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December 28, 2006  
Sent Via Certified Mail

Attn: Director of Claims  
Oxford Health Plans  
Clinical Appeals Department  
PO Box 7078  
Bridgeport, CT 06601

Re: Patient:  
Policy:  
Treatment Date: 11-22-2006  
Claim Number:  
Amount: Total Charged - \$320.00 Amount Paid By Oxford - \$108.03

Dear Director of Claims,

**According to your recent payment and explanation letter it appears your company has inappropriately reduced payment which may consequently place the extra financial burden upon the patient, your member.**

**Please accept this letter as a courteous request from our office, on behalf of the patient \_\_\_\_\_, to pay our claim based on the standard usual, customary and reasonable (UCR) rates for this geographic region in order to avoid excessive financial burden to the patient.**

**We'd also like to state that**

1. As you are likely aware, most insurance policies or employee benefits plans fall under either state or federal disclosure laws. Most disclosure laws applicable to insurance contracts and employee benefits plans require unambiguous language related to both in and out-of-network medical treatment. As a general rule, preferred provider arrangements are coverage arrangements where the carrier applies an agreed upon discount to the benefits payments to providers who signed a contract agreeing to such discounts in exchange for **"participating"** status. We have no such agreement.
2. **If your company outlines exclusions, or procedures you do not cover or pay for, you must clearly communicate that to your members so they may know the financial burden will fall on them.**
3. **If your company outlines reductions in payment for certain procedures or has determined an "allowable" amount for certain procedures you must clearly state those figures AND clearly communicate that to your members so they may know that any difference between these rates and the providers charges will be the responsibility of your member.**
4. **As you may know, we do not participate with Oxford Health Plans** and our name would not appear on any list of providers which you distribute. Further, the applicable policy or summary plan document must address how out-of-network treatment will be paid and our office must be paid according to this benefit wording rather than as a **"participating"** provider. Typically, when no contract exists between a provider and insurer, the claim must be paid based on reasonable billed charges rather than a discounted rate.
5. Moreover, **it appears you are in violation of Federal Law by accessing a secondary network** within the patient's primary geographic area. [HCH Health Serv. Of GA, Inc v. Employers Health Ins. Co., 1998]
6. Furthermore, even if you were able to access the secondary fee schedule with Multiplan, our contract with Multiplan, countersigned by the CEO of Multiplan, clearly states that our regular fee schedule has been accepted as the contracted rate. Please see the attached file for your review.
7. **Oxford's decision to unlawfully access the secondary network rates in an attempt to reduce your liability to us for this patient's claim is both unacceptable and egregious.** I have sent a copy of this letter and attached documents to **ERISA as a formal complaint, as a patient initiated complaint and a provider initiated complaint.**

We ask that this claim be paid in full to this office immediately, and that all future claims be processed within the statutes as set forth by the Federal government.

Sincerely,

David Ondrick  
Director of Operations

CC – James Benages, Manager Employee Benefit Security Administration, Boston Regional Office