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Your Good Cause May Not Be Good Enough

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CMS has clarified the "new and material information" standard for reopening claims for good cause, when more than a year has passed since the claim was initially paid or denied. On January 16, 2009, CMS released **Transmittal 1671**, which clarifies what constitutes good cause. Good cause is said to exist when the information reviewed during the initial determination clearly contained an error on its face or when there is "new and material" information that was "not available or known" during the initial claim determination and when that information could result in a different determination or decision. As such, providers and suppliers seeking to reopen a claim must submit additional documentation along with an explanation of how it establishes good cause. Merely submitting evidence that was not previously submitted will no longer be sufficient to meet the good cause standard; the evidence must not have been known or readily available at the time of the initial determination.

The good cause standard still gives contractors great leeway to reopen claims. CMS states that data analysis identifying high error rates or patterns of potential overutilization satisfies the good cause standard, thus permitting contractors to reopen and review claims beyond the one year period. The transmittal also clarifies that a contractor's request for, and subsequent review of, medical records or supporting documentation satisfies the "new and material" evidence requirement. Although medical documentation was available upon the contractors request any time during initial review of the claim, in the eyes of CMS, this documentation is "new and material" because it is not routinely submitted to contractors. This further supports CMS's position that recovery audit contractors (RAC) audit findings constitute good cause for adjusting claims.

When it comes to third party payor errors, however, providers and suppliers will have a harder time getting claims reopened when the wrong primary payor was initially identified. The transmittal emphasizes that third party payor errors do not constitute good cause for reopening a claim if "Medicare processed the claim in accordance with the information in its system of records or on the claim form." For example, a hospital is told by a patient that a commercial payor is primary to Medicare, and the hospital bills and is reimbursed by this third party payor. If the third party payor later determines that the patient was not covered for the date of service and thus Medicare is primary, CMS will not consider this "new" information as meeting the good cause standard. According to CMS, all providers and suppliers have a legal obligation to determine the correct primary payor, even if the third party payor itself makes an error. Thus, according to CMS, third party payor errors may only be reopened during the first year when no showing of good cause is required.

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Ober|Kaler's Comments: This transmittal reminds providers and suppliers of the importance of correctly identifying primary payors, effectively managing denials and, where appropriate, requesting a reopening within one year from the initial decision in order to take advantage of the "any reason standard." If a reopening is requested after one year, providers and suppliers must be prepared to provide new and material evidence that constitutes good cause. Although claim decisions are reopened at the discretion of Medicare contractors and therefore non-appealable, if appeal time remains the initial claim denial may be appealed.