Part B J4 Telephone Reopenings

(866) 865-5458

Monday – Friday, 8 a.m. – 4 p.m. CT

Applies to Part B CO, NM, OK and TX providers

The reopening process is separate and distinct from the Medicare claim appeals process. A reopening is initiated to correct an error in response to suspected fraud, an error made by official sources, clerical errors or in response to information not available or known to exist at the time a decision was issued for a service. CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors by submitters and Medicare contractors, such as mathematical or computational mistakes or inaccurate data entry.

Important notes:

- If the deductible has been applied on the claim being reopened, it should be submitted as a written reopening request. (Providers should use the correct Part B Reopening form.)
- Any changes resulting in overpayments may not be handled as reopenings.
- Clerical error corrections are made at the contractor's discretion. There may be situations where the representative (telephone or written) will inform the provider to request a redetermination.

Generally, providers will request a reopening in writing; however, to expedite the reopening process, the following are examples of minor errors or omissions and other situations that can be corrected by calling the Part B Provider Telephone Reopening line:

- Changes to the number of services/units (increases only).
- Procedure code changes (higher codes only).
- Billed amount changes.
- Dates of service changes.
- Place of service changes.
- Omitted services due to contractor error.
- Omitted services due to provider error (only for services that cannot be filed alone and are now being submitted).
- Claim denied because the HIC number was missing or incorrect.
- Adding or deleting the following specific modifiers:
  - 25.
  - 26.
  - 50.
  - 57.

    - 76.
    - 77.
    - GV.
    - GW.
    - LT.
    - RT.
    - TC.

There may be instances where an issue cannot be resolved during the telephone reopening process. An issue may not be resolved on the telephone when:

- The issue is too complex to be handled over the telephone.
- Additional medical documentation is needed from the provider.

The following are examples of issues that cannot be corrected through the telephone reopening process:

- Requests submitted with notes or records.
- Additions or corrections to some modifiers.
- An in-depth review is required.
- The need for additional documentation.
- Limitation on liability (waiver issues) that results in reversing a party's liability.
- Overpayment disputes or protests.
- Diagnosis code corrections/additions. (Diagnosis code corrections will no longer be accepted on the telephone reopening line. Since diagnosis code changes are generally complex in nature and require in-depth research, a written request should be submitted for these types of corrections.)
- Overpayments (a need for complex overpayment calculations or offsets).
- Medical necessity denials and reductions.
- Review of operative reports, office notes, laboratory/pathology reports.
- The need for medical staff input.
- An initial determination date that is more than one year prior to the request for a reopening.
- Analysis of documents such as operative reports and clinical summaries.
- Ambulance claims corrections.
- Provider number changes.
- Chiropractic claims corrections.
- Multiple surgery pricing situations.
- Medically Unlikely Edits (MUEs).
- KX modifier.

If the issue cannot be resolved due to one of these reasons, the Customer Service Representative (CSR) will inform the caller that the reopening cannot be handled over the telephone and a written request for a redetermination or reopening must be submitted.

The TrailBlazer[SM] Part B Reopenings Web page located at http://www.trailblazerhealth.com/Appeals/Reopenings/ReopeningsPartB.aspx includes information and resources to assist providers with submitting a reopening request. A Reopening Request Form is also available for use and may be downloaded from this Web page.

For more information on the reopening process, please refer to the Internet-Only Manual (IOM) Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 34, Section 10.4.

What Can Providers Expect When Calling the TrailBlazer Part B Provider Telephone Reopening Line?

- The time frame for requesting a telephone reopening is one year from the date of the initial determination or redetermination.
- When requesting a telephone reopening, the caller must provide the following information:
  - Legacy number or National Provider Identifier (NPI), Provider Transaction Account Number (PTAN) and Tax Identification Number (TIN).
  - Patient's first initial and last name.
  - HIC number.

  Note: Items must match exactly.
- There is a limit of three claim adjustment requests per call for telephone reopenings. However, if you have 25 or more requests for the same reason, it is possible an express adjustment can be performed.
  - Express adjustments are performed when minor corrections need to be made on 25 or more claims for the same reason.
  - When you call, let the CSR know you are requesting an express adjustment because you have 25 or more of the same situation.
  - The CSR will take the information and your request will be handled through the express adjustment process.
  - To request an express adjustment through the Telephone Reopening line, you must have specific information ready when you call, including dates of service, processed dates, procedure codes, billed amounts, modifiers, the provider number and Medicare Remittance Notice check number. Requests for express adjustments will be placed in date received order. These requests will be processed within 60 calendar days of the date received.