blue california
Promise Health Plan

Policy Title: Re-opening and Revising Organization Determinations		POLICY #: 50.2.33 Line of business: Medicare Adv	
Department Name: Utilization Management	**Original Date** 8/15	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 3/21**	

PURPOSE

To describe the process by which the Blue Shield of California Promise (Blue Shield Promise) Utilization Management (UM) Department will process clerical errors (which include minor errors and omissions) as re-opening of an Organization Determination (OD). Errors and omissions will not be processed as an OD reconsideration.

POLICY

Blue Shield Promise Health Plan will process organization determinations that contain clerical errors or involve an omission that requires remedial action as a re-opening of a OD in compliance with Medicare Managed Care Manual Chapter 13 Section 130- Re-opening and Revising Determinations and Decisions.

DEFINTION:
A Re-opening: is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. Clerical error includes human and mechanical errors at the health plan or PPG level, such as:

- Mathematical or computational mistakes;
- Inaccurate data entry; or
- Denials of claims as duplicates.

Meaning of New and Material Evidence: "New and material evidence" is evidence that had not been considered when making the original decision. This evidence must show facts not previously available, which could possible result in a different decision. New information also includes an interpretation of a benefit). ***The submittal of any additional evidence is not a basis for re-opening in and of itself***.

Meaning of Clerical Error: a clerical error includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding and computer errors.

Meaning of Error on the Face of the Evidence: an error on the face of the evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file. For example, a piece of evidence could have been contained in the file but misinterpreted or overlooked by the person making the determination.

PROCEDURE

I. Re-opening

1. Guidelines for Re-opening:
    a. The following are guidelines for a re-opening request:
        i. The request must be made in writing;
        ii. The request for a re-opening must be clearly stated;
        iii. The request must include the specific reason for requesting the re-opening (a statement of dissatisfaction is not grounds for a re-opening and should not be submitted).
2. Time-frames for Re-opening:
    a. Within 1 year from the date of the organization determination or reconsideration for any reason;
    b. Within 4 years from the date of the organization determination or reconsideration for good cause
3. Requirements for Re-Opening:
    a. At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the OD was procured by fraud or similar fault;
    b. At any time if the OD 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
    c. At any time to effectuate a decision issues under the coverage (National Coverage Determination (NCD)) appeals process.
4. Re-opening of OD and reconsideration requested by a party:
    a. A party may request that for a re-open of an OD or reconsideration within 1 year from the date of the OD or reconsideration for any reason;
    b. A party may request a re-open of an OD or reconsideration within 4 years from the date of the OD or reconsideration for good cause.
    c. A party may request that a reopen of an organization determination at any time if the OD 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.
5. Good cause for Re-opening of a OD
    a. Good cause may be established when:
        i. There is new and material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or
        ii. 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.
            1. When a change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or hearing decision under this section.
    b. A re-opening to effectuate coverage (NCD) decisions
6. Notice of a revised determination or decision
    a. A notice of a revised determination may be initiated by the Blue Shield Promise UM Department or contracted PPG upon internal identification of an error or omission or at the request of a Party.
    b. When any determination or decision is re-opened and revised in accordance with the above described circumstances under sections 1, 2, 3, 4 and 5, the UM Department shall mail its revised determination or decision to the parties at their last known address.

c. The adverse revised determination or decision must state the rationale and basis for the re-opening and revision
d. The notice shall include the enrollee's right to appeal

7. Effectuating determinations reversed by the Blue Shield Promise Health Plan
    a. Standard Service Requests
        i. If is has been determined by Blue Shield Promise to completely reverse the initial adverse organization determination (i.e., initial service denial), authorization to provide the service under dispute, it will be processed as expeditiously as the enrollee health condition requires but no later than 30 calendar days of receipt by the UM Department (or no later than upon expiration of an extension) from the date the request for reconsideration is received by the UM Department.
    b. Expedited Service Requests
        i. If on reconsideration of an expedited request for service and it has been determined by Blue Shield Promise to completely reverses the initial organization determination, it will be processed as expeditiously as the enrollee health condition requires but no later than 72 hours after the date of receipt by the UM Department (or no later than upon expiration of an extension)
8. Payment Requests
    a. When Blue Shield Promise completely reverses the initial adverse organization determination (i.e., initial claim denial), the organization must pay for the service no later than 60 calendar days after the date it receives the request for reconsideration.

II. Former Medicare Health Plan Enrollees Effectuation Requirements

1. Effectuation requirements for re-opening for former enrollees
    a. Blue Shield Promise is legally responsible under its contract and the regulations to authorize, provide, or pay for all Medicare covered services that are denied and upon appeal are found to be services the health plan should have authorized, provided, or paid for its enrollees.
    b. Blue Shield Promise Health Plan will honor the processing and payment for services that have been authorized as a result of meeting the conditions of a re-opening in compliance with Medicare Managed Care Manual Chapter 13 Section 140.

REFERENCES

Medicare Managed Care Manual

Chapter 13 – Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals Applicable to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs), (collectively referred to as Medicare Health Plans)

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