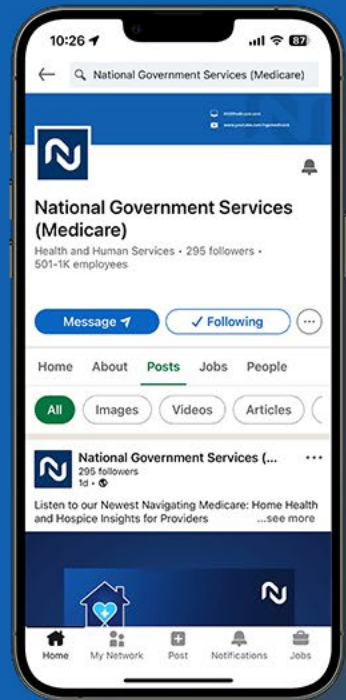
# Benefits of Electronic Attachment Program

- ADRs can be sent electronically to provider
  - Instead of NGS mailing additional documentation request (ADR) letter
- X12 277 Request for Additional Information transaction allows us to send ADRs electronically through your current billing process
  - No paper ADR
- When you submit your medical records electronically, an acknowledgement transaction is generated
  - Provides an immediate receipt for documentation
- Eliminates paper and reduces administrative burden associated with paper process of printing and mailing
- Fewer denials for providers who are currently utilizing claim attachment feature are reporting up to 50% reduction in claim status calls and up to 50% reduction in denials
- Increased revenue for providers using electronic attachments program; reporting being paid up to 30 days sooner




# Questions?

Thank you!



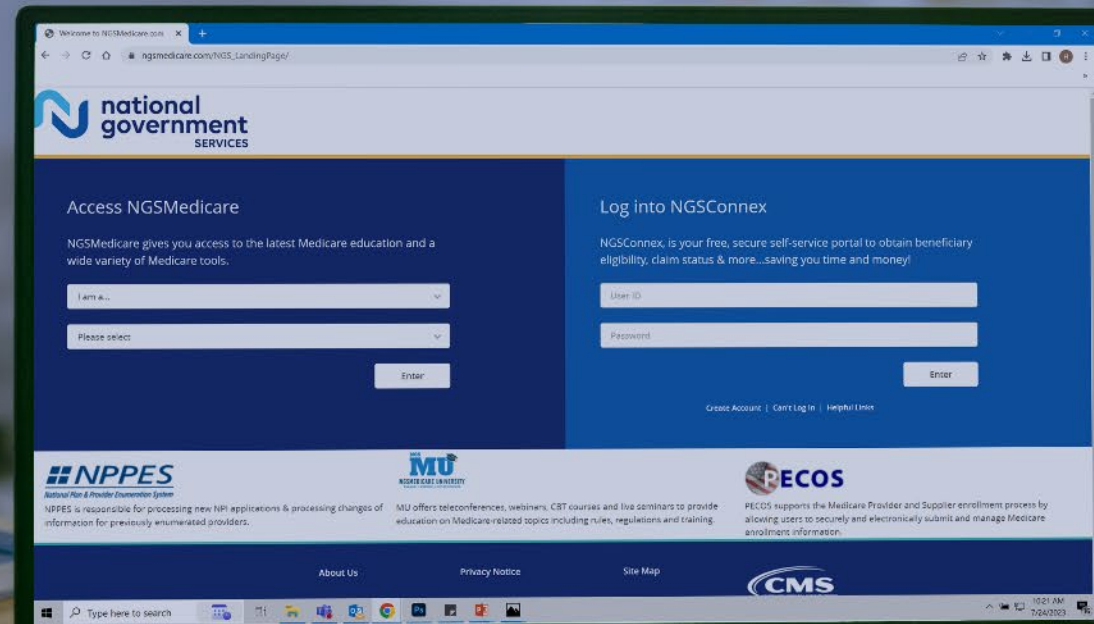
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Educational Content

# Find us online



[www.NGS Medicare.com](http://www.NGS Medicare.com)

Online resources, event calendar, LCD/NCD, and tools



[IVR System](#)

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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