United States
Office of Personnel Management
The Federal Government's Human Resources Agency

Multi-State Plan Program Administration Letter

Number: 2013-001 **Date:** September 5, 2013

Subject: Multi-State Plan Program external review process and consumer complaints

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The U.S. Office of Personnel Management (OPM) published a final rule on March 11, 2013 establishing the Multi-State Plan Program (MSPP). 78 Fed. Reg. 15560. The rule called for OPM to "conduct external review of adverse benefit determinations using a process similar to OPM review of disputed claims under [the Federal Employees Health Benefits Program (FEHBP)], subject to standards and timeframes set forth in 45 CFR 147.136(d)." *Id.* at 15595 (to be codified at 45 C.F.R. § 800.503(a)[1]).

The scope of the MSPP external review process extends to all final denials of claims under a Multi-State Plan (MSP)—including those not based on medical judgment as identified in regulations promulgated by the Departments of Health and Human Services, Labor, and the Treasury (the "Tri-Departments"). 45 C.F.R. § 147.136(d)(1)(ii)(A). OPM will receive a request for external review, make an initial assessment on whether the denial is based on medical judgment, and, if so, forward the request to an independent review organization (IRO) for external review. A request not involving medical judgment will be resolved internally by OPM to ensure uniform and equitable administration of MSPP contracts.

In most States, if not all, the Department of Insurance (DOI) or another State agency uses an existing process for the collection and resolution of consumers' health insurance-related complaints. That process will also apply to MSP enrollees who have complaints about their coverage. OPM's process for external review will be limited to requests specific to one or more claims and will not apply to other types of complaints that are traditionally resolved by State agencies. The final rule defines a claim as a "request for: (i) payment of a health-related bill; or (ii) provision of a health-related service or supply." 45 C.F.R. § 800.501(a)(1). A claim may be prospective or retrospective, i.e., a request for preauthorization or for reimbursement.

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[1] Although published within a notice of final rulemaking, this section will not become final until a corresponding regulatory amendment to 45 C.F.R. § 147.136(d) is finalized by the Departments of Health and Human Services, Labor, and the Treasury and OPM has published an additional notice. 78 *Fed. Reg.* at 15560.

This memo provides a definition of "request for external review" and a series of examples to illustrate what types of consumer situations would constitute a request for external review. OPM intends to develop processes, in close collaboration with States and the National Association of Insurance Commissioners (NAIC), to ensure that information is mutually shared to promote the best interests of consumers.

Definition of Request for External Review

A request for external review is a timely, written[2] request from an MSP enrollee (or enrollee's authorized representative) to OPM to reverse an issuer's denial (including a partial denial) of the enrollee's claim.[3]

After an MSP enrollee's claim has been denied (in whole or in part) by an issuer and the denial upheld on internal review, the enrollee may file a request for external review. 45 C.F.R. §§ 800.502, 503. A request for external review is specific to the denial of one or more claims and requests reversal of such denial(s).

A request for external review must be filed in writing by either the enrollee whose denied claim is the subject of the request, or by an authorized representative of the enrollee. If the latter, the enrollee must submit a letter to OPM indicating he/she is authorizing a representative. Enrollees with questions may contact the MSPP, toll free, at (855) 318-0714.

Examples

The following examples illustrate the difference between requests for external review and complaints.

Example 1: An MSP enrollee in one State visits a tertiary specialist in a bordering State because there are no practicing tertiary specialists in the enrollee's home State. The MSP issuer reimburses the enrollee at the allowable out-of-network rate. Following the procedures outlined in her consumer notices and plan documents, the enrollee writes to the MSP issuer requesting that the visit be covered as in-network. The issuer upholds its decision. The enrollee immediately writes a letter to OPM stating that her visit should have been covered as in-network.

In this example, the enrollee's letter constitutes a request for external review. The MSP issuer's refusal to cover the enrollee's visit as an in-network benefit is a partial denial of the enrollee's claim. The enrollee followed the appropriate process by filing an internal

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[2] An expedited review may be initiated orally rather than in writing.

[3] The scope of the MSPP External Review Process, which is more thoroughly discussed in separate guidance, includes rescissions of coverage, as described at 45 C.F.R. § 147.128, regardless of whether such rescission is associated with one or more specific claims. *See* 45 C.F.R. § 147.136(a)(2)(i) (defining adverse benefit to include "rescission of coverage, as described in § 147.128 (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time)."

appeal with the issuer and then submitting a timely, written request for reversal of the issuer's decision.

Example 2: An MSP enrollee learns that a tertiary specialist that he had visited previously is no longer an MSP in-network provider. The enrollee writes a letter to OPM requesting that the care by the specialist be covered as in-network.

In this example, the enrollee's letter is a complaint because he did not seek re-adjudication of a discrete claim, but a widening of the network available under the MSP. OPM would coordinate with the DOI in the enrollee's State to resolve the complaint.

Example 3: An MSP enrollee has received treatment intermittently for chronic back pain from a chiropractor for several years. Such treatment was covered on the enrollee's previous plans, but is specifically excluded under the enrollee's MSP plan, although the MSP is offered by the same issuer from which the enrollee had purchased previous policies. The enrollee calls both the DOI in her State and OPM to express her preference that the benefits package for the MSP should include chiropractic services.

In this example, the enrollee's calls are complaints. OPM would coordinate with the State DOI or the appropriate State agency to resolve the issue.

Example 4: An MSP enrollee has been advised by her oncologist that a certain treatment for her cancer is medically appropriate. Although the requested treatment has been proven effective for use with other forms of cancer, it has not been approved for the enrollee's particular condition. The enrollee seeks preauthorization to receive the treatment and is denied based on the exclusion of experimental or investigational care as outlined in the plan documents. The enrollee sends a form to OPM authorizing her provider to appeal on her behalf. After appropriately pursuing an internal appeal and being denied, the provider submits a request for external review to OPM on the enrollee's behalf.

This is an example of a request for external review. The denial of preauthorization for a specific item or service constitutes an appealable denial. The enrollee has authorized the provider in writing to submit the request, so OPM would conduct review upon receiving appropriate documentation from the provider.

This denial would be reviewed by both an IRO contracted by OPM and by OPM itself because the denial is based on the medical evidence supporting the use of the treatment in question, as well as the exclusion of experimental or investigational treatment under the MSP. OPM would review the extent of coverage under the enrollee's plan, and an IRO would review available medical evidence to determine whether the proposed treatment is experimental or investigational.

Example 5: A Qualified Health Plan enrollee is denied benefits for a medically necessary treatment covered under her plan, which is offered by an issuer that offers an MSP in the same State. The enrollee files a request for external review with OPM.

In this example, OPM would coordinate with the State's Health Insurance Marketplace, DOI, or other appropriate agency to ensure that the consumer is referred to appropriate resources because OPM's authority to conduct external review is limited to MSPs.

Sincerely,

John O'Brien
Director, Healthcare & Insurance