SHARP HEALTH PLAN POLICY AND PROCEDURE	
Title: Organization Determination Reopenings - Claims	**Product Line** (check all that apply)**:** ☐ Group HMO ☐ Individual HMO ☐ PPO ☐ POS ☒ Medicare ☐ N/A
Division(s): Finance Health Services and Operations	
Department(s): Appeals and Grievances, Claims Research, Customer Care, Network Development, Provider Contracts and Regulatory Affairs	
Owner (Title): Claims Research Supervisor	
Relevant Regulatory/Accrediting Agencies/Citations (specify): ☒ CMS: MMCMM Chapter 13- §130; MCPM Chapter 34 ☐ DMHC: _____ ☐ NCQA-HP: _____ ☐ NCQA-WHP: _____ ☐ OTHER: _____	
Approved by: (Signature of VP, Compliance Officer, or CEO) Signature on File	**Approval date:**

I. PURPOSE: This Policy and Procedure establishes Sharp Health Plan's (Plan) guidelines for the processing all reopenings.

II. POLICY: It is the policy of Sharp Health Plan (Plan) to adhere to requirements of the regulations in 42 CFR§405.980, when processing Claims Reopenings.

III. DEFINITIONS:

A. Administrative Law Judge (ALJ): Adjudicator employed by the Department of Health and Human Services (DHHS), Office of Medicare Hearings and Appeals (OMHA) that holds hearings and issues decisions related to level 3 of the appeals process.

B. Appointed Representative: The individual appointed by a party to represent the party in a Medicare claim or claim appeal.

C. Assignee: With respect to an assignment of appeal rights, an assignee is a provider or supplier who is not already a party to an appeal, who has furnished items or services to a beneficiary, and has accepted a valid assignment of the right to appeal a claim executed by the beneficiary.

D. Assignment of appeal rights: The transfer by a beneficiary of his or her right to appeal under the claims appeal process to a provider or supplier who is not already a party, and who provided the items or services to the beneficiary.

E. Assignor: A beneficiary whose provider of service or supplier has taken assignment of a claim, or assignment of an appeal of a claim.

F. Clerical Errors: Human or mechanical errors on the part of the party or the contractor, such as:

1. Mathematical or computational mistakes;
2. Transposed procedure or diagnostic codes;
3. Inaccurate data entry;
4. Misapplication of a fee schedule;
5. Computer errors; or
6. Incorrect data items, use of a modifier, or date of service.

G. Customer Service Record (CSR): A Customer Service Record (CSR) is generated for each entry in the GE Customer Service Module. CSRs are used to track customer inquiries and requests for assistance.

H.

I. Date of Receipt: A determination, decision or notice is presumed to have been received by the party five days from the date included on the determination or decision, unless there is evidence to the contrary.

J. Date of Service (DOS): The date on which the service was provided.

K. Independent Review Entity (IRE): An independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations.

L. Medicare Advantage Plan (MAO): A plan defined at 42 CFR, 422.2 and described at 422.4.

M. OnBase: The imaging software database used to store all claims and PDRs.

N. Organization Determination: Any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;

- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee;

O. Reopening: A remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record.

IV. PROCEDURE:

A. **Identification of a Reopening**: Sharp Health Plan will Reopen an Organization Determination if:

1. A clerical error is identified while conducting routine monitoring processes**;**
2. An IRE revises the reconsidered determination**;**
3. An ALJ revises the hearing decision; or
4. The MAC revises the hearing or review decision.

B. **Validate the Reopening:** Once received by the Claims Research Specialists they will verify that the Reopening is valid and meets all the necessary criteria.

1. **Criteria for a valid Reopening:** In order to be considered valid, each Reopening must meet the following criteria:
   a) The request must be in writing;
   b) The request for a Reopening must be clearly stated;
   c) The request must include the specific reason for requesting the Reopening (a statement of dissatisfaction is not grounds for a Reopening, and should not be submitted);
   d) The receipt of a Reopening must be within one (1) year from the initial determination; or
   e) The receipt of a Reopening must be within four (4) years from the date of the organization determination or reconsideration for good cause; or
      i) 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.

f) The receipt of a Reopening can be at any time if there exists reliable evidence that the Organization 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; or

g) The receipt of a Reopening can be at any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

2. If the Reopening request fails to meet the criteria above, the Reopening request will not be processed.

C. **Assign an Issue Tracking Number:** After the Reopening has been validated, the Claims Research Specialist logs the Reopening into HealthEdge to assign an electronic tracking number to each Reopening. Each Reopening has its own individual tracking number.

D. **Effectuating Reopenings:** The Claims Research Specialist must effectuate the determination by:

1. **Standard Service Requests:** The Claims Research Specialist will make payment or request a refund within sixty (60) calendar days from the date the reopening is received.

2. **IRE Requests:** The Claims Research Specialist will make payment within thirty (30) calendar days from the date Sharp Health Plan receives notice that the IRE reversed the determination.

3. **All Other Review Entities:** The Claims Research Specialist will make payment within sixty (60) calendar days from the date Sharp Health Plan

E. Appeal Rights: Reopenings are a separate and distinct process from the appeal process. If the Reopening action results in a revised adverse determination, then new appeal rights would be offered on that revised determination.

F. Reopening Filing and Record Keeping:

1. All Reopenings and attachments are maintained by Sharp Health Plan for a period of ten (10) years.

V. ATTACHMENTS: N/A

VI. REFERENCES:

VII. TAGS: Reopenings, Claims, Claim Appeals; Organization Determination

VIII. REVISION HISTORY:

Date	Modification (Reviewed and/or Revised)
12/22/2017	Reviewed and Revised for HealthEdge
01/01/2015	Original Document