UNDERSTANDING CMS RE-OPENS/RECONSIDERATIONS

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COMPLIANCE
LAWS
RULES
REGULATIONS
GUIDELINES
DIRECTIVES
RECOMMENDATIONS

OBJECTIVES

- What is a re-open (Definitions)
- When to create a re-open
- Who can request a re-open
- What is a reconsideration (Definitions)
- Who can request a reconsideration
- Re-open vs. reconsideration

DEFINITIONS

- **Appointed Representative** – The individual appointed by a party to represent the party in a Medicare claim or claim appeal
- **Clerical Error** – (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
- **New and Material Evidence** – New and material evidence information 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.

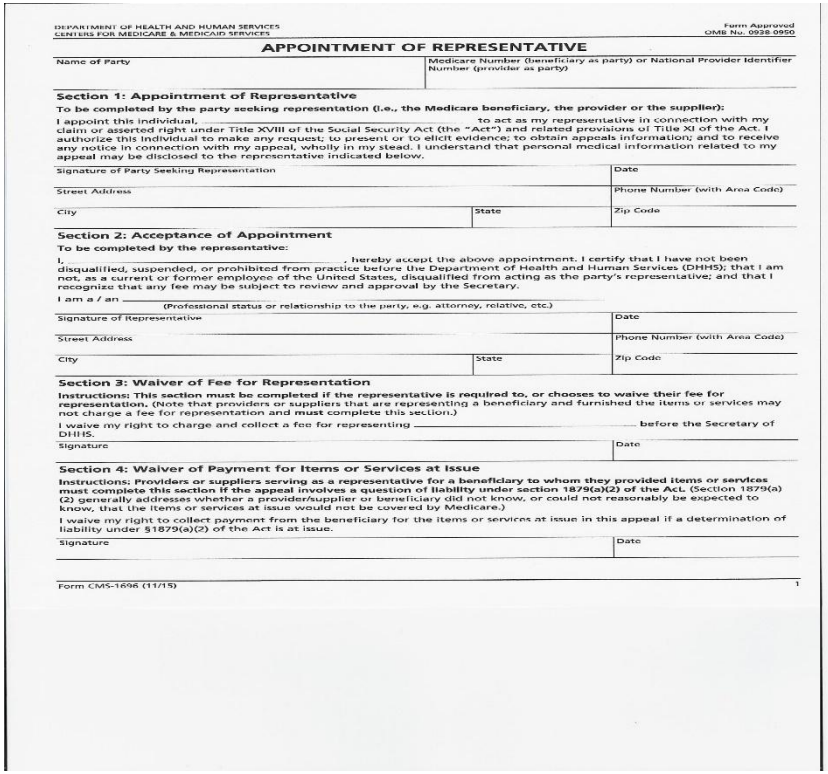
Note: **The submittal of any additional evidence is not a basis for reopening in and of itself.**

DEFINITIONS, CONT.

- **Reconsideration** – An enrollee's first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
- **Re-Open** – is a process used to correct minor errors or omissions to a previously processed claim without using the formal appeals process.

DEFINITIONS, CONT.

- **Representative Form** – Is a document that allows you to name someone to make decisions for you. This person is often a relative, friend, lawyer or doctor.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party | Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation | Date

Street Address | Phone Number (with Area Code)

City | State | Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (DHHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative | Date

Street Address | Phone Number (with Area Code)

City | State | Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature | Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature | Date

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Charging of Fees for Representing Beneficiaries before the Secretary of DHHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of DHHS (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1 800 MEDICARE or email: **AltFormatRequest@cms.hhs.gov**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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HOW ARE REOPENS CREATED?

To request a reopen, the following guidelines must be applied:

- The request must be made in writing;
- The request for a reopening must be clearly stated;
- The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and
- The request should be made within the time frames permitted for reopening (as set forth in section 130.2).

TIME LIMITS FOR REOPENS

Reopening's of organization determinations and reconsiderations initiated by a Medicare health plan:

- Within 1 year from the date of the organization determination or reconsideration for any reason;
- Within 4 years from the date of the organization determination or reconsideration for good cause as defined in §130.3;
- At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the organization determination was procured by fraud or similar fault;

TIME LIMITS FOR REOPENS, CONT

- At any time if the organization 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; or
- At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

TIME LIMITS FOR REOPENS, CONT.

Reopening of organization determinations and reconsiderations

requested by a party:

- A party may request that a Medicare health plan reopen its organization determination or reconsideration within 1 year from the date of the organization determination or reconsideration for any reason;
- A party may request that a Medicare health plan reopen its organization determination or reconsideration within 4 years from the date of the organization determination or reconsideration for good cause in accordance with section 130.3; or

TIME LIMITS FOR REOPENS, CONT.

- A party may request that a Medicare health plan reopen its organization determination at any time if the organization 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.

WHO MAY REQUEST A RECONSIDERATION?

- Any party to an organization determination (including a reopened and revised determination), i.e., an enrollee, an enrollee's representative or a non-contract physician or provider to the Medicare health plan may request that the determination be reconsidered.

Note: ***Contract providers do not have appeal rights***. An enrollee, an enrollee's representative, or physician (regardless of whether the physician is affiliated with the Medicare health plan) are the only parties who may request that a Medicare health plan expedite a reconsideration.

WHO MAY REQUEST A RECONSIDERATION?

- For standard pre-service reconsiderations, a physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration on the enrollee's behalf without submitting a **representative form**.
- See additional information in section 70.1.1. When a non-contract physician or provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the non-contract physician or provider must sign a waiver of liability; i.e., the non-contract physician or provider formally agrees to waive any right to payment from the enrollee for a service.


Q&A