Federal Employee Health Benefits (FEHB) Guide to Disputing a Claim

PRESBYTERIAN
Health Plan, Inc.

FEHB members have the right to dispute either a pre- or post-service claim. The following procedures outline this process.

How to Dispute a Pre-Service Claim

If you have a pre-service claim and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 800-356-2219. If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process.

To Reconsider a Non-Urgent Care Claim

Within six (6) months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in this guide.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Pre-certify your hospital stay or if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply.
2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

To Reconsider an Urgent Care Claim

In the case of an appeal of a pre-service urgent care claim, within six (6) months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in this guide.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, email, fax, or other expeditious methods.

To File an Appeal with the Office of Personnel Management (OPM)

After we reconsider your pre-service claim, if you do not agree with our decision, you may ask the OPM to review it by following Step 3 of the disputed claims process detailed in this guide.

The Disputed Claims Process

You may appeal directly to the OPM if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to the OPM, including additional requirements not listed in Sections 3, 7 and 8 of the FEHB plan brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this FEHB Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 of the FEHB plan brochure, *if you disagree* with our pre-service claim decision, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Presbyterian Customer Service Center at:

Mail: Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489

Phone: 1-800-356-2219 (For TTY call 711 or toll-free 1-800-659-8331)

Fax: (505) 923-8163

Website: www.phs.org/fehb

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step 1

Ask us in writing to reconsider our initial decision. You must:

a. Write to us within six (6) months from the date of our decision; and

b. Send your request to us at:
Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489
and

c. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d. Include copies of documents that support your claim, such as providers' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e. Include your email address, if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you and our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step 2

In the case of a post-service claim, we have 30 days from the date we receive your request to:

- Pay the claim; or
- Write to you and maintain our denial; or
- Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

Step 3

If you do not agree with our decision, you may ask the OPM to review it.

You must write to the OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to the OPM at:

United States Office of Personnel Management
Healthcare and Insurance, Federal Employees FEHB Insurance Operations, FEHB 3,
1900 E Street, NW,
Washington, DC 20415-3630.

Send the OPM the following information:

a. A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
b. Copies of documents that support your claim, such as providers' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
c. Copies of all letters you sent to us about the claim;
d. Copies of all letters we sent to you about the claim; and
e. Your daytime phone number and the best time to call.
f. Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note:

- If you want the OPM to review more than one claim, you must clearly identify which documents apply to which claim.
- You are the only person who has the right to file a disputed claim with the OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.
- The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

Step 4

The OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. The OPM will send you a final decision or notify you of the status of their review within 60 days. There are no other administrative appeals.

If you do not agree with the OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against the OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

The OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before the OPM when the OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (505) 923-5678 or toll-free at 1-800-356-2219 (TTY (505) 923-5699 or toll-free at 877-298-7407). We will expedite our review (if we have not yet responded to your claim); or we will inform the OPM so they can quickly review your claim on appeal. You may call the OPM Health Insurance at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.
