ENFORCEMENT NOTICE E09-39

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceedings by the Commissioner of Banking and Insurance to impose civil penalties and other measures against Oxford Health Insurance, Inc., Reference No. 7678026 and Oxford Health Plans (NJ) Inc., Reference No. 7695506	)))))	NOTICE PURSUANT TO N.J.S.A. 17B:30-55a TO CEASE, DESIST AND REMEDIATE VIOLATIONS

TO: Oxford Health Insurance, Inc.
Oxford Health Plans (NJ), Inc.
48 Monroe Turnpike
Trumbull, CT 06611

This matter having been opened by the Commissioner of Banking and Insurance, State of New Jersey ("Commissioner"), upon information that Oxford Health Insurance, Inc., an insurance company incorporated under the laws of the State of New York and currently authorized to transact insurance business in New Jersey as a life and health insurer, pursuant to N.J.S.A. 17B:23-1 et seq., and Oxford Health Plans (NJ), Inc., a medical service corporation incorporated under the laws of the State of New Jersey and authorized to transact business pursuant to N.J.S.A. 17:48A-1 et seq., collectively referred to herein as "Oxford," may have violated certain provisions of the laws of the State of New Jersey; and

WHEREAS pursuant to the Health Claims Authorization, Processing and Payment Act, N.J.S.A. 17B:30-48, et seq. ("HCAPPA") restricts a carrier's ability to seek reimbursement for alleged overpayments and prescribes on limited conditions under which a reimbursement demand can be based on extrapolation of sampled claims; and

WHEREAS HCAPPA specifically prohibits reimbursement requests based on extrapolation of other claims except: (a) in judicial or quasi-judicial proceedings, including arbitration; (b) in administrative proceedings; (c) in which relevant records required to be maintained by the health care provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or (d) in which there is clear evidence of fraud by the health care provider and the payer has investigated the claim in accordance with its fraud prevention plan and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor ("OIFP"), see N.J.S.A. 17B:27-44.2.d(10) and 26:2J-8.1.d(10); and

IT APPEARING THAT since the effective date of HCAPPA Oxford has repeatedly made reimbursement requests against numerous medical providers and medical facilities based on extrapolation and as a result of audits conducted on behalf of Oxford by outside vendors (see Attachment A); and

IT FURTHER APPEARING THAT Oxford's reimbursement requests have not come under any exception to HCAPPA that would otherwise permit the requests to be based on extrapolation; and

IT FURTHER APPEARING THAT in August 2008, representatives of the New Jersey Department of Banking and Insurance ("Department") initiated a telephone conference with Oxford's regulatory counsel to report complaints of unlawful reimbursement requests based on extrapolation and to communicate the Department's corresponding concerns about Oxford's activities; and

IT FURTHER APPEARING THAT during that telephone conference Oxford indicated that the reimbursement requests were based on Oxford's position that there evidence of fraud on the part of the providers against whom the requests had been made; however when further

questioned by the Department, Oxford admitted that it had not referred any of the underlying matters to the OIFP; and

IT FURTHER APPEARING THAT rather than discontinuing and remediating its unlawful actions, a day or two immediately following the telephone conference with the Department, Oxford made numerous referrals to the OIFP-- referring the providers previously contacted for reimbursement -- in an apparent effort to provide a justification or cure for Oxford's violations of HCAPPA; and

IT FURTHER APPEARING THAT Oxford made such referrals to the OIFP inappropriately, since prior to such referrals Oxford had acted in a manner inconsistent with the position that there was clear evidence that the providers had committed fraud: e.g., referrals had not been made until after Oxford had been contacted by the Department and informed that it was violating HCAPPA; Oxford had made affirmative efforts to negotiate reduced reimbursement amounts with the providers and abandoned previous demands "in the spirit of cooperation;" Oxford allowed the targeted providers to remain in its network to provide medical services to its members; Oxford failed to initiate litigation against any of the providers including those that refused to pay the requested reimbursement, and therefore never brought actions alleging fraud; and Oxford's communications with the providers did not mention Oxford's purported belief that the providers were engaged in fraud -- thus Oxford's conduct was inconsistent with the basis upon which it referred the providers to the OIFP and subjected the providers to potential civil and/or criminal investigations and prosecutions by the New Jersey Division of Criminal Justice; and

IT FURTHER APPEARING THAT in the months following the telephone conference initiated by the Department, Oxford did not discontinue requests for reimbursement based on extrapolation; and

IT FURTHER APPEARING THAT the Department learned that Oxford was also requesting reimbursement based on extrapolation against medical facilities, e.g. hospitals, regarding which Oxford also failed to make referrals to the OIFP; and

IT FURTHER APPEARING THAT when questioned about these facility requests, Oxford stated that its authority for making such requests derived from its contracts with the facilities, and while the Department could not envision a contract that could supersede prohibitions against extrapolation contained in HCAPPA, the Department nevertheless requested copies of the contracts; and

IT FURTHER APPEARING THAT Oxford provided the Department with two contracts with facilities -- the contracts were executed years before the effective date of HCAPPA, did not provide for extrapolation, and in fact contained "conformance with law" provisions, and therefore, Oxford's explanation to the Department attempting to justify reimbursement requests based on extrapolation was inaccurate and misleading because the contractual provisions did not support Oxford's unlawful actions;

NOW THEREFORE IT IS on this 23rd day of June 2009,

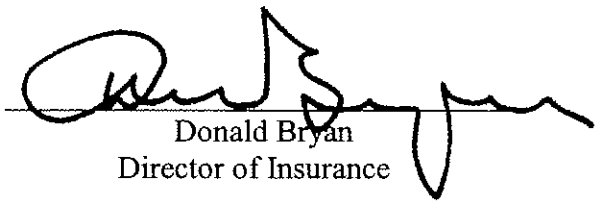
NOTICE IS PROVIDED pursuant to N.J.S.A. 17B:30-55 for Oxford to CEASE AND DESIST from further reimbursement request activity in violation of HCAPPA; and

NOTICE IS FURTHER PROVIDED that within 30 days of the date of this NOTICE, Oxford shall fully remediate its violations by taking measures including but not limited to: reimbursing all affected providers for all amounts obtained in violation of HCAPPA, together with interest at 12%, and submitting supplemental information to the OIFP consistent with its remedial action;

NOTICE IS FURTHER PROVIDED that within 45 days of the date of this NOTICE, Oxford shall submit a report to the Department, to the attention of Lee Barry, Assistant

Commissioner, detailing all remediation efforts and providing supporting correspondence, documentation, payment calculations and proof of payment; and

NOTICE IS FURTHER PROVIDED that the Department reserves the right to seek sanctions against Oxford for each unlawful action taken in connection with its reimbursement requests. N.J.S.A. 17B:30-55 provides for penalties of up to $10,000 per day for violations of HCAPPA.



Donald Bryan
Director of Insurance

ATTACHMENT A

Date: 11/[redacted]/2007

Dr. [redacted]

Dear Dr. [redacted]:

In an effort to review the coding accuracy and appropriateness of claims and encounters submitted to Oxford, we will be conducting an audit of your Oxford patient claims. This audit will review the medical billing and coding for E&M claims as submitted by your office. This information is necessary to administer the plan in which these patients are or have been insured under Oxford Health Plans. We know that providing us with this information can be time consuming and we appreciate your cooperation in the process.

We want to avoid any confusion, and be clear in our process with you. Thus, we wanted to address some common questions you may have:

1. This review of your medical records is part of Oxford's health care operations and is required in accordance with federal and state requirements.
2. **The review is not for purposes of reviewing quality of care**, it is a review to determine the appropriateness of coding used when submitting claims and/or encounters. It is also different than credentialing or various other types of reviews Oxford conducts for other purposes.
3. In accordance with the **Health Insurance Portability and Accountability Act (HIPAA)**, because this is part of Oxford's health care operations, you are permitted to submit records in response to this request without separate authorization from the patients.
4. Even if your practice is **no longer contracted** with Oxford, you are **still required** to provide documentation for periods in which you provided services to a member.

Attached is a list of members whose medical records have been selected for review, and the dates they were members of Oxford. By forwarding the medical records to Oxford you are certifying that they are complete, accurate, and that Oxford may rely on them as such. Only submit **copies** of the records for dates of service within the range provided. It is only necessary to submit the entire medical record if all the services you provided to the member are within the period being reviewed. The records and notes must be legible to anyone with some familiarity with medical terminology. **Legibility** is **the responsibility of the provider** - if your notes and records are not legible to people other than yourself and immediate staff, they must be transcribed, made legible and signed for authenticity. Be sure to clearly stamp or annotate that the medical record is a copy and not the original and to send copies of both the handwritten note as well as the transcribed copy. Also, to ensure we have all pertinent information, remember to copy **both sides of two-sided documents**.

Please submit the requested records within **30 days from the date of this letter**.

Secure Fax: 1-888-740-7520
By Mail: Oxford Health Plans
c/o Parses, Inc.
3350 W. Buschwood Park Dr., Ste. 120
Tampa, FL 33618

Once our review is complete, the results will be shared with your office. At that time, we will be available to discuss any questions or concerns you might have, including any unique aspects of your practice or patient population that might affect the services you provide or the coding of your claims.

Your cooperation is greatly appreciated. If you have any questions, please don't hesitate to contact us at (866) 572-7737

Sincerely,

Maria Pilarinos

Maria Pilarinos
Provider Compliance Analyst

Enclosures: Medical Record Reference Sheet, Instructions.

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

Date: 08/[redacted]/2008

Dr. [redacted]

Dear Dr. [redacted]:

As part of Oxford Health Plans' practice of evaluating and understanding the provision of care provided to our Members, we periodically conduct medical record audits. We know that providing us with information can be time consuming, and we appreciate your cooperation.

A random sample of your Oxford patient files have been reviewed by Parses, Inc., a professional documentation review company. The certified, professional coder at Parses who reviewed the sample records has been performing audits for facilities, providers and insurers for many years, and has extensive training and experience in this area. Oxford's agreement with Parses, Inc. is fully HIPAA compliant and contains a confidentiality provision protecting Member records from disclosure.

Enclosed is a copy of the audit report Oxford received from Parses detailing the Current Procedural Terminology (CPT) codes you submitted for the Oxford patients reviewed and their findings as to the CPT codes that were appropriate. Please note that all medical records submitted were audited using an Evaluation and Management (E&M) coding tool to assure compliance and consistency with Centers for Medicare & Medicaid Services (CMS) Rules, as well as with both the 1995 and 1997 CMS Documentation Guidelines for E&M. The auditors use whichever guidelines are most favorable to the individual physician and specific medical record and claims under review. For your convenience, you can find the 1995 and 1997 CMS Guidelines at: *http://www.cms.hhs.gov/medlearn/emdoc.asp*.

During this review, Parses identified **77 instances** (**out of 140** total instances reviewed) of incorrect Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes submitted by your office. Based on our calculations, this represents an overpayment of **$20,379.81** for all in-office, sick E&M services you rendered to Oxford Members from July 2002 through October 2007.

To assist you in understanding these results, we have enclosed documents showing the statistical methodology followed, the appropriate codes and an audit report detailing Parses' findings. The audit report provides full details for each of the **140** claims reviewed; including information that supports what was used to determine a proper code.

The results of your audit can also be viewed by logging onto [redacted] This secure website will permit you to view electronic images of the medical records together with the detailed audit results for each patient encounter. You will need to enter your provider identification number as your User Name and a password that can be obtained by calling Parses at 1-866-572-7737.

If you believe you have additional pertinent records, please contact Parses at 1-866-572-7737.

Please take time to review the enclosed materials carefully. If you are in agreement with these findings, we are available to work with you to facilitate the return of the excess payment you received. If there are any unique aspects of your practice that were not revealed during the audit, we would be happy to discuss them with you. In order to have a full discussion of any of these findings, it is important that you provide us a detailed written explanation of the following in advance of any scheduled discussion for any specific dates of service you believe were coded incorrectly by Parses:

1. The elements within each medical record corresponding to the history of present illness, past medical history and review of systems that you believe were not captured in the audit.
2. The elements within each medical record corresponding to the physical exam that you believe were not captured in the audit.
3. The elements within each medical record corresponding to medical decision-making, including presenting diagnosis, data reviewed and risk of treatment, that you believe were not captured in the audit.

We will delay any action on this matter for 45 days from the date of this letter, to provide you with the opportunity to review the audit findings and prepare any response you deem appropriate. Once you have had a chance to review the above material, please contact us so we can discuss it. If you would like, we can arrange for a medical director to be included in that conversation. If I can be of any assistance to make this process easier or if you would like more information to help you understand coding practices, please feel free to contact me at 1-800-889-7658, extension 7886. We appreciate your cooperation and responsiveness.

Sincerely,

Maria Pilarinos

Maria Pilarinos
Provider Compliance Analyst

OXFORD
HEALTH PLANS

September [redacted], 2008

[redacted] M.D.

Dear Dr. [redacted]

I am in receipt of your letter dated September [redacted], 2008.

Although you sent in a detailed response to each visit that Parses has reviewed, you did not provide any additional documentation that may support the level of code that you billed.

In good faith, Oxford is willing to offer you a settlement offer of $6500.00 to resolve this matter.

To conclude, if you would like to amicably resolve this matter, please contact me by October 10, 2008.

Sincerely,

Maria Pilarinos
Fraud and Abuse Analyst

203 459 6000
48 Monroe Turnpike Trumbull

OXFORD
HEALTH PLANS

August [redacted] 2006

[redacted] Hospital

Dear [redacted],

A review of Implantable payments were conducted by our vendor OmniClaim Inc. for [redacted] Hospital, [redacted] Hospital and [redacted] Hospital. After a thorough review, it was determined that a combined total overpayment in the amount of **$1,121,847** exists. The details of this review were given to you on August [redacted], 2006 from our vendor OmniClaim Inc. The details of this review are included in the enclosed documentation. We would appreciate your assistance in reimbursing our office for the amount overpaid of **$1,121,847**, as indicated on the attached report. See breakdown below:

[redacted] Hospital: $920,850
[redacted] Hospital: $181,278
[redacted]: $19,719

We ask that you please return the overpayment amount to:

Oxford Health Plans
Attn: Tony Clericuzio
7120 Main Street
Trumbull, CT 06611-9533

Please submit payment with in 30 days. If we do not receive payment within this timeframe, we will begin to offset or your account will be referred to a collection agency. Should you have any questions, please contact me at (203)601-6551.

Thank you for your prompt attention to this matter.

Sincerely,

Tony Clericuzio
Project Manager
Cost Containment and Recovery

CC: [redacted]

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

Date: 11/[redacted]/2008

Dr. [redacted]

RE: RECONSIDERATION

Dear Dr. [redacted]:

Parses, Inc. ('Parses'), on behalf of Oxford Health Plans ('Oxford'), has completed its review of the documentation you provided, including any additional documentation provided at the time of your request for reconsideration.

The enclosed Medical Records Reference Sheet contains a claims-specific summary of the results. Additionally, we have included a complete audit trail for each claim reviewed, which fully discloses the exact findings of the coding specialist. You may also view your results side-by-side with a copy of the medical records you provided by logging into your secure user account at [redacted]
Your **USER NAME** is: [redacted] and your **PASSWORD** is: [redacted].

How the reconsideration process was conducted
This reconsideration review was conducted by a qualified, independent coding specialist, who was not involved in the first review. These coding specialists are nurses, physicians, and certified coders who reviewed the actual medical records you provided, using both sets of the most current Centers for Medicare and Medicaid Services (CMS) Documentation Guidelines for Evaluation and Management Services. By using both the 1995 or 1997 guidelines, the coding specialists are able to provide the highest possible Evaluation and Management code supported by your documentation.

Based on the additional information provided and the results of this reconsideration, we have found 20 dates out of 78 dates of service in error.

In the spirit of cooperation and respect, Oxford has decided not to pursue recovery of the overpayment identified at this time.

Take advantage of this free video series to learn more about E&M coding
We hope your customized audit trails provided you with a valuable educational resource. We are also providing you with 90 days' free access to the PARSES On-Demand Internet Video Library: E&M Documentation Requirements Video Series. This video series is comprised of ten topic-specific streaming videos that range in length from two to eight minutes each.

Video Access: **http:**[redacted]
User Name: [redacted]
Password: [redacted]

Thank you in advance for your cooperation and prompt attention to this matter. Please note that this concludes the regular appeals process and review requirements. Please contact Maria Pilarinos for next steps at 1-800-889-7658, extension 7886.

Sincerely,

Maria Pilarinos

Maria Pilarinos