group health Cooperative of eau claire **KMTSJ, Inc.**	DEPARTMENT:	Utilization Management
	SUBJECT:	Reopening Initial Determinations
	PRODUCT LINE:	DSNP
	POLICY NUMBER:	UM123
	ORIGINAL POLICY EFFECTIVE DATE:	07/21/2024
	LAST REVISED DATE:	N/A
	LAST REVIEWED DATE:	N/A

SCOPE:

This policy ensures that Group Health Cooperative of Eau Claire (the Cooperative) has processes in place to reopen determinations when appropriate and process them according to CMS regulations.

POLICY:

A reopening is a remedial action taken to change a binding determination or decision even though the binding determination or decision (i.e., initial determination or level 1 appeal) may have been correct at the time it was made based on the evidence of record. The reopening process will not be used in a manner that interferes with member access to the appeals process.

PROCEDURE:

Requirements for Reopening and Revising

A reopening request:

1. May be initiated by any of the following:
    a. The Cooperative to revise the initial determination or redetermination;
    b. An IRE to revise the reconsideration determination;
    c. An ALJ or attorney adjudicator to revise their decision; or
    d. The Council to revise the ALJ or attorney adjudicator decision, or its review decision; or
    e. The member or any other party to the determination or decision.

2. May be made verbally or in writing;
3. Should include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening); and
4. Must be made within the timeframes permitted for reopening (as set forth in §80.3).

After reopening, a revised determination or decision is binding unless it is appealed or otherwise subsequently reopened. Only the portion of the determination or decision revised by the reopening may be appealed.

The timeframe to request an appeal of the revised determination or decision begins on the date of the revised determination or decision.

The reopening process is separate and distinct from the appeals process. When a party has filed a valid request for a level 1 appeal, level 2 appeal, ALJ or attorney adjudicator decision, or Council review, no adjudicator has jurisdiction to reopen a case that is under appeal until all appeal rights for that case are exhausted or a subsequent request by the appellant to withdraw the appeal has been granted.

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Time Frames for Reopening Initial Determinations

The Cooperative may reopen an initial determination on its own motion:

1. Within 1 year from the date of the initial determination for any reason (unless the request is under appeal).
2. Within 4 years from the date of the initial determination for good cause as defined in § 405.986.
3. At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.
4. At any time if the initial 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.
5. At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

The member or any party to the determination or decision may request a reopening of the initial determination according to the timeframes below:

1. Within 1 year from the date of the initial determination for any reason.
2. Within 4 years from the date of the initial determination for good cause in accordance with § 405.986.
3. At any time if the initial 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. Third party payer error does not constitute clerical error. See § 405.986(c).

Timeframes for Processing a Reopening

For a reopening request by the member or a party to the decision that the plan agrees to reopen, the reopening action should be completed within 60 days from the date of receipt of the party's reopening request.

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Reopening Based on Good Cause

Constitutes Good Cause for Reopening	Does Not Constitute Good Cause for Reopening
• 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. • 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. In other words, the decision was clearly incorrect based on all the evidence presented in the appeal file.	• 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. ○ **Part C Only:** This provision does not preclude MA plans from conducting reopenings to effectuate coverage decisions issued under the authority granted by section 1869(f) of the Act. See §405.986(b).

Reopening Based on Clerical Error

For purposes of this section, clerical error includes human and mechanical errors on the part of the MA plan such as:

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

The Cooperative will remedy a clerical error (which include minor errors and omissions) using the reopening process instead of the appeal process. If the Cooperative receives a request for reopening and does not agree that the issue is a clerical error, the Cooperative will dismiss the reopening request. Although a party cannot appeal an MA plan's decision not to reopen, the Cooperative will notify the party of their rights to appeal the initial adverse decision, provided timeframes to appeal the denial has not expired (see §80.6 for notice requirements).

New and Material Evidence

For evidence to be considered new and material for reopening, it must meet the following requirements:

- Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination decision;
- Does not include evidence that was or reasonably could have been, available to the decision-maker at the time the decision was made; and
- May result in a conclusion different from that reached in the initial determination or redetermination.

In determining whether the evidence is new and material, the Cooperative considers whether evidence is new and material from the perspective of the person or entity requesting or initiating the reopening.

Notification Requirements for Reopening and Revisions

If the request for reopening is denied by the Cooperative, the member or other party will be notified that the determination or decision will not be reopened. If the request was received in writing, the plan will notify the requestor in writing of the decision not to reopen. The decision on whether to reopen is binding and not subject to appeal.

When a determination or decision is reopened and revised (including revision of the rationale for a decision that is not revised) by the Cooperative, the plan will deliver written notification to the parties to that determination or decision as described in §80.6.

When any determination or decision is reopened and revised, (including revision of the rationale for a decision), the Cooperative will deliver written notification to the parties to that determination or decision at their last known address and within timeframes outlined in §80.3.2.

Written notification will:

- State the rationale and basis for the reopening and revision;
- State the specific reason for the revision or change in rationale, written in a manner that is understandable to the member; and
- Provide information on any appeal rights.

Type of Request	**IRE Reconsiderations**	**Other Entity Reconsiderations**
Standard Service	• Provide as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days. • If it is not appropriate to provide within 14 calendar days, authorize within 72 hours.	Authorize or provide no later than 60 calendar days
Standard Part B Drug	Authorize or provide within 72 hours	Authorize or provide no later than 60 calendar days
Standard Payment	No later than 30 calendar days	No later than 60 calendar days
Expedited Items or Services	Authorize or provide no later than 72 hours	Authorize or provide no later than 60 calendar days
Expedited Part B Drug	Authorize or provide no later than 24 hours	Authorize or provide no later than 24 hours

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Reference Sources:

Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
July 16, 2024

APPROVED: Michelle Bauer MD. DATE: 07/21/2024

Formal policies and procedures require department manager review, approval, and signature. Executive and/or administrative policies and procedures require CEO/General Manager review, approval, and signature.

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision