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Reopening vs. Redetermination- What is Appropriate?

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Deciding to perform a reopening or submit an appeal can be a tough decision. A better understanding of the differences can make it easier to choose which action is appropriate.

Reopening

A Reopening is a process where providers can make adjustments to a claim that has finalized for denial or payment and are considered minor clerical errors or omissions. Providers are required to complete all research prior to requesting a phone, written or self-service reopening. Documentation does not need to be submitted with a reopening request.

The following are the types of corrections that may be completed through Reopenings:

- Diagnosis
- Place of service
- Month/day of service
- Procedure code
- Modifiers
- Units/number(s) of service

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Redetermination

A Redetermination is the first level of appeals and is an independent re-examination completed on claims where there is dissatisfaction with the original claim decision. Supporting documentation is usually needed to support a redetermination to show why the original claim was billed.

The following reasons may be the cause of a claim denial where a redetermination would need to be submitted if there is dissatisfaction with the original decision on a remittance advice, the

- Recovery Auditor Contractor (RAC) or Comprehensive Error Rate
- Testing (CERT) determination.
- Local Coverage Determination (LCD)
- National Coverage Determination (NCD)
- Frequency denials
- Medically Unlikely Edits (MUE)
- Not medically necessary denials e.g., C0-50