FEHB Program Carrier Letter
All Carriers

U.S. Office of Personnel Management
Insurance Services Program

Letter No. 2005-08 **Date:** March 30, 2005

Fee-for-service [7] Experience-rated HMO [8] Community-rated HMO [7]

SUBJECT: **Carrier Responsibilities - Reconsideration Process and Medical Necessity Determinations**

This letter clarifies and expands upon earlier OPM letters concerning the type of medical/clinical records OPM requires for inclusion in a Reconsideration File, upon which a Carrier bases its reconsideration decision. Specifically, this letter addresses denied claims that involve determination of medical necessity.

OPM has previously sent Carriers two FEHB Program Letters addressing the overall reconsideration process and outlining procedures that ensure reconsideration decisions have undergone a thorough review before issuance (Copies of these letters are attached for your review and reference):

- On March 25, 1996, OPM sent Program Letter No. 96-16 — Carrier Responsibilities in Disputed Claims Process. This letter addresses the types of medical records applicable to the Carriers' reconsideration process.
- July 22, 1997, OPM sent Program Letter No. 97-30 — Disputed Claims and the Carriers' Reconsideration Files. This letter addresses the documentation responsibility of Carriers.

In addition, these two Program Letters outline the documents required for the Reconsideration File. These documents adequately authenticate the information a Carrier used in reaching a reconsideration decision. When an enrollee submits a disputed claim inquiry, Carriers must ensure that the Reconsideration File contains all the documentation required by OPM.

When a member's Reconsideration File lacks the applicable medical records, the Carrier's reconsideration review process is called into question. What information did the Carrier use to base the denial of benefits? The lack of necessary medical documentation in a Reconsideration File requires OPM to request additional clinical information through the member. This ultimately delays OPM's decision; adds an additional burden on the member and medical care providers to obtain and forward the additional medical records; and increases the administrative workload of OPM staff.

Relevant medical record documentation can vary on a case-by-case basis. However, as a general rule for all claims involving determination of medical necessity, the Reconsideration File must contain, at a minimum, and as appropriate the medical/clinical records identified in the table below.

Minimum Medical/Clinical Records Required

Source of Service	Type of Medical/Clinical Records
Primary care/family physician	History and physical exam, reports of diagnostic studies associated with evaluation of the condition/symptoms; and office notes for a period of 18 months prior to the date(s) of service under dispute or date of pre-authorization denial.
Specialists	Initial evaluation, reports of diagnostic studies associated with evaluation of the condition/symptoms; and office notes from initial date of service (or 18 months prior) to date of service denied or date of pre-authorization denial.
Pathology	Pathology reports for all surgical procedures, including abortions.
Physical therapy	Initial and interim evaluations, session notes, and discharge evaluation; for any condition for which physical therapy would be considered an appropriate/alternative treatment modality for the service requested, e.g. breast reduction; prosthesis.
Occupational therapy	Evaluation/assessment, e.g., prosthetic device.
Others	Determined on a case-by-case basis.

For illustrative purposes, the following table includes some example procedures along with the types of medical/clinical records to be included as part of the Reconsideration File. This is not an exhaustive list of examples or applicable medical/clinical records.

Illustrative Examples

Example Procedure	Type of Medical/Clinical Records
Breast Reduction/ Abdominoplasty	Primary care/family physician, dermatology, orthopedics, gynecology, plastic or general surgery, chiropractic services, mammograms for two previous years, original pre-surgical photographs, and surgical and pathology reports.
Abortion	Primary care/family physician, obstetrician/gynecology, genetic counseling, surgical and pathology reports.
Residential treatment center (RTC)/facility	Primary care/family (pediatric) physician, complete medical records from RTC from date of admission, complete medical record from previous acute care hospitalization (if associated with transfer to RTC) or discharge summary, records associated with outpatient therapy rendered over prior two years (initial evaluation, session notes, treatment plan, discharge evaluation).
Medical/Surgical Admissions (length of stay determination)	Complete hospital medical record (from admission through discharge, including discharge summary)
Ambulance	Ambulance transport log(s) and associated Emergency Department record.
CPT Coding	Clinical records (e.g., office notes) and/or operative/procedure report for date(s) of service in dispute.
Others	Determined on a case-by-case basis.

When applicable, original pre-surgical photographs should be requested by the Carrier and kept on file at the Plan for not less than 120 days from the date of the reconsideration decision letter (following a disputed claim inquiry to OPM). In situations where a Carrier sustains its denial upon reconsideration, OPM expects the Carrier's written decision letter to the enrollee to be clear and concise; include rationale that adequately explains to the enrollee why the initial claim denial was correct; and explain the supporting contractual basis for denial.

When forwarding Reconsideration Files, Carriers need to separate the submitted documents into two sections — medical records and nonmedical records. This will facilitate OPM's review of Carrier Reconsideration Files. OPM will rely on the Carriers to identify these two sections when submitting Reconsideration Files.

OPM believes these procedures, added to the guidance in Program Letters Nos. 96-16 and 97-30, will enhance both the reconsideration and disputed claim processes and improve the service Carriers and OPM give to enrollees.

Sincerely,

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for Insurance Services Programs

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