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

Multi-State Plan Program Administration Letter

Number: 2016-002 **Date:** May 16, 2016

Subject: Multi-State Plan Program External Review Process Update

Introduction

Pursuant to the U.S. Office of Personnel Management's (OPM) Multi-State Plan (MSP) Program regulation at 45 C.F.R. § 800.503, OPM administers the External Review Process for disputed adverse benefit determinations submitted by enrollees in the Multi-State Plan health insurance options.[1] In determining the MSP Program External Review Process standards, OPM analyzed section 2719 of the Public Health Service Act (PHSA) and 45 C.F.R. § 147.136(d) (amended effective January 19, 2016)[2]. The MSP Program External Review Process standards are at least as protective to consumers as the processes applicable to State-level issuers (SLIs) under otherwise applicable State or Federal external review processes.

OPM has provided extensive information to assist State-level issuers in understanding and meeting our requirements related to the MSP Program External Review Process. In 2013, OPM finalized its MSP Program Regulation,[3] which included OPM administration of the Program's External Review Process. Next, we published an MSP Program Administration Letter[4] on the standards and timeframes developed to provide a uniform, consumer-protective process for enrollees in MSP options. OPM also maintains a dedicated webpage[5] to provide current information to MSP enrollees about how to file external review requests. This information is also useful for SLIs because it contains the proper OPM contact information relevant to external review requests. Additionally, in our MSP Program Annual Letter for Plan Year 2017,[6] OPM stated that MSP enrollees must use the MSP Program External Review Process for denials of

[1] 45 CFR § 800.503.
[2] 80 FR 72192 (November 18, 2015).
[3] 78 FR 15560. OPM published an updated final rule in February of 2015 (found at 80 FR 9649), but the External Review provisions are unchanged.
[4] MSP Program Administration Letter, 2013-002, "Multi-State Plan Program External Review Process." Published November 27, 2013. http://www.opm.gov/media/4592632/pal_2013-002.pdf .
[5] Multi-State Plan Program and the Health Insurance Marketplace, External Review. http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/.
[6] Multi-State Plan Program Issuer Letter, 2016-001, "Multi-State Plan Program Annual Letter for Plan Year 2017." Published January 13, 2016. https://www.opm.gov/media/5206258/multi-state-plan-program-plan-year-2017-annual-letter-.pdf.

prescription drugs not listed on the plan's formulary. This letter also included the standards and timeframes related to the prescription drug exceptions process.

This guidance document is intended to clarify the standards associated with the External Review Process, with a focus on those standards that pertain to SLI obligations. OPM's MSP Program regulation incorporates by reference the Federal external review process established by the Department of Health and Human Services (HHS) under 45 C.F.R. § 147.136(d). In its interim form, § 147.136(d) stated OPM's authority to create its own external review standards. When finalizing this rule in January 2016, HHS clarified the language in (d) to expressly provide that an MSP option satisfies the "effective Federal external review process" requirement when it complies with standards established by OPM. Due to this clarification, OPM is issuing this guidance to highlight existing and supplemental external review standards relevant to SLIs in the MSP Program. In particular, the supplemental standards identified in this guidance are derived from experience gained after more than two years of administering the MSP Program External Review Process and recognizing certain aspects of the process that had not previously been addressed.

The External Review Process Standards

The following are the standards of the External Review Process that apply to SLIs.

Scope

OPM's External Review Process provides MSP enrollees with an opportunity to seek an independent level of review for final adverse benefit determinations (ABDs) concerning issues of medical judgment (including treatments determined to be experimental or investigational), determinations made pursuant to the terms of the insurance contract, and rescissions.

Notice

SLIs must ensure that MSP enrollees are afforded sufficient notice of their right to external review of a final ABD. This notice comes in two forms: (1) an explanation of an enrollee's appeal rights found in the policy document, and (2) language sufficient to notify an enrollee in receipt of a final ABD of their right to file a request for external review with OPM. Model language for use in a policy document can be found in the appendix to this document. OPM has also published a model final ABD with appropriate external review language.[7]

Eligibility for External Review

For an MSP enrollee to be eligible for external review, the following requirements must be met:

(1) The enrollee has received an ABD from the issuer;
(2) The enrollee has exhausted the issuer's internal appeal process or qualifies for deemed exhaustion based on one of the following circumstances:

[7] Model Notice of Final Internal Adverse Benefit Determination, https://www.opm.gov/forms/pdfimage/opm1842.pdf.

a. The issuer has waived the exhaustion requirement;
b. The issuer failed to comply with a requirement of the internal appeal process, other than a de minimis violation; or
c. The enrollee applies for expedited external review concurrently with expedited internal appeal.

(3) The appeal must concern one of the following categories:
a. A decision based on medical judgment;
b. An interpretation of contract coverage not involving medical judgment; or
c. A rescission of the contract between the issuer and enrollee.

(4) The enrollee must request external review from OPM within one (1) year of receipt of a final ABD, subject to OPM's discretion in certain rare cases.

Filing a Request for External Review

After the internal appeals process has been exhausted, an MSP enrollee has one (1) year from receipt of notice of the final ABD to file for external review with OPM. An enrollee may file a request for external review with OPM beyond the 1-year deadline if they provide a reasonable explanation for the untimely filing. In the event that an enrollee in a State without a time limit files a request for external review more than one year after final denial, OPM will consider the absence of a State-imposed time limit to be a circumstance that warrants an exception to the 1-year time limit, and OPM will allow the belated external review.

There shall be no fee imposed on an enrollee in connection with a request for external review. There is also no minimum dollar amount required for a claim to be eligible for external review.

OPM distinguishes between standard and expedited requests for external review. An expedited request is one in which the enrollee's provider has determined that the denial of care would seriously jeopardize the enrollee's life or health, or jeopardize his or her ability to regain maximum function, or where he or she has received emergency services, but has not been discharged. Expedited cases are entitled to accelerated processing, while cases not meeting these criteria will be subject to the standard timeframes, discussed below.

Review of a Request for External Review

Upon receipt of a request for external review, OPM will determine whether the request is eligible. If eligible, OPM will request the reconsideration file from the issuer. Only a case that is ineligible for the process on its face will be closed by OPM without requesting a reconsideration file.

The reconsideration file must include all information applicable to the claim or request in question. This includes, but is not limited to, medical documentation for medical denials, explanations of benefits and policy documents where applicable, and any correspondence from the enrollee or provider relevant to the disputed claim.

An SLI to whom a reconsideration file request is directed must respond within 3 business days for a standard request. The reconsideration file for an expedited external review request must be provided to OPM within 24 hours of receipt of notice of the expedited request.

If the SLI has reversed its earlier denial of coverage or payment (*e.g.* in the case of an administrative reversal or "goodwill gesture"), the SLI must notify OPM of the reversal and provide written notice of the reversal. OPM will close the case without rendering judgment and will notify the enrollee.

Final Decision

In the case of a standard (non-expedited) external review request, OPM will generally render a decision within 30 days of OPM's receipt of a completed request for external review. However, OPM may extend the review timeline if additional information is provided that changes the nature of a case.

For expedited external review requests, OPM will generally render a decision made by the Independent Review Organization (IRO) within 72 hours of receipt of the request. For enrollees in States with timeframes of less than 72 hours, OPM will generally require that expedited external review is completed within the timeframe applicable in the State.

In making a decision in a contractual case, OPM will adhere to the terms of the enrollee's plan or coverage document unless the terms are inconsistent with applicable State or Federal law.

OPM's decision (or the decision of OPM's contracted IRO in a medical judgment case) is final and binding on the SLI and the enrollee except to the extent that other remedies may be available under State or Federal law.

Implementation of an Overturned Decision

In instances where OPM's external review decision overturns the SLI's internal appeal determination, the SLI is required to implement OPM's decision and approve the requested service or authorize payment.

After OPM provides notice of the overturned decision, the SLI must immediately approve a request for authorization or payment, consistent with any applicable State timeframes. OPM will provide the SLI with this notice in the form of a letter addressed to the affected enrollee, a copy of which is provided to the SLI.

This implementation timeframe applies to both pre-service and post-service cases. For pre-service authorization, "approve" means the SLI provides the enrollee authorization for the services as requested, subject to the terms of the enrollee's policy document. For claims for services already received, "approve" means that the SLI has reprocessed the claim and authorized payment according to the terms of the enrollee's policy contract. In either case, the SLI must provide appropriate notice to the enrollee electronically and/or via postal mail.

Complaints vs. Requests for External Review

An SLI should make clear the distinction between a request for external review and a complaint within its MSP option policy documents. A request for external review is a timely, written request from an MSP enrollee (or enrollee's authorized representative) to OPM to reverse an SLI's denial (including a partial denial) of the enrollee's claim or request for pre-authorization of services. A request for external review is specific to the denial of one or more claims and requests reversal of the denial by an SLI. OPM retains jurisdiction over the External Review Process for MSP enrollees.

In contrast, a complaint is not specifically related to the denial of a claim, but involves dissatisfaction in how the SLI is providing service. Consumer complaints are handled by the State in which the MSP option is offered. To avoid consumer confusion, policy documents for MSP options should clearly distinguish the two circumstances by distinguishing the terms "external review request" and "complaint" and directing enrollees to the appropriate agency. OPM has published guidance to help distinguish complaints from requests for External Review.[8]

Adverse Benefit Determination Notices

OPM notes that, while it is imperative that enrollees have access to clear and accurate information in the policy documents, individuals often do not seek information about their appeal rights until they need them. For this reason, SLIs' ABD notices must also contain accurate information. OPM's Model Notice of Final Internal Adverse Benefit Determination provides a template for SLIs to use in developing ABD documents for MSP enrollees.

Issuer Action

The standards in this document must be applied and reflected in all policy documents and notices beginning in plan year 2017 and all subsequent plan years. SLIs should ensure that their processes comply with the information in this document and that their policy documents and final ABDs reflect these standards, where applicable.[9]

[8] MSP Program Administration Letter, 2013-001, "Multi-State Plan Program external review process and consumer complaints." Published September 5, 2013. http://www.opm.gov/media/4499065/20130905_mspp_al.pdf.
[9] The MSP Program Model Notice of Final Internal Adverse Benefit Determination has not changed. OPM's Model Language for the External Review Portion of a State-level issuer's Policy Document, found as an appendix to this document, is also unchanged.

Appendix: OPM's Model Language for the External Review Portion of a State-level Issuer's Policy Document

OPM is requiring SLIs to adopt standardized content that reflects the standards and timeframes for the MSP Program External Review Process. Each of the categories listed below are important to inform consumers about their appeal rights. OPM recognizes that SLIs may have different formats for their policy documents based on State requirements or standardization across a company's health insurance business. Nevertheless, all SLIs must include correct external review standards and timeframes in their policy documents for MSP enrollees. In addition, SLIs must provide appropriate and accurate contact information for the MSP Program External Review Process. OPM reviews this documentation annually for compliance.

Model language begins below:

External Review

The MSP Program External Review Process enables every MSP enrollee to obtain an additional, independent level of review of any adverse benefit determination. An adverse benefit determination includes any denial, reduction, or termination of a benefit by your insurance company, including a denial of payment, in whole or in part, for the benefit.
The External Review Process is available to you if your case requires any of: (1) medical judgment, (2) interpretation of coverage under your contract, or (3) rescission.

- A case involving medical judgment may include a decision not to provide benefits because your insurance company determines that a service, treatment, or drug:
    - is not medically necessary, appropriate, or effective;
    - was not provided in an appropriate health care setting or the level of care is not appropriate; or
    - is considered experimental or investigational.
- A case that involves your insurance company's interpretation of your coverage under the MSP policy documents and does not involve medical judgment is considered to be a contract coverage case.
- A case will be considered a rescission if it involves cancellation or discontinuance of coverage that has a retroactive effect.

In addition, the External Review Process is available to you if your insurance company does not provide benefits for a prescription drug because it is not listed on your plan's formulary. See the section *External Review for Prescription Drug Exceptions*, below, for further information.

There is no cost for MSP enrollees to use the MSP Program External Review Process.

Prerequisites and scope
When you receive information from your insurance company that benefits were not provided for a service, treatment, or drug you received, or your request for prior approval/authorization indicates that benefits will not be provided, you have the right to appeal that decision through your insurance company's internal appeal process. You must first use your insurance company's internal appeal process before you can ask OPM for external review, except in certain circumstances. Those circumstances include:

1) Your doctor has determined that your case is urgent, meaning that you have a medical condition that seriously jeopardizes your life or health if the care you requested is not received within 30 days; or
2) Your insurance company does not complete your internal appeal requesting prior authorization of a service or treatment within 30 days (72 hours for urgent cases); or
3) Your insurance company does not complete your internal appeal for coverage of care you have already received within 60 days; or
4) You are denied emergency services.

If any of these circumstances apply to you, you may request external review without first completing your insurance company's internal appeal process.

Deadline to file
Generally, you have one (1) year from when you receive an adverse benefit determination to file a request for external review with OPM. However, OPM will allow exceptions if you can provide a reasonable justification to demonstrate that circumstances warrant an external review more than one year after denial by your insurance company.

How to submit a request
OPM will accept a request for external review submitted in any of the following ways:

Email: mspp@opm.gov
Phone: (855) 318-0714 (toll free) or (202) 606-0400
Fax: (202) 606-0033
Mail: MSP Program External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You may alternatively choose to have another person act on your behalf. This person is called an "authorized representative." If you would like to designate an authorized representative, you must submit a completed, signed External Review Authorized Representative Form to OPM. The form can be found on OPM's External Review webpage at http://www.opm.gov/forms/pdf_fill/opm1841.pdf. OPM prefers that you use the form found on OPM's External Review webpage. However, OPM will accept any Authorized Representative Form that grants your permission for an authorized representative to work with OPM on your behalf. Your signature is required on any form authorizing someone else to act on your behalf, unless there are medical conditions preventing you from signing.
More information is available at http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. **You may also call OPM toll free at (855) 318-0714 if you need help with your request for External Review.**

OPM will confirm receipt
OPM will notify you when it has received your External Review request. Then, OPM will determine whether your request qualifies for the External Review Process. If your request

qualifies, OPM will notify you, and you will be given 20 calendar days to submit any additional information to support your claim. OPM will also request a complete case file from your insurance company, including information on how they processed your claim or request for benefits. If OPM determines that your request is not eligible for External Review, OPM will notify you and explain why your request was ineligible for External Review.

Expedited (Urgent) External Review
An urgent situation is one in which your doctor has determined that the denial of care would seriously jeopardize your life or health, or jeopardize your ability to regain maximum function, or where you have received emergency services, but have not been discharged. In these instances, you can request an External Review from OPM without first completing the internal appeal process. You should file an expedited internal appeal with your insurance company and an External Review from OPM at the same time. OPM will give you a decision in an expedited External Review case within 72 hours of receipt. **OPM strongly recommends that you or your authorized representative request an expedited review by phone or email.**

[*DRAFTING NOTE to State-level issuer*: For enrollees in States with timeframes of less than 72 hours, OPM will require that expedited external review be completed within the timeframe otherwise applicable in the State. Issuers in these States must include the applicable timeframe in their policy documents.]

Reviews conducted by the Independent Review Organization (IRO) & OPM
OPM uses an Independent Review Organization (IRO) to review cases that require medical judgment. The IRO has medical staff who can judge the appropriateness of the insurance company's decision to deny care or deny payment for care already received. For cases that do not involve medical judgment, OPM staff will review the case and decide whether the requested service or payment is covered by the enrollee's health insurance contract. For cases that require both medical judgment and an interpretation of the health insurance contract, the IRO will make a decision related to the medical judgment aspect(s) of the case, while OPM will make a decision on the contractual aspect(s) of the case.

Decision timeframe for standard (non-expedited) cases
In most cases, you will receive a final decision within 30 calendar days after submitting your request or your additional information. Some cases will take longer to allow you to submit additional information.

Decision is binding
The decision you receive from OPM's MSP External Review Process is binding. If you disagree with the decision, you should consult a lawyer to see if you have any other options.

External Review for Prescription Drug Exceptions
MSP enrollees can also file a standard or expedited external review request with OPM for internal appeal denials of prescription drugs that are not listed on a plan's formulary. OPM will issue final decisions within 72 hours of receiving a request for a standard decision and within 24 hours of receiving an expedited request.

MSP enrollees should file for external review for prescription drug exceptions in the same manner as they would file any other external review request.

OPM will accept a request for external review submitted in any of the following ways:

Email: mspp@opm.gov
Phone: (855) 318-0714 (toll free) or (202) 606-0400
Fax: (202) 606-0033
Mail: MSP Program External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415