Connecticut Insurance Department
Market Conduct Exam
Of
Oxford Health Plans, LLC (Oxford)
Docket No. MC 17-65

Revised Corrective Action Plan As Of October 3, 2017

Utilization Review Practices

1) Six (6) determinations not to certify care failed to provide proper Connecticut external appeal language.

   Company Response: Connecticut Inpatient Case Management staff received training on 11/30/16 regarding the correct data entry strategy for discharge dates to avoid partial denials being pulled in a universe report for examinations that should be limited to approvals. Additionally, the system migration of Connecticut business from PULSE to ICUE: Integrated Clinical User Experience is scheduled for October 2017. It is anticipated that we will not encounter this issue with ICUE.

2) Thirty-five (35) determinations not to certify care failed to provide proper Connecticut external appeal language as there was a miscoding of a health product.

   Company Response: Oxford employs unique coding to define license, product type (HMO, PPO, and POS), gatekeeper arrangement and funding type of the sold business. These codes are also used in letter programming to identify the member's product (plan). It was identified that code EDSF was erroneously included in a Connecticut Approval letter causing Connecticut enrollees to receive New York Appeal rights. This was corrected immediately and a post audit was performed on February 1, 2017 to confirm proper appeal mapping to product codes.

3) Eleven (11) appeal determinations failed to provide proper Connecticut external appeal language.

   Company Response: This letter template was amended in July 2015 to include the following language: "Please understand that this is your final level of internal appeal with us."

4) Two (2) Explanations of Benefits failed to provide proper Connecticut external appeal language.

Company Response: The Connecticut Appeal Rights for Explanation of Benefits was revised as of 8/1/17 to eliminate a second level of appeal. The revised language is as follows:

Appeal
A Member has the right to request a review of a claim denial. The Member or the Designee must send a written request for an appeal within **180 days** of receipt of this EOB to **Oxford Correspondence Department, P.O. Box 29134, Hot Springs, AR 71903** or 1-801-938-2100 via fax, or call Customer Care at 1-800-444-6222. The request must include the reason(s) the Member believes that the claim should not have been denied, the Member's name and Oxford ID number, a copy of this form (or the claim number on this form) and any documentation/information the Member would like to submit in support of the appeal. Oxford will provide the Member with a written response not later than **20 business days** from the Correspondence Department's receipt of the Member's request for an appeal.

5) Three (3) appeal determinations failed to provide the qualifying credentials of the reviewing physician.

Company Response: The request to update the letter templates with the qualifying credentials of the reviewing physician was made on 10/7/15 and the update was released into production on 1/6/16.

6) Oxford Health Plans, LLC did not have sufficient documentation for regulatory review.

Company Response:

It was noted that two appeal files did not have initial determination letters available. Our research indicates manual error to be the root cause in both instances.

With regard to file number JM 32, we were unable to submit the initial denial letter. The letter documentation process has been revised to include documentation of image numbers and letter type identification after letters are generated. Team training on the process and this process revision occurred in January, 2016. Additionally, refresher training of this process occurred for all team staff July 12, 2017.

With regard to file number JM 35, we were unable to provide the retrospective claim denial letter. The designated staff that manage Otoacoustic Emissions (OAE) testing claims have received refresher training related to the letter documentation process and the importance of record retention and system documentation. Staff refresher training took place during employee/supervisor 1 to 1 meetings during the month of September, 2017.

7) Oxford Health Plans, LLC failed to take corrective action to provide proper Connecticut external appeal language in appeal determinations as stipulated in Docket MC 12-141 and as indicated in the corrective action plan provided on April 10, 2013.

Company Response: Corrective Action Plans are entered and tracked within our Governance, Risk and Compliance database (eGRC). The entries detail the finding category, the responsible business area, completion dates and the steps taken to improve compliance. Oxford did take corrective actions to resolve the bold font issue detailed in Docket MC 12-141. Upon recent review, it was identified that a health product was miscoded resulting in improper external appeal rights. Second level appeal rights were included in appeal language, when this option is no longer available. Effective immediately, and as part of ongoing monitoring of Corrective Action Plans, outreach will be performed to our internal business teams to inquire as to any newly identified issues. This information will be tracked in the eGRC database under the most recent examination, allowing for risk remediation.

***Recommendation in Report: Recommended that Oxford Health Plans, LLC review its policies and procedures to ensure that it does not enter a discharge date for inpatient review prior to a medical director file review.

Company Response: Connecticut Inpatient Case Management staff received training on 11/30/16 regarding the correct data entry strategy for discharge dates to avoid partial denials being pulled in a universe report for examinations that should be limited to approvals. Additionally, the system migration of Connecticut business from PULSE to ICUE: Integrated Clinical User Experience is scheduled for October 2017. It is anticipated that we will not encounter this issue with ICUE.