FEHBP Letter

All Carriers

U.S. Office of Personnel Management
Office of Insurance Programs

FEHBP Letter No. 96 – 16F **Date:** March 25, 1996

SUBJECT: Carrier Responsibilities in Disputed Claims Process

The Office of Personnel Management (OPM) is intent on improving the disputed health benefits claims process. The purpose of this letter is to explain the responsibilities of the carriers and the enrollees in the process, and to clearly state our expectations of the parties involved.

When an FEHB carrier denies a medical or dental claim, OPM regulations provide that the enrollee may ask the carrier t reconsider its denial of the claim. If the carrier upholds its denial of the claim in dispute, we expect the carrier to adequately explain to the claimant why the claim denial was correct. The basis for the denial of the claim must be the carrier's FEHB benefits as negotiated with OPM. In order to establish its case that the claim was correctly denied, the carrier must document a file with the applicable records. Proper documentation varies by case and should be determined on a case-by-case basis. Below is a list of potential records and the reasons they may be necessary.

Medical records may be needed in order to review claims:

1. For inpatient hospital or other facility confinements, nursing care, or services denied as:
    - Not medically necessary,
    - Not appropriate for the patient's condition,
    - Custodial; or
2. Where the denial is based upon specific medical criteria or a medical assessment (as opposed to a contractual denial).
3. To determine if a procedure meets the contractual definition of experimental/investigative

Medical records include:

- Hospital admission, history and physical exam,
- Discharge summary,
- Doctor's orders sheets,
- Doctor's progress records,
- Medical references
- Nurses' notes,
- CPT codes, and
- For dental claims, particularly accidental dental injury, dental X-rays, itemized bills, clinical records regarding the patient's history, and statements from the attending dentist.

Operative reports may be needed in order to evaluate surgical claims for:

- What was done,
- The complexity of what was done,
- The appropriateness of the service coding, or
- Documentation of multiple surgeries.

Statement of physicians and other providers attesting to their findings upon examination of the patient or rationale and justification for prescribing a certain course of treatment.

Itemized bills (from providers) and **Explanation of Benefits forms** (from the carrier, including other coverage if coordination of benefits is a factor in the dispute) showing:

- What services were billed,
- What was charged,
- How the service was coded,
- How the claimed services were paid, and
- What the enrollee was told by the carrier at the time the claim was processed,

Foreign claims may require additional information, including

- Exchange rate information, and
- Translation into English of all documents not written in English

PPO discounts or other applicable provisions of any agreements between the carrier and the provider (including hold harmless) should be described.

If the carrier upholds its denial upon reconsideration, its written decision to uphold the denial must include a clear justification of the basis for the decision, stated in terms of applicable FEHB brochure provisions, as well as a statement to the enrollee that he or she has the right to appeal this decision to OPM.

It is the enrollee's responsibility to establish why the claim should be paid, citing specific brochure provisions. However, OPM will request a copy of the carrier's file containing the above documentation and weight the carrier's decision and the evidence to support it against the evidence submitted by the enrollee in support of payment. In addition, OPM may request an explanation from the carrier concerning the processing of the claim, including any of the following:

- The patient's diagnosis,
- The amount of claim in dispute,
- How Plan allowances were determined,
- Whether or not the provider of services is a member of the plan's PPO network, or participates with the carrier in some other arrangement,
- How benefits were coordinated with other insurance coverage the patient may have had, and
- Whether the carrier's Medical Director or outside consultants were involved in the decision process.

OPM will also consider any other information the enrollee, provider, or the carrier deem necessary to support their positions and include in their respective submissions.

Sincerely,

Lucretia F. Myers
Assistant Director
for Insurance Programs