No. UM-013	Reopening and Revising Determinations and Decisions for Medicare Advantage Members	
Effective Date: 1/1/2020 Committee Approval: 1/18/22 Previous Versions: N/A	POLICY AND PROCEDURE	
CMS: Medicare Managed Care Manual, Chapter 13, Section 130 "Reopening and Revising Determinations and Decisions," 4/20/12		

Reopening and Revising Determinations and Decisions for Medicare Advantage Members

Purpose:

To comply with the Centers for Medicare and Medicaid Services (CMS) requirement of establishing a process when reopening or revising organizational determinations and/or decisions for Medicare Advantage (MA) members.

Canopy Health has established a process in place for reopening or revising a final favorable or adverse determination/decision. A reopening and/or revision is a different and separate process from an appeal or a reconsideration of a denial (see UM-008 Referral Policy). The process includes the definition of when a reopening or revision may be allowed, the description of the step by step process taken by the Medical groups/IPAs when a request for a reopening and/or revision of a final determination is received, the timeframes of when a reopening and/or revision may be allowed, and turn-around time followed for processing these requests.

Definitions:

Reopening – A remedial action taken to change a final determination or decision even though the determination was correct based upon the evidence of record. It must be requested by the member or member's representative, or a contracted provider acting on the member's behalf.

A. A final organizational determination may be reopened or revised prior to the 60 day deadline to file a Reconsideration only if:
    1. The file contains a Clerical Error. A Clerical Error can include but is not limited to:
        a. An error in data entry of CPT/HCPCS codes, fees/rates, dates, quantity, etc.
        b. Selection of an incorrect provider which may result in a different benefit being applied.
        c. Computer errors, such as claim/authorization batch file loading incorrectly.
        d. Revision of a decision due to conveying the incorrect decision to the member, member's representative and/or provider.
        e. Miscommunication to the member and/or provider, i.e., the provider was told an authorization was not needed; however, one was required for the requested service.
    2. Any additional information or documentation unrelated to a clerical error must be treated as an Appeal or Request for Reconsideration and must be forwarded to the health plan as such (see, UM GA-001 Appeals and *Grievances)*.

B. A final organizational determination may be (not required) reopened or revised after the 60 day deadline to file a Reconsideration has passed and there is no active appeal of the determination under the following circumstances:
    1. A previously favorable or adverse determination may be reopened for the following reasons, including definitions:
        a. Clerical Error – A clerical error includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding, and computer errors; examples above
        b. New and Material Evidence – Evidence that had not been considered when making the original decision. This evidence must show facts not previously available, which could possibly result in a different decision. New information also includes an

interpretation of existing information that the adjudicator deems to be credible, (e.g., different interpretation of a benefit).

c. Fraud or Similar Fault – Such examples could be but are not limited to:
   - The member, member's representative or provider knowingly making misrepresentations of fact to obtain payment for services for which no entitlement would otherwise exist.
   - Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs.
   - Making prohibited referrals for certain designated health services.

2. Examples of "Other" reasons include, but are not limited, to:
   a. Error on the Face of the Evidence – This occurs when a determination or decision is clearly incorrect based on all the evidence present in the file/case.
   b. A piece of evidence could have been contained in the file but was misinterpreted or overlooked by the person making the determination.
   c. The Physician Network receives notice from the health plan regarding a retroactive change in Member's eligibility with the MA Plan.
   d. A retroactive change in coverage Criteria or payment rules as issued and required by CMS.

C. To consider reopening a request the following is required:
   1. The request will be made in writing and can be submitted via mail, fax or, email.
   2. The request for a reopening will be clearly stated.
   3. The request will include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and

4. The request should be made within the permitted reopening time frames. See Section D of this policy.
5. If the request is received by telephone, the member or member's physician will be requested to submit the request and documentation to support the case in writing.
6. A phone call will be placed to the member's health plan to confirm that an appeal is not in process at the time of the request
7. All documents received will be attached to the file for review.

D. Timeframes and Requirements for Reopening:

1. After the 60 day Reconsideration timeframe has expired and within 1 year from the date of the organizational determination or reconsideration for any reason;
2. Within 4 years from the date of the organizational determination or reconsideration for good cause as indicated in Section B of this Policy;
3. At any time if there exists reliable evidence (i.e. relevant, credible, and material) that the organizational determination was procured by fraud or similar fault;
4. At any time if the organizational determination is unfavorable, in whole or in part, to the party there to, but only for the purpose of correcting a clerical error on which that determination was based;
5. At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

E. When reopen criteria is met:

1. The request will be processed following the same medical necessity review process;
2. The case will be forwarded to the Medical Director/designee for review;
3. Notification of a revised decision will be sent in writing utilizing CMS approved letter template; and
4. The letter will be mailed to the requesting parties to the last known address.

F. When reopen criteria are NOT met, the requestor will be contacted and:

1. Notification of the adverse determination stating the rationale and basis for the decision will be sent in writing to the last known address; and

2. Letter sent will also include explanation of appeal rights.

G. When processing a reopen for clerical errors, if the organization disagrees there is a clerical error, the organization will dismiss the reopening request and advise the party of any appeal rights, provided that the time frame to request and appeal on the original denial has not expired.

H. The timeframe for completion of the review and the mailing of the written notification of the reopen request organizational determination will be based on the priority of the original request:

1. Non-urgent/routine request - reopening process and notification will follow the standard time frames or as soon as the member's health condition requires; and
2. Urgent/expedited - reopening process and notification will be done within 72 hours from the date and time of receipt of the request or as soon as the member's health condition requires.

Revision History:

Version Date	Edited By	Reason for Change
01/01/2020	R. Scott	Creation date.