

Utilization Management Services

OneNet is pleased to offer utilization management services to help our payers keep track of utilization trends and ensure appropriate health care services are delivered in the most appropriate, cost-effective setting. OneNet Utilization Management is provided by CARE Programs, a part of OptumHealth Care Solutions, a UnitedHealth Group company.

Payer Information

Payer Name: _____

Name of Payer Representative: _____ Phone Number: _____

Type of Payer: Insurance Company TPA Self-Funded Group Labor Union / Health and Welfare Fund

For TPAs and insurance companies:
Does this document apply to all groups? Yes No

If no, please list the applicable group name and number below or on an attached sheet for multiple groups. If services vary for groups, separate forms should be used.

Group Name: _____ Group Number: _____

Selected OneNet UM services are for:

- OneNet network participants only
- OneNet network participants and other individuals
- Other individuals (UM access only)

If you are requesting that OneNet provide UM services for individuals who are not OneNet participants, please provide the approximate number of individuals, state(s) in which they reside and, if applicable, the name and toll free number of any PPO networks they may use.

Name of Network: _____

Toll Free Number: _____ Approx. Membership: _____

Residing State(s): _____

Please Note: *Clinical review, pre-certification, pre-authorization and case management services provided through OneNet Utilization Management are based on medical necessity and appropriateness of care. OneNet does not approve or deny claims. Claim payment and the decision to accept or deny a claim are the sole responsibility of the payer.*

For Completion By OneNet PPO

OneNet Account Manager: _____ Phone: _____

OneNet Sales Representative: _____ Phone: _____

Please review the utilization management services described on the following pages and select any additional options that you would like to purchase.

I. Medical and Surgical Utilization Management

OneNet Utilization Management (UM)

Inpatient UM

Comprehensive utilization management for all inpatient hospital admissions and inpatient surgical services. Includes pre-admission review and concurrent review (*Retrospective review is provided when applicable*).

Outpatient UM

Pre-certification and clinical review for outpatient medical services and outpatient surgical procedures specified on the pre-certification list chosen by the payer.

To complete your UM plan, please select your preferences for Second Surgical Opinion, Optional Outpatient Services, Pre-certification, and Durable Medical Equipment:

I. Second Surgical Opinion preference (*applies to Inpatient & Outpatient UM*)

- Second Surgical Opinion is not required
- Second Surgical Opinion is required (SSOP) (if checked, please attach your SSOP list)
 - Yes No If SSOP is required, may OneNet waive the Second Surgical Opinion with the approval of the Medical Director?

II. Pre-Certification List preference: (*select one*)

- OneNet Standard Pre-Certification List (*attachment I; no list changes or customization*)
- Customized Pre-Certification List (*attach copy of list; custom list is subject to review and approval by OneNet*)

III. Optional Outpatient Services requiring Clinical Review and Pre-Certification/Pre-Authorization: (*check all that you would like to include; you are not required to select any of these options*)

- Outpatient Medical Rehabilitation (*physical therapy, speech therapy, occupational therapy, chiropractics*)
- Durable Medical Equipment (*if selected, please specify your DME List preference below*)

IV. Durable Medical Equipment List preference: (*select one if you selected DME as an optional outpatient service*)

- OneNet Standard Durable Medical Equipment List (*attachment II; no list changes or customization*)
- Pre-authorization on DME of \$ _____ or more (*amount applies to each piece of equipment*)
- Customized DME List (*attach copy of list; custom list is subject to review and approval by OneNet*)

II. Case Management

Do you require notification of case management services? Yes No

If yes, please provide the name, e-mail, address and telephone number of the person to notify.

Name: _____ e-mail: _____

Address: _____ Telephone: _____

If you are using another case management company in addition to OneNet, please provide the name and telephone number of your case management company.

Name of Case Management Company: _____

Telephone Number: _____

Select either: **OneNet Standard Case Management**, or **Full Case Management**

OneNet Standard Case Management *(included in standard pricing)*

A Utilization Management event is required to initiate OneNet Standard Case Management services. OneNet Standard Case Management includes non-acute facility pre-admission review, concurrent review for acute care, medical rehabilitation, sub-acute care, skilled nursing facility and inpatient hospice. Services also include medical necessity review of discharge plans, plans of care, home health care (review of skilled nursing visits, infusion therapy, hospice, physical therapy, occupational therapy, speech therapy, dietician/nutritionist, medical social worker, home health aide service, durable medical equipment) and catastrophic medical conditions/events.

OneNet Case Management will verify benefits prior to initiating services, especially if there are questions about a specific benefit.

When benefits questions come from the provider or participant, the caller will be referred to the payer or benefits administrator.

Standard Case Management Add-On Service

Individual Case Management *(additional cost applies)*

Case Management services for specified individuals with catastrophic, chronic or acute medical conditions and events upon payer request. **No UM event is required;** services are performed when requested. Basic Certified Case Management (CCM) / Case Management Society of America (CMSA) criteria are applied to establish whether a person can benefit from case management services. The participant must sign a consent form to participate, as required by law. *(see attachments III and IV)*

- OR -

Full Case Management *(additional cost applies)*

In addition to Standard Case Management services for individuals with UM events, Full Case Management **includes additional service triggers including, but are not limited to, diagnosis, trauma, enrollee self-referral, employer referral, insurance carrier referral, TPA referral and re-insurance carrier referral.** Basic Certified Case Management (CCM) / Case Management Society of America (CMSA) criteria are applied to establish whether a person can benefit from case management services. The participant must sign a consent form to participate, as required by law. *(see attachments III and IV)*

III. Utilization Reports

OneNet Standard Utilization Reports

The following reports are included:

- **Daily Activity Report** – Generated for each certified or non-certified service; report provides demographic information and details of certified/non-certified services for inpatient, outpatient and home health service.
 Check here to receive this report electronically
- **Weekly Summary Report** – Weekly summary of certified or non-certified service for inpatient, outpatient and home health services.
 Check here to receive this report electronically
- **Complex Care Report** – Generated from Case Management (CM) for each certified or non-certified case management service; generated only on days when there is activity to report.
- **Annual Utilization Report** – Includes inpatient, outpatient, home health, durable medical equipment, outpatient rehabilitation and case management utilization, as well as non-certified and appeal reporting. Generated once a year.
- **Appeals Report** – Summary-level report, sent quarterly, containing data on appeals for non-certified services and whether the outcome was upheld or overturned.

Custom Report Requests (additional costs may apply)

We understand that you may be interested in tracking information not included in our standard reports or receiving UM data in a specific format. If you would like to request a custom report format that includes specific UM information (e.g. Quarterly Utilization Report, etc.), please give a brief description in the space below. We will review your request and let you know if we can accommodate you. Pricing will vary depending on the scope of the request and programming requirements.

Attach a sample of your report format and/or an additional sheet if more space is required

IV. Appeals Process

First Level Appeals *(Standard)*

OneNet PPO manages first-level appeals and first-level expedited appeals for UM payers in accordance with state and federal regulations and accrediting agency standards. External consultant (specialty physician) opinions are used in accordance with state and federal regulations and accrediting agency standards.

First Level Appeals

- Are requests by providers or participant for a second review for medical necessity that either confirms or overturns a non-certification recommendation.
- Must be initiated within regulatory timelines from date of receipt of the non-certification recommendation
- Allow providers to submit additional medical information or medical records for consideration
- First level appeals are considered urgent (expedited) if the patient's condition seriously jeopardizes his/her life or health, or his or her ability to regain maximum function; or in the opinion of a provider with knowledge of the patient's condition, causes severe pain that cannot be managed without the proposed care.

OneNet's Responsibilities Are

- To include instructions for initiating an appeal with the initial written notice of non-certification
- Request and review additional medical information offered by the provider once an appeal is requested, as applicable.
- Provide a written notification of the results of the appeal review within regulatory timelines to the payer, participant and provider

Second Level Appeals

- Check this box if your organization elects to have OneNet handle second-level appeals related to utilization management.** If this option is not selected, the payer is responsible for completing all elements of the second level appeals process, including but not limited to: identifying designated personnel to address, receive and respond to all appeal issues; requests for additional information; appeal reviews and decisions; written notification; and all aspects of any further appeals that may be allowed. The payer is responsible for ensuring that the second-level appeal processes are in compliance with all applicable state and federal regulations.

V. Additional Services Available

- Clinical Information for Claims Adjudication** *(additional cost applies)*

Provides the payer clinical information that is intended to assist the payer in adjudicating claims for a proposed treatment or procedure that does not fall under UM review criteria. Clinical information is taken from OneNet's standard resources and does not include obtaining information from outside physicians or consultants.

The clinical information provided by OneNet is for reference only; the payer may not disclose or indicate to the participant or health care practitioner that OneNet provided clinical information or review services.

All administrative functions and notifications associated with the payer's decision are the full responsibility of the payer. These include, but are not limited to, claims payment or denial issues, any appeal processes, verbal and written notification to participants, physicians, and health care practitioners, and utilization management service-related adverse benefit determinations and appeal rights.

Description of Notification Processes

OneNet PPO, LLC is responsible for the initial review for medical necessity and notification process, and the first-level appeal process. As part of these processes, OneNet will notify participants, health care practitioners and payers. OneNet will advise the participant, health care practitioner and payer when the clinical review appeal process is exhausted. Clinical review, pre-certification, pre-authorization and case management services provided through OneNet Utilization Management are based on medical necessity and appropriateness of care. OneNet does not approve or deny claims. Claim payment and the decision to accept or deny a claim are the sole responsibility of the payer. Descriptions of OneNet UM's review, notification and appeals processes are included below:

Adverse Determination Process (Non-certification)

OneNet assumes responsibility for initial written letters communicating non-certification recommendation on behalf of the payer, group or third party administrator. These letters represent the first time OneNet, on behalf of the payer, issues a notification of an adverse determination or an administrative denial (i.e. non-certification due to provider failing to provide information required for medical necessity review). Letters are created and sent to the physician, health care practitioner and participant in accordance with state and federal laws and regulations, and accrediting agency standards. **All notifications occur in accordance with the Department of Labor (DOL) and state regulatory time frames and accrediting agency standards.**

Non-Urgent Pre-admission/Pre-certification Process

Determinations are made after receiving clinical information. When additional clinical information is needed to determine medical necessity, the participant, physician, vendor or health care practitioner is sent a request. The additional information must be sent by the treating physician/health care practitioner, or the participant and his/her representative, and received by OneNet within state, federal and accrediting agency time frames for the receipt of additional information to be considered. Certification or an adverse determination is communicated to the participant or health care practitioner on behalf of the payer. The notice of adverse determination is provided in writing to the payer, requesting health care practitioner, treating facility and participant.

Concurrent Review Process

Ongoing inpatient hospital stays will be reviewed for continued medical necessity. Frequency of the review is based upon initial recommendation of certified days and the severity or complexity of participant's condition and discharge planning activity occurring. Determinations are made after receiving clinical information. When additional clinical information is needed to determine medical necessity, a request is made to the participant, physician, vendor or health care practitioner. The additional information must be provided by the treating physician/health care practitioner, or the participant and his/her representative, and received by OneNet within state, federal and accrediting agency time frames for the receipt of additional information to be considered. Notification of continued stay certification will be communicated verbally to the attending physician or hospital.

Urgent/Emergent Pre-certification Process

Urgent/emergent pre-certification is the expedited review of proposed health care services at the request of the physician or health care practitioner. To be considered urgent/emergent, the proposed services must treat a condition or illness that, without immediate medical attention, would (a) seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, (b) cause the participant to be a danger to themselves or to others, or (c) in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. If a request does not meet the criteria, it does not qualify as expedited review and is reviewed under the non-urgent review process.

With urgent reviews, determinations are made expeditiously and the requesting physician or health care practitioner who is acting on behalf of the participant is notified verbally of the determination. When OneNet determines there is not enough information to complete the review of the urgent/emergent request, the treating physician/health care practitioner or the participant is notified by telephone and in writing (may be via fax) of the specific information required. To be considered, the additional information must be sent

by the treating physician/health care practitioner, or the participant and his/her representative, and received by OneNet within state, federal and accrediting agency time frames for the receipt of additional information.

For urgent/emergent pre-admission/pre-certification requests that result in an adverse determination, the determination is made and verbally communicated to the physician/health care practitioner acting on behalf of the participant. In addition, written or electronic mail confirmation of the determination is provided to the participant, payer and physician/health care practitioner according to state-specific adverse determination notification requirements.

Referral Process for Individual Case Management and Full Case Management Options

Basic Certified Case Management (CCM) / Case Management Society of America (CMSA) criteria are applied to establish whether a person can benefit from case management services. Three attempts will be made to contact the participant (including written information on the case management benefit and program) within five business days of receipt of the referral. The participant must sign a consent form to participate in case management, as required by law. The payer is notified when OneNet is not successful in contacting the participant and in cases of non-compliance.

Procedures for an Extended Stay in a Facility or Additional Health Care Services

For an extended stay in a health care facility or additional health care services, determinations are made in accordance with state and federal regulations and accrediting standards. When OneNet determines that there is not enough information to complete the request, the treating physician or health care practitioner is notified expeditiously of the specific information required by telephone and in writing. An authorization suspension letter is also sent to the physician or health care practitioner, patient and treating facility. To be considered, the additional information must be sent by the treating physician/health care practitioner, or the participant and his/her representative, and received by OneNet within state, federal and accrediting agency time frames for the receipt of additional information. For determinations that result in an adverse determination, the determination is verbally communicated to the physician/health care practitioner acting on behalf of the participant. In addition, written notice is sent to the participant and the physician/health care practitioner.

Procedures for Retrospective Review of Health Care Services

If it is determined that a review of medically necessary services and supplies is necessary after services have been provided to a participant, determinations are made in accordance with state and federal regulations and accrediting agency standards. If OneNet determines there is insufficient information to complete the request, the health care practitioner, or the participant and his/her representative, are notified by mail, electronic mail or fax of the specific information required. To be considered, the additional information must be sent by the treating physician/health care practitioner or by the participant and his/her representative, and received by OneNet within state, federal and accrediting agency time frames for the receipt of additional information. **Ultimately, it is the responsibility of the payer and/or participant to ensure that the information needed to complete the retrospective review is provided to OneNet.**

If the retrospective review of medically necessary services and supplies results in adverse determination, the adverse determination will be verbally communicated to the health care practitioner who is acting on behalf of the participant. In addition, the notice of adverse determination will be provided in writing to the participant and the requesting health care practitioner.

Standards for Written Notification of Adverse Determination (Non-Certification)

Written notice of Utilization Management adverse determinations to the participants of self-funded, ERISA regulated groups and insurance carriers will contain the following information:

1. The detailed, specific, factual basis for the determination, in clear, understandable language.
2. Reference to the specific criteria and standards, including guidelines, on which the determination was based.
3. Upon request, a statement that a copy of the guidelines or criteria will be provided free of charge.

4. The name, business address and business telephone number of the Medical Director or Associate Medical Director, as appropriate, who made the determination. This is not included in letters for ERISA groups.
5. A statement that the Medical Director is available by telephone to discuss the determination with the physician/health care practitioner on behalf of the participant.
6. A statement that the participant, his or her representative, or a physician/health care practitioner on behalf of the participant has the right to file an appeal within prescribed state or federal regulatory time frames of receipt of a prospective, concurrent or retrospective adverse determination.
7. A statement referring the practitioner or participant to the payer for the written details of the participant's health plan benefit and eligibility summary plan.
8. A statement that the participant or health care practitioner filing a grievance on behalf of the participant may file a complaint with employer's benefit administrator in accordance with their benefit design plan.
9. A statement advising participants subject to ERISA of their right to file a civil suit.

First-Level Appeal

At the time a participant and health care practitioner are notified in writing of an initial adverse determination, instructions are provided for filing a first-level appeal. OneNet processes both first-level appeals and first-level expedited appeals in accordance with state and federal regulations and accrediting agency standards. External consultant (specialty physician) opinions are used in accordance with state and federal regulations and accrediting agency standards. OneNet notifies the participant, the physician/health care practitioner and the payer of the determination in writing.

Second-Level Appeals

The payer may select to have OneNet PPO handle any second-level appeals that may occur. OneNet processes second-level appeals in accordance with state and federal regulations and accrediting agency standards, including use of external consultant (specialty physician) opinions when reviewing second-level appeals. OneNet notifies the participant, the physician/health care practitioner and the payer of the second-level appeals determination in writing.

If OneNet is not selected, all elements of second-level appeals are the responsibility of the payer, who must ensure all processes are in compliance with all applicable state and federal regulations.

OneNet PPO Standard Pre-Certification/Pre-Authorization List^{1, 2}

Inpatient Review

All inpatient admissions require review / notification as specified below:

- Emergency / Urgent admissions – notify within 48 hours
- All elective inpatient admissions (i.e. non-emergency) – review/pre-certification prior to admission
- Childbirth: normal delivery/caesarian delivery – notify of planned date of delivery

Outpatient Review

In addition to All Inpatient Admissions, the following procedures, if performed on an outpatient basis, require Clinical Review and Pre-certification / Pre-authorization:

Abdominoplasty / Panniculectomy	Hysterectomy
Angioplasty with Stent Placement (PTCA)	Joint Replacement (hip, knee, shoulder)
Artificial Disc Replacement	Laminectomy/Fusion
Blepharoplasty	Laparoscopic Cholecystectomy
Breast Reconstruction, Non-Cancer Related	Lymph Node Dissection
Breast Reduction	Major Facial Surgeries
Breast Implant Removal	Mastectomy, Non-Cancer Related
CABG – Coronary Artery Bypass Graft	Nissen Fundoplication
Cardiac Catheterization Without Stent Placement	Pelvic Laparoscopy
Cardiac Rehabilitation	Penile Prosthesis
Carotid Endarterectomy	Percutaneous Discectomy
Circumcision, Non-Newborn	Pulmonary Rehabilitation
Congenital Anomaly Repair	Rhinoplasty / Septoplasty
Cosmetic or Reconstructive Surgery	Sclerotherapy
Dental Surgery	Temporomandibular Joint Pain Treatment or Surgery
Discectomy / Fusion	TURP – Transurethral Resection of Prostate
Endoscopic Transthoracic Sympathectomy	Uvulopalatopharyngoplasty (UVPP)
Gastric Bypass	Vagal Nerve Stimulator
Gynecomastia Surgery	Vein Stripping or Vein Sclerotherapy
Hemangioma	Vertebroplasty

1. In all cases, the requestor of services must verify benefits and eligibility with the payer.
2. **This list is subject to change.** Please check with your OneNet account manager for the most current list. All elective surgical procedures will be reviewed by OneNet for medical necessity unless otherwise instructed by the benefit administrator.

Attachment II

Durable Medical Equipment and Orthotic Devices Not Requiring Pre-authorization

OneNet has eliminated the pre-authorization requirements on the following Durable Medical Equipment (DME) and orthotic codes. DME vendors must maintain on file a signed and dated prescription from the ordering physician. The participant's medical records must contain information that supports the medical necessity of the item ordered. The DME vendor and physician or health care practitioner remains responsible for verifying participant benefits and eligibility. **This list is subject to change; contact your OneNet account manager for the most current list.**

NOTE: All other DME and orthotic devices not on this list require pre-authorization.

Code	Item	Code	Item
A4206	Syringe with Needle, Sterile lcc	E0562	Heated Humidifier used with CPAP
A4250	Urine Test or Reagent Strips or Tabs (100 Tabs or Strips)	E0570	Nebulizer (RR or NU)**
A4253	Blood Glucose Test or Reagent Strips per 50 Strips	E0601	CPAP Device (NU or RR)*****
A4255	Platforms for Home Blood Glucose Monitors, 50 per Box	E0607	Glucometer
A4258	Spring-powered Device for Lancet, Each	E0840	Traction Headboard
A4259	Lancets, per Box of 100	E0850	Traction Freestanding
A4565	Sling	E0860	Traction Overdoor Cervical
A4570	Splint	E0870	Traction Frame for Footboard
A4627	Spacer, Bag or Reservoir, with or without Mask	E0880	Traction Stand, Free Standing
A6448 – A6542	Compression Bandages	E0890	Traction Frame Attached to Footboard
A7003	Administration Set – Nebulizer	E0900	Traction Stand, Free Standing Pelvic Traction
A7004	Small Volume Non-filtered Pneumatic Neb, Disposable	E0942	Head Harness for Traction
A7005	Administration Set – Nebulizer	L0120	Cervical Collar
A7006	Administration Set – Nebulizer	L0130	Molded Collar, Thermoplastic
A7013	Disposable Filter for Nebulizer	L0140	Cervical Semi-rigid Collar
A7014	Non-disposable Filter for Nebulizer	L0172	Cervical Semi-rigid Collar
A7015	Aerosol Mask used with Durable Med. Equip. Nebulizer	L0210	Rib Belt
A7030	Full Face Mask used with CPAP	L0500	LSO – Flexible
A7031	Face Mask Interface, Replacement for Full Face Mask	L0515	LSO Elastic with Rigid POS Panel
A7032	Replacement Cushion for Nasal Application Device	L1800	Knee Orthosis, Elastic
A7033	Replacement Pillows for Nasal Application Device	L1810	Knee Orthosis, Elastic with Joints
A7034	Nasal Interface (Mask or Cannula)	L1815	Knee Orthosis, Elastic with Pads
A7035	Headgear used with CPAP	L1820	Knee Orthosis, Elastic Knee Joints
A7036	Chinstrap used with CPAP	L1825	Knee Orthosis, Elastic Knee Cap
A7037	Tubing used with CPAP	L1830	Knee Orthosis, Immobilizer Canvas
A7038	Filter, Disposable used with CPAP	L1902	Ankle Gauntlet
A7039	Filter, Non-disposable used with CPAP	L1906	AFO Multi Lig Ankle Support
A7044	Oral Interface used with CPAP	L1930	AFO Plastic
A7046	Replacement Water Chamber used with CPAP	L2112	AFO – Soft, Pre-fab
E0100	Cane with Tip	L2114	AFO – Semi-rigid, Pre-fab
E0105	Cane Quad	L2116	AFO – Rigid, Pre-fab
E0110	Crutches	L3208	Surgical Boot, Each, Infant
E0111	Crutches	L3209	Surgical Boot, Each, Child
E0112	Crutches	L3211	Surgical Boot, Each, Junior
E0113	Crutches	L3212	Benesch Boot, Pair, Infant
E0114	Crutches	L3213	Benesch Boot, Pair, Child
E0116	Crutches	L3214	Benesch Boot, Pair, Junior
E0130	Walker – Rigid	L3260	Ambulatory Surgical Boot
E0135	Walker – Folding	L3265	Plastazote Sandal, Each
E0141	Walker – Rigid,Wheeled	L3650	Shoulder Orthosis Fig 8
E0143	Walker – Folding,Wheeled	L3660	Shoulder Orthosis Fig 8 Canvas Webbing
E0154	Platform Additions for Walkers	L3670	Shoulder Orthosis Acrimino/Clavicular
E0155	Wheels for Walker	L3700	Elbow Orthoses, Elastic
E0159	Brake Attachments for Wheeled Walker	L3710	Elbow Orthoses, Elastic with Metal Joints
E0163	Commode Chair Stationary	L3800	WHFO Short
E0164	Commode Chair Mobile	L3810	WHFO Thumb Abduction
E0165	Commode Chair, Stationary Detachable Arms	L3815	WHFO Thumb Abduction, Second MP Abduction
E0166	Commode Chair Mobile	L3820	WHFO IP Extension
E0202	Phototherapy (Bilirubin) Light/Blanket (RR)	L3825	WHFO IP Extension, MP Extension
E0561	Non-heated Humidifier used with CPAP	L3830	WHFO IP Extension, MP Extension

Durable Medical Equipment and Orthotic Devices Not Requiring Pre-authorization (continued):

Code	Item	Code	Item
L3835	WHFO IP Extension, MP Spring Extension	L3940	WHFO Palmer, Dorsal Wrist
L3840	WHFO IP Extension, Spring Swivel Thumb	L3942	WHFO Palmer, Reverse Knuckle Bender
L3845	WHFO IP Extension, Thumb IP Extension Assist	L3944	WHFO Palmer, Reverse Knuckle Bender
L3850	WHFO IP Extension, Action Wrist	L3946	WHFO Composite Elastic
L3860	WHFO IP Extension, Adjust MP Flexion	L3948	WHFO Composite Elastic, Finger Knuckle Bender
L3908	WHFO IP Extension, Wrist Extension Cock-Up***	L3950	Combo Oppenheimer Knuckle
L3912	WHFO IP Extension, Flexion Glove***	L3952	Combo Oppenheimer Knuckle
L3914	WHFO IP Extension, Wrist Extension Cock-Up***	L3954	Spreading Hand
L3916	WHFO IP Extension with Outrigger	L4350	Pneumatic Ankle Splint
L3917	Prefab Metacarpal Fracture Othosis	L4360	Pneumatic Walking Boot
L3918	WHFO IP Extension, Knuckle Bender	L4370	Pneumatic Full Leg Splint
L3920	WHFO IP Extension, Knuckle Bender	L4380	Pneumatic Knee Splint
L3922	WHFO IP Extension, Knuckle Bender	L4396	Static AFO for Positioning
L3924	WHFO IP Extension, Oppenheimer	S8095	Wig (Cranial Prosthesis)*****
L3926	WHFO IP Extension, Thomas Suspension	S8185	Flutter Device
L3928	WHFO Finger Extension	S8999	Ambu Bag
L3930	WHFO Finger Extension with Wrist Support	CPT 94772	Pneumogram
L3932	WHFO Finger Extension Safety Pin Spring		Prosthetic Contact Lens V2500-2599*****
L3934	WHFO Finger Extension Safety Pin Spring		Hearing Aids V5030, V5050, V5060, V5120, V5130, V5140*****
L3936	WHFO Palmer		Ostomy Supplies A4361-A4434, A5051-A5131
L3938	WHFO Palmer, Dorsal Wrist		

Diabetic supplies are frequently covered under a participant's pharmacy benefit. To determine if diabetic supplies are covered under the participant's pharmacy benefit or DME benefit, contact the Benefits Administrator listed on the participant's enrollment card.

**No authorization is required for purchase or rental for the following respiratory-related ICD-9 codes: 277.0, 460-519, 786.07, 786.09, 786.1, 786.2.

***Codes L3908, L3912 and L3914 may be specifically excluded by the participant's policy for diagnosis of carpal tunnel syndrome.

****No authorization is required for purchase for the following eye disorder-related ICD-9 codes: 379.3, 379.31, 366-366.9, 743.3-743.39, V43.1, V45.61 and 371.60-371.62 (in lieu of corneal transplant).

*****Coverage is limited to specific group policies. To determine if this item is a covered benefit for a specific participant, contact the Benefits Administrator listed on the participant's enrollment card.

*****No authorization is required for purchase or rental for the following OSA-related ICD-9 codes: 780.50, 780.51, 780.53, 780.57.



Attachment III

Case Management Request Form

For Use With OneNet's Individual Case Management and Full Case Management Service Options

Please complete the patient's information accurately as this information is frequently requested from the provider. If the information provided is inaccurate or incorrect, the provider may refuse to share clinical information citing HIPAA compliance.

Send completed form to: carehelp@optumhealth.com with courtesy copy to: lisa.jacobs@optumhealth.com, kyle.elbert@optumhealth.com, and traci_cross@uhc.com. **Please submit all forms via secure e-mail transmission to assure protection of the patient's personal health information.**

Requestor Information

Request Date: _____

Requestor: _____

Requestor Type: Payer TPA Patient Reinsurance Carrier

Requestor Phone Number: _____

Requestor e-Mail Address: _____

Payer Name: _____

Group Name: _____ Group Number: _____

Subscriber Information

Subscriber Name: _____ Subscriber ID or SSN: _____

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____ Patient Date of Birth: _____

Provider Information

Provider Name: _____ Specialty: _____

Provider Address: _____

Provider Phone Number: _____

Facility Name: _____

Facility Address: _____

Facility Phone Number: _____

Specific Information Requested for Case Management:

Case Management Patient Letter & Consent Form

For Use With OneNet's Individual Case Management and Full Case Management Service Options

Dear [PATIENT NAME INSERTED]:

Your insurance company has contracted CARE Programs, an affiliate of UnitedHealth Group, to provide Case Management services on their behalf. This service is part of your insurance plan at no additional cost to you. Participation in this accredited Case Management Program will enable you to take charge of your health and well-being.

You have been specially selected to participate in the Case Management Program benefit available to help individuals with such conditions as Diabetes, Coronary Artery Disease, Congestive Heart Failure and Musculoskeletal Pain, take better control of their health. The goal of this program is to empower you to improve your overall health and assist you in managing your condition in the best way possible.

Optum CARE Programs' Registered Nurse Case Managers specialize in helping you:

- Navigate through today's complex insurance environment
- Maximize your health care benefits
- Locate community resources that you may be able to use
- Achieve your personal health goals

Please read the enclosed "Introduction to Case Management Services" brochure. This brochure contains valuable information on the services you will receive when you agree to take advantage of this program. We support you on taking this beneficial step towards living a healthier life.

Please call the Registered Nurse at [TOLLFREE NUMBER INSERTED] extension [EXTENSION INSERTED], if you have questions that perhaps were not answered in the FAQ (Frequently Asked Questions) section of the brochure.

I ask that you sign and return the Case Management Consent/Authorization Form that is enclosed along with a self-addressed stamped envelope. By signing this form, you are giving your consent to allow me to provide case management services and to obtain necessary information from your health care providers.

Together, we can make your health plan work harder for you.

Sincerely,

[NAME OF CARE REPRESENTATIVE INSERTED]

CARE Programs

Case Management Dept.

Patient Name: [NAME INSERTED BY CARE]

Nurse Case Manager: [NAME INSERTED BY CARE]

CASE MANAGEMENT AGREEMENT AUTHORIZATION FORM

I and/or my designated representative (spouse, legal guardian) authorize CARE Programs to provide Case Management services to assist in the coordination of health care services I may need.

This authorization is valid for one year or for the time of my health insurance policy coverage, whichever is less.

Member/Guardian Signature

Date

I give permission for my spouse, family member, significant other, or personal representative whose name(s) are listed below, to communicate with the CARE Programs Case Manager regarding my health care.

Please list below the individuals you give the CARE Programs Case Manager permission to speak with about your personal health history and care.

Name

Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____