DELIVERED VIA EMAIL ONLY

August 15, 2018

Jennifer Miner
Insurance Associate Examiner
Connecticut Department of Insurance
P.O. Box 816
Hartford, CT 06142-0816

Re: Updated letter template_ Link to access clinical criteria online

Dear Ms. Miner:

Per your examination report dated July 24, 2018, for the examination conducted on OptumHealth Care Solutions (OHCS), it was noted that OHCS failed to follow the procedure of including a reference to a weblink to access the clinical criteria online.

Enclosed please find the updated template language which includes providing a reference to a weblink to access the clinical criteria online.

Thank you for your time and consideration in this matter.

With regards,

Linda Johnson

Linda L. Johnson
Director, Compliance
Optum
763.361.7925

Enc. Template Language

[^b] Explanation of Member Appeal Rights [^bo]

[^b] Can I designate a representative to appeal on my behalf? [^bo]
A member may designate a person to act on his or her behalf, including the member's health care provider, to appeal this decision ("Designee"). To do so, the member must provide us with written consent, at the time of the appeal, for the Designee to act on his or her behalf. The consent must be signed by the member, or by the member's guardian, if the member is a minor. The Oxford approved consent form to designate a representative may be obtained on the Oxford Website at [^i] www.oxfordhealth.com. [^io]

We will accept an appeal without written consent and treat the following health care providers as the member's representative in the following instances:

(1) From a licensed practitioner with primary responsibility for the member's treatment (provider of record) if the admission, service, procedure or extension of stay has not yet been provided or if this determination creates a financial liability for the member.

(2) From a physician or other licensed, accredited or certified health care professional with knowledge of the member's medical condition for appeals of benefit determinations concerning urgent care.

A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the member's condition would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the determination.

[^b] How can I obtain a copy of the criteria used to make this determination? [^bo]
Members may obtain a copy of the criteria, including the clinical review criteria, used to deny a claim. A claim is any request by a covered member for certification of a benefit, or payment for a service, as required under the terms of the member's health plan. A claim is denied when it does not meet the criteria established by the member's plan. If the member would like a copy of the criteria, documents, records, communications and other information and evidence used to make this determination, the member must send a written request to [^b] OptumHealth Care Solutions, Inc., P.O. Box 5800, Kingston, NY 12402. [^bo] The criteria will be provided to the member free of charge. The internal rules, guidelines and protocols are also accessible at the Optum website, [^u] www.myoptumhealthphysicalhealth.com [^uo]. Go to: [^i] "Review Clinical Policies" [^io] to find the criteria and guidelines related to your request.

[^b] How do I submit a First Level Appeal Request? [^bo]

A member has the right to request a review of a claim denial. The member or the Designee may file a [^b] First-Level Member Appeal to OptumHealth Care Solutions [^bo] within [^b] 180 days [^bo] of receipt of this determination letter. While an appeal may be initiated by calling OptumHealth Care Solution, Inc at 1-877-369-7564 or Oxford Customer Service at 1-800-844-6222, we strongly recommend that the member file an appeal in writing. The written request will give us a clear understanding of the issues being appealed. Please send the request for appeal along with any document/information already requested (if not previously submitted) and any additional information the member would like to submit in support of the appeal to [^b] Clinical Appeals Department, OptumHealth Care Solutions, Inc., P.O. Box 5800, Kingston, NY 12402 [^bo] or fax to 1-866-695-6923. The person who reviews your appeal will not be the person, or a subordinate of that person, who made the original decision.

[^b] When will I receive a decision on my appeal? [^bo]
Upon receipt of an appeal request, we will provide a full and fair review of the member's claim. An apeal of an adverse benefit determination where the services have not been rendered (pre-service appeal) will be resolved not later than [^b] 15 calendar days [^bo] from the Clinical Appeals Department's receipt of the member's appeal request. An appeal of an adverse determination where the services have been rendered (post-service appeal) will be resolved not later than [^b] 30 calendar days [^bo] from the Clinical Appeals Department's receipt of the member's appeal request.

[^b] Can I file an expedited appeal? [^bo]
If the member's health or life or if the member's ability to regain maximum function could be seriously jeopardized by pursuing the standard appeal process, the member or the Designee may request an expedited utilization review appeal. The member has two available options. These options are not available for health care services that have already been provided.

(1) Internal Expedited Appeal: The member may request an internal expedited appeal by contacting OptumHealth Care Solution, Inc at 1-877-369-7564 or Oxford Customer Service at the number on the Oxford member ID card. The Clinical Appeals Department will provide notification indicating whether the request was accepted as an expedited or standard appeal. A determination on an expedited appeal will be made within [^b] 72 hours [^bo] from receipt of the appeal. You may request an expedited external review at the same time as requesting an expedited internal appeal for urgent care.

(2) External Expedited Appeal: The member also has the option to seek review by an independent review organization in emergency or life-threatening circumstances. The member or the Designee may make a request to the Commissioner of Insurance for an expedited external appeal without first completing the internal appeals process if:

(a) the time frame for completion of an expedited internal appeal would seriously jeopardize the member's life or health or jeopardize the membe's ability to regain maximum function; and

(b) the member, or provider acting on the member's behalf with the member's consent

has filed a request for expedited internal review.

For more information on how to file an external appeal, please read the explanation under "Do I have a right to an External Appeal?" below. If the member chooses the option, the member must submit the appeal by contacting the Connecticut Insurance Department at P.O. Box 816, Hartford, CT 06142-0816 (telephone number: 860-297-3910).

[^b] What if I believe I have been given erroneous information or need assistance with my appeal ? [^bo]
You can contact the Office of the Healthcare Advocate or the Insurance Department when you believe you have been given erroneous information or need assistance. The Office of the Healthcare advocate's and the State of Connecticut Insurance Department contact information is as follows:

[^b] State of Connecticut
Office of the Healthcare Advocate [^bo]
P.O. Box 1543
Hartford, CT 06144
Phone: 1-866-HMO-4446
Fax: (860) 297-3992
Email: [^u] Healthcare.advocate@ct.gov [^uo]

[^b] State of Connecticut
Insurance Department
Consumer Affairs Unit [^bo]
P.O. Box 816
Hartford, CT 06142-0816
Phone: (860) 297-3910
Email: [^u] cid.ca@ct.gov [^uo]

[^b] What additional appeal rights do I have if my First-Level Appeal is denied? [^bo]
If the claim remains denied, additional member appeal rights will be supplied with the First-Level Appeal determination letter. These additional appeal rights include (1) an external appeal pursuant to Connecticut State Law (refer to the section below, "Do I have a right to an External Appeal") or (2) a [^b] voluntary [^bo] standard appeal internally to the Oxford Grievance Review Board (GRB), described as follows.

All members who have received a First-Level Appeal determination where any part of the claim remains denied, or their Designee, on their behalf,may submit a [^b] Voluntary Second-Level Member Appeal [^bo] through the Oxford internal appeal
process to the Grievance Review Board (GRB) within [^b] 60 calendar days [^bo] of receipt of the First-Level Appeal determination letter. The request for appeal and any additional information must be submitted to [^b] Oxford Grievance Review Board,
P.O. Box 29134, Hot Springs, AR 71903 [^bo] (Customer Service telephone number: 1-800-444-6222). The member or Designee will need to include all information requested

previously by Oxford (if not previously submitted), and include any additional facts or information that the member believes to be relevant to the issue. A pre-service or concurrent appeal will be resolved not later than [^b] 15 calendar days [^bo] from the GRB's receipt of the member's request for a Second-Level Appeal. A post-service appeal will be resolved not later than [^b] 30 calendar days [^bo] from the GRB's receipt of the member's request for a Second-Lelvel Appeal. The First-Level Appeal determination letter will also supply members with information about their expedited appeal rights.

[^b] Do I have a right to an External Appeal?

The member may file an external appeal for services that were denied for lack of medical necessity or as experimental/investigational with a life threatening condition. External appeals are initiated by submitting a request for external review to the office of the Insurance Commissioner. The appeal will be reviewed by health care professionals who have no association with us.
The member must first complete the First- and Second-Level Appeal process UNLESS it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life threatening situation. In an emergency or life threatening situation or would jeopardize the member's ability to regain maximum function. An expedited, external appeal can also be requested if the member's request was denied as an experimental or investigational condition and the member's treating health care professional certifies in writing that the requested experimental/investigational treatment would be significantly less effective if not promtly initiated.
In an emergency or life threatening situationthe member, or provider acting on behalf of the member with the member's consent, would not need to complete all internal (First- and Second-Level) appeals in order to file for an external appeal.

To file an expedited external appeal, the member can submit an application with the Connecticut Insurance Department immediately following receipt of the utilization review company's initial adverse determination or at any level of adverse appeal determination. The member can also file an expedited, internal appeal at the same time.

If the expedited appeal is not accepted on an expedited basis, and the member has not previously completed First Level Internal appeal, the member may resume the internal appeal process (on a standard or expedited basis) until all internal appeals are exhausted and then may file for a standard external appeal within 120 days following receipt of the final denial letter.

If all internal appeals were previously exhausted, the member's rejected expedited appeal will automatically be eligible for consideration for standard appeal. The member is not required to submit a new application.

If we fail to adhere to timeframe requirements on any level (Initial Review or Appeal), the covered person is deemed to have exhausted the carrier's internal grievance process and may file an external review, regardless of whether the carrier asserts substaintial compliance or deminimis error.

The external appeals process is not available to members who are covered under a non-governmental self-insured plan or to denials regarding workers' compensation.

The member may have the right to have this denial decision reviewed by health care professionals who have no association with us by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgement as to the medical necessity, appropriateness, health are setting, level of care or effectiveness of the health care service or treatment you requested. The member may contact the Connecticut Insurance Department, Consumer Affairs Unit at P.O. Box 816, Hartford, CT 06142-0816 or at 860-297-3910; Toll-Free: 1-800-203-3447, or Email: cid.ca@ct.gov.[^bo]

[^b] Please note: The following determinations are ineligible for external review: (1) benefit determinations, and (2) other determinations that are not based upon medical necessity or the experimental/investigational exclusion.^bo]

[^b] If my claim still remains denied, what additional right do I have? [^bo]
Members who have obtained their health benefits through an employer group plan may have additional rights under the Employee Retirement Income Security Act (ERISA). ERISA rights do not apply if the membe's coverage for health benefits was (1) obtained through employment with a church or government group or (2) purchased as an individual plan from Oxford. If we have not approved the member's claim after all mandatory internal reviews have been completed, the member may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act.

[^b] Can I obtain a copy of the documents relevant to my denied claim? [^bo]
Members of ERISA plans may obtain copies of the documents, records, and other information relevant to a denied claim. Whether a document is relevant is defined under ERISA. If the member would like a copy of these documents, the member must send a written request to [^b] Oxford ERISA Disclosure Requests, P.O. Box 29133, Hot Springs, AR 71903. [^bo] This information will be provided to the member free of charge.

[^b] Please note: [^bo] A Second-Level Appeal is voluntary under ERISA when the member's First-Level Appeal is expedited. In other words, if the First-Level Appeal was expedited, ERISA eligible members need not complete a Second-Level Appeal to pursue their ERISA rights.

[^b] How can I obtain an interpreter to assist me if I am hearing impaired or I need language assistance? [^bo]
For a hearing impaired interpreter, contact the TTY/TDD line at 1-800-201-4875. Please call 1-800-303-6719 for assistance in Chinese, Mandarin or Cantonese, 1-800-201-4746 for assistance in Korean, 1-800-449-6222 para ayuda en espanol or the telephone number on your Oxford member ID card for assistance in English and other languages.
Interpreters are available Monday through Friday between 8:00 AM and 6:00 PM.