national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Understanding the Reopening and Appeals Process Open Forum

6/13/2024

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NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 reopening and redeterminations.

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

Agenda

- Levels of Appeal
- Holistic Approach
- Unprocessable, Reopening or Redetermination
- Levels of Appeal
- Reopenings
- Redeterminations
- Documentation Requirements

Levels of Appeal

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

Holistic Approach

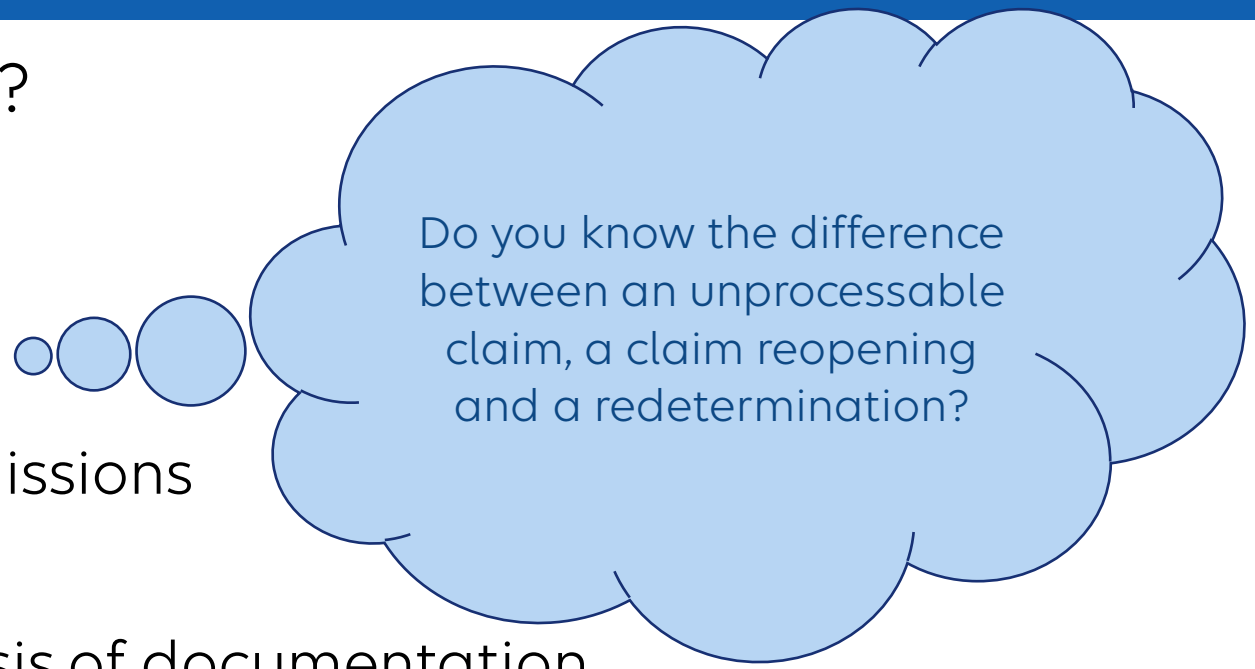
Best Practices: Holistic Approach

- 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



Levels of Appeal

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

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

Telephone Reopening Unit

- Requests that can be completed via the Telephone Reopening Unit (TRU) or Part B Reopening Request Form
  - Adding or changing order/referring/supervising physician
  - Add/change rendering provider
  - Assignment of claims (contractor errors only)
  - CLIA certification denials
  - Duplicate denials
  - Fee schedule corrections (contractor error only)
  - MBI corrections (contractor error only)
  - Medicare Advantage plan denials (clinical trial or hospice only)
  - Modifier GV and GW
  - MSP (Medicare now primary)
  - Patient paid amount (contractor error only)
  - Place of service changes
- These requests cannot be completed through NGSConnex

Redeterminations

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

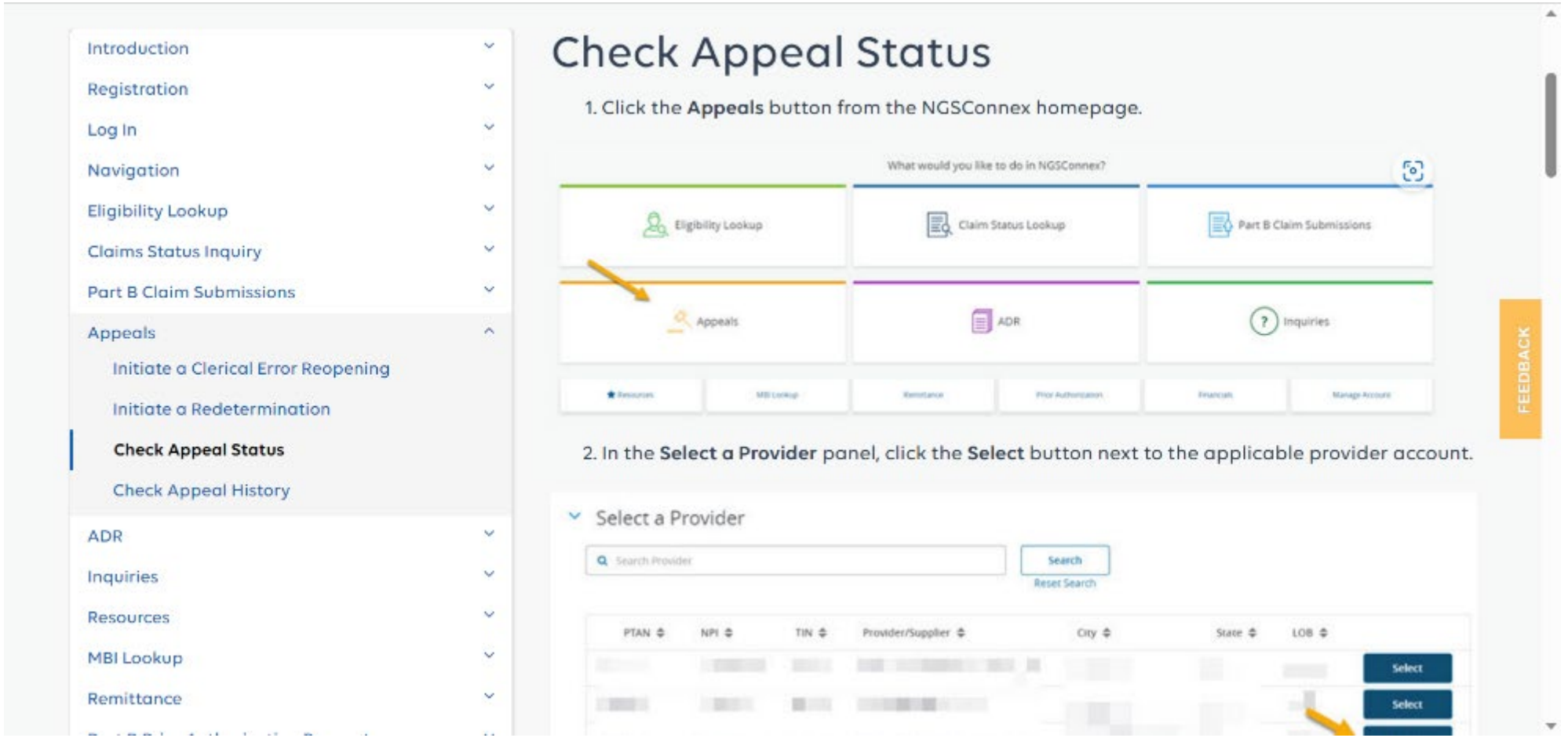
Redetermination Documentation

- 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

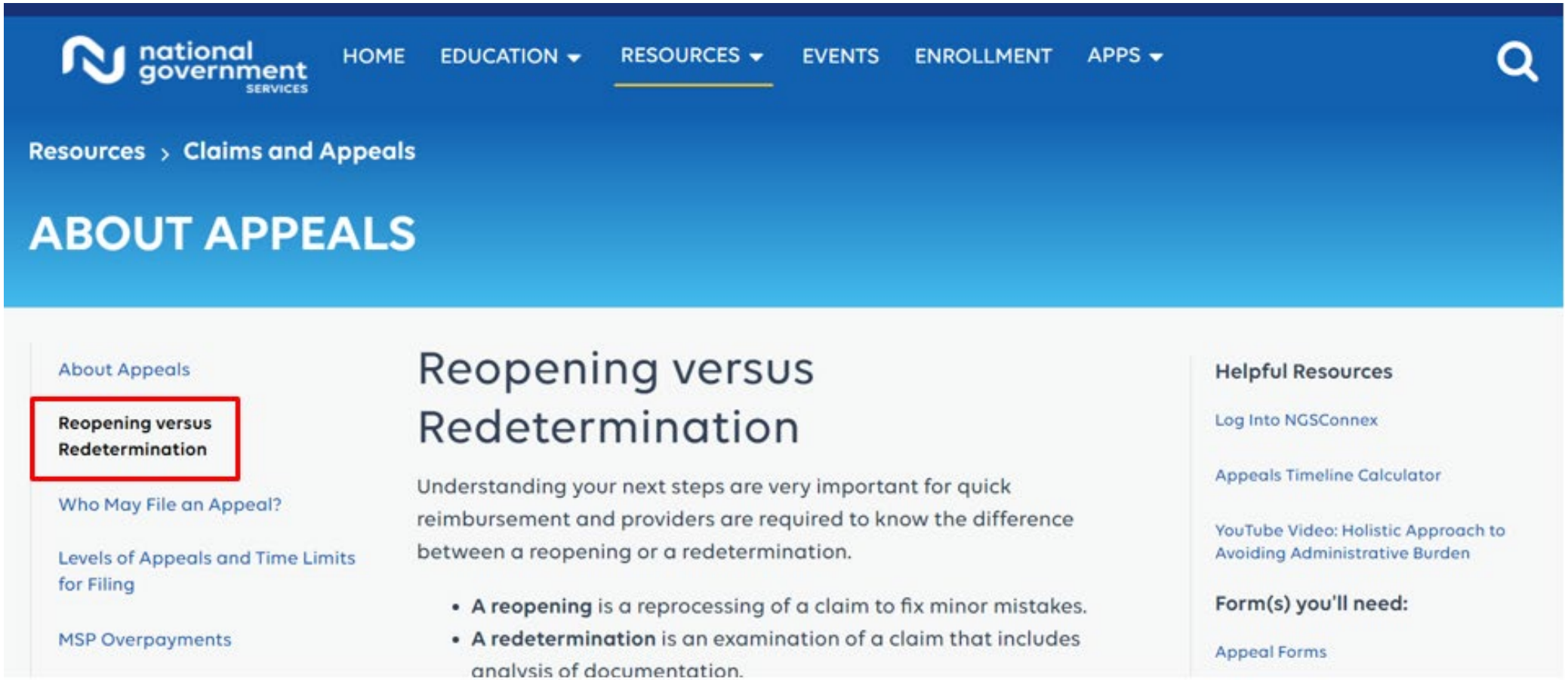
NGSConnex User Guide



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.)



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

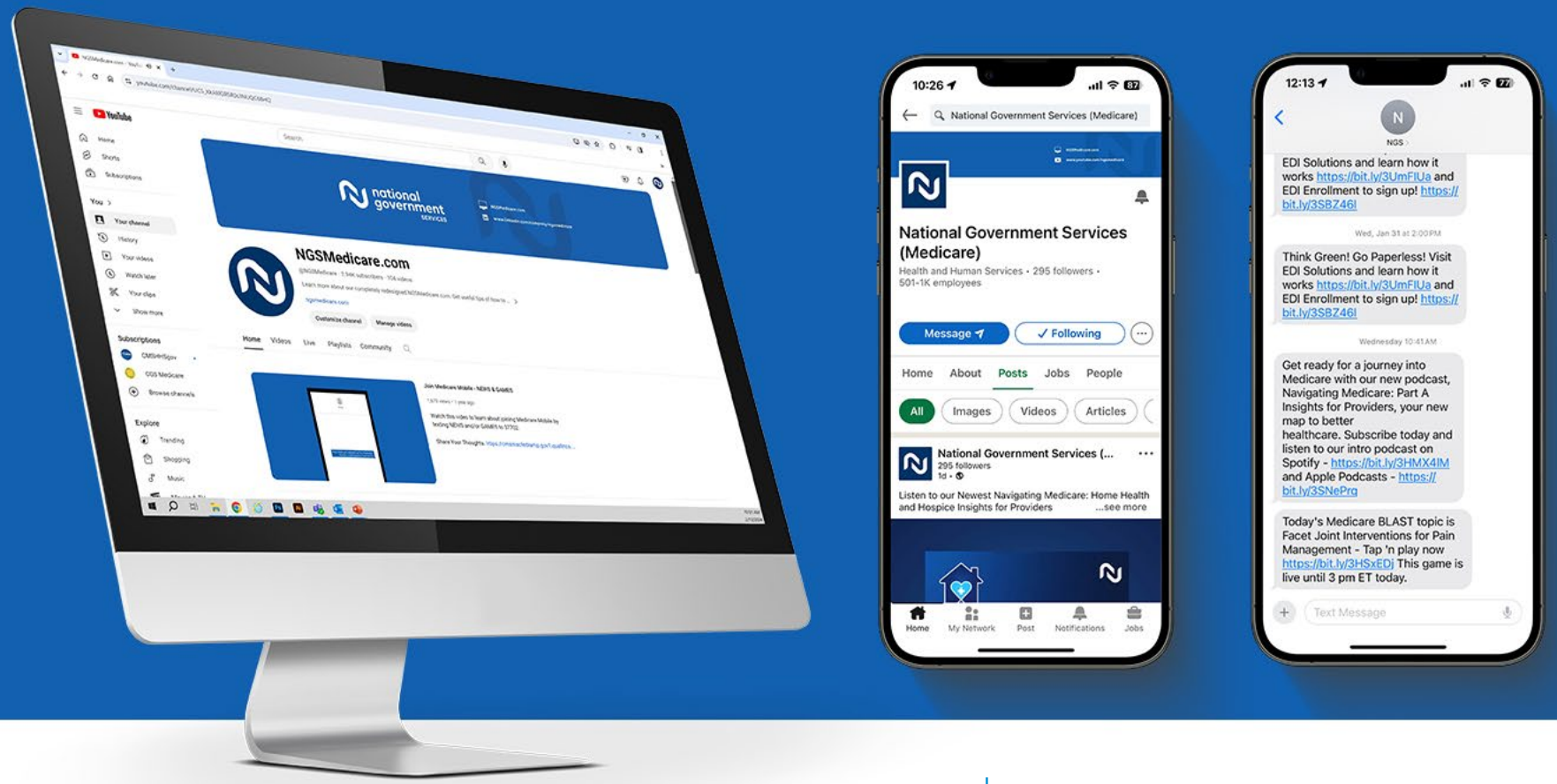
- Increase revenue, decrease administrative burden by using
- Electronic attachments
  - ANSI 275: Benefits of Electronic Attachments
  - 275: How To Get Started – Five Easy Steps
  - ANSI 277: Benefits of the 277 RFI
  - 277: How To Get Started – Five Easy Steps
- Information and data that comes together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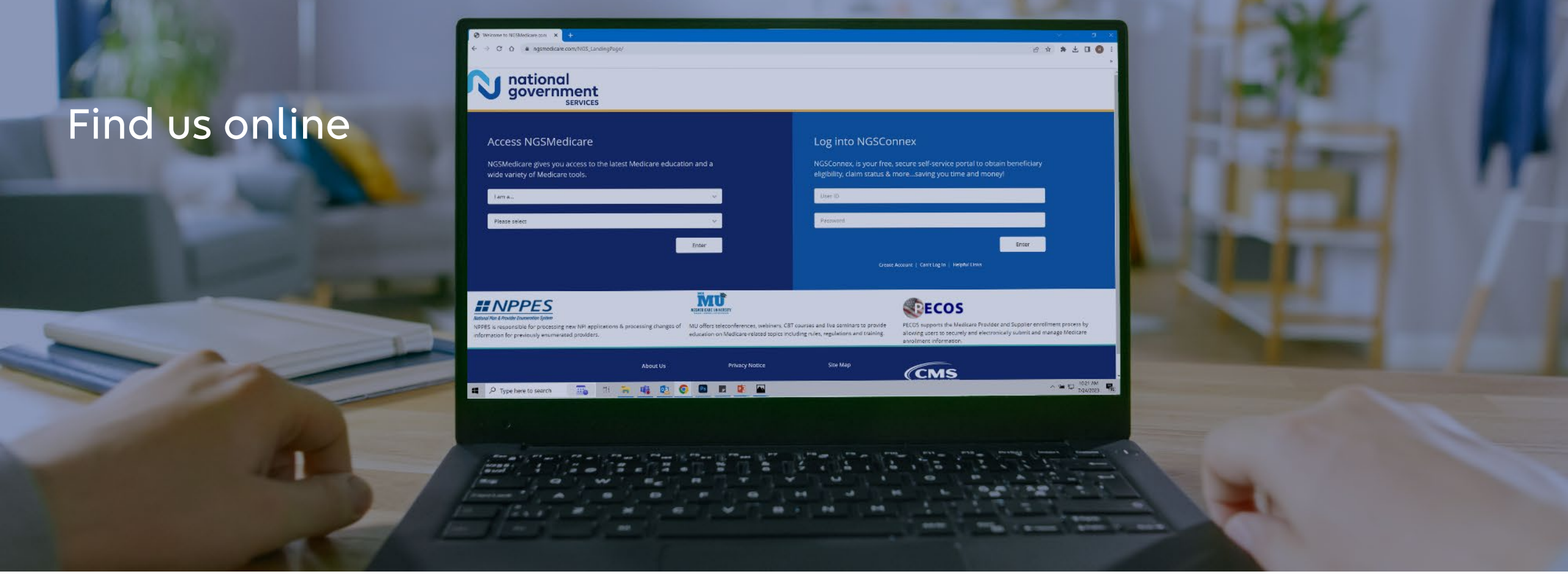

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

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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