Voluntary Prior Approval Process

1. You sign this Voluntary Prior Approval Agreement Form upon your initial visit to indicate that you are opting to obtain prior approval for non-participating physical therapy or occupational therapy services that you understand the process, that you agree to the procedures described here and that you authorize your non-participating provider to submit information on your behalf.

2. You ask your non-participating provider to submit a completed one page Patient Summary Form along with this signed Voluntary Prior Approval Agreement Form directly to OptumHealth (fax to 1-866-695-6923). You or your non-participating provider can obtain a copy of the Patient Summary Form by calling OptumHealth at 1-877-369-7564 or by visiting OptumHealth's Web site at *www.myoptumhealthphysicalhealth.com.*

3. OptumHealth will respond to both you and your provider for each Patient Summary Form received, indicating the time frame and services that have been approved or that the services have not been approved.
    a. If the services are approved, you are responsible only for out-of-network cost shares (e.g., deductible and coinsurance amounts).
    b. If the services are not approved and you choose to receive care, you will be responsible for the cost in full. You may appeal that decision by following the procedures attached with the response or as described in your Certificate of Coverage.

4. If your treating provider believes that you need care beyond the approved number of services and/or time frame provided, he/she should submit a new updated Patient Summary Form, including asking you to complete the Patient Section of the Patient Summary Form to assess your progress. *If the new forms are not submitted, the claims will be reviewed retrospectively as described.*

5. If you change non-participating therapy providers and wish to continue to use the Voluntary Prior Approval process, the new provider should submit your new **Voluntary Prior Approval Agreement Form** along with a newly completed Patient Summary Form.

Submission of this form indicates that you understand the Voluntary Prior Approval process; you agree to the procedures outlined in this letter and that you authorize your non-participating provider to submit a Patient Summary Form on your behalf.

Treating Practitioner's Name_____

Clinic Name (if available):_____

Treating Practitioner's Street Address: _____

Treating Practitioner's City, State, ZIP: _____

Treating Practitioner's Tax Identification Number: _____

Treating Practitioner's Phone Number: _____

Member's Name: _____ Member's DOB: _____

Member's ID Number: _____

Member/Guardian Signature: _____ Date: _____

Retrospective Review and Voluntary Prior Approval Process

You have selected a provider who does not participate in the Oxford network. In keeping our commitment to help members get the most out of their health care coverage, we are providing you with important information regarding coverage of out-of-network care.

Understanding the Costs Associated with Out-of-network Care
As part of your Oxford plan, you may receive physical therapy and occupational therapy services on an in-network or out-of-network basis (if your plan has out-of-network benefits). Both in- and out-of-network care is subject to review for medical necessity. Services are considered to be out-of-network when rendered by a nonparticipating physician or health care professional. When you receive care from a non-participating physician or health care professional, your out-of-pocket costs are usually higher than when you receive care from a participating physician or health care professional. In cases where you receive care from a non-participating physician or health care professional, you are financially responsible for paying for all services that are not determined to be medically necessary, as well as the out-of-network cost shares outlined in your Certificate of Coverage.

Finding a Participating Physical or Occupational Therapist
If you would like to find a participating provider, please visit our Web site at *www.oxfordhealth.com* and click on "Search for an Oxford doctor." To request a printed list of physical or occupational therapists in your area, call OptumHealth Customer Service at 1-877-369-7564.

Using a Non-Participating Physical or Occupational Therapist
If you choose to use a non-participating physical or occupational therapist, there are two options available to you for determining coverage, the Retrospective Review process or the Voluntary Prior Approval process.

Option 1: Retrospective Review Process

For services from a non-participating physical or occupational therapist, OptumHealth typically reviews the associated claims on behalf of Oxford, along with your provider's documentation for medical necessity, **after** the treatment is rendered. This is referred to as a Retrospective Review. If a service is deemed to be not medically necessary or not a covered benefit you will be responsible for the costs in full.

1. You or your treating physician or health care professional submits claims to Oxford Claims Department, P. O. Box 7082, Bridgeport, CT 06601-7082
2. OptumHealth will review the claim along with your provider's documentation for medical necessity after the treatment is rendered.
3. If medical notes are not submitted along with the claim, we will send a request to you and your treating practitioner advising that medical notes will need to be provided to support medical necessity. If clinical notes are not received, you will be responsible for the cost of the service.
4. If the service is determined to be medically necessary and you have out-of-network benefits, services will be reimbursed subject to applicable coinsurance and deductible amounts. If a service is ***not*** determined to be medically necessary or not a covered benefit, you will be responsible for the costs in full and have the right to appeal the denial.

Option 2: Voluntary Prior Approval Process - Determining Services that are covered In Advance

To help you make informed decisions regarding your care, we offer an alternative to retrospective review. This option is called **Voluntary Prior Approval**. The Voluntary Prior Approval process enables you or your non-participating provider to request coverage for services **in advance** so that you will know whether the proposed treatment will be covered. This will enable you to make informed decisions about receiving continuing services, to limit the situations where you have to pay for a non-approved service. Once services are reviewed as part of the Voluntary Prior Approval process, they will not be reviewed again on a retrospective basis. Approved services will be reimbursed when you submit your claim. If follow-up Patient Summary Forms are not submitted for continuing care services beyond the initial approval period, the services will be reviewed retrospectively as described above. To avoid this, please ensure that your treating provider submits Patient Summary Forms in a timely fashion. To take advantage of this process, follow the directions below included with the attached Voluntary Prior Approval Agreement Form.

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

[1] MD/DO [2] DC [3] PT [4] OT [5] Both PT and OT [6] Home Care [7] ATC [8] MT [9] Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

(1) Traumatic (2) Unspecified (3) Repetitive (4) Post-surgical → (5) Work related (6) Motor vehicle

Date of Surgery

Type of Surgery

(1) ACL Reconstruction
(2) Rotator Cuff/Labral Repair
(3) Tendon Repair
(4) Spinal Fusion
(5) Joint Replacement
(6) Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° ____ . ____
2° ____ . ____
3° ____ . ____
4° ____ . ____

Patient Type

(1) New to your office
(2) Est'd, new injury
(3) Est'd, new episode
(4) Est'd, continuing care

Nature of Condition

(1) Initial onset (within last 3 months)
(2) Recurrent (multiple episodes of < 3 months)
(3) Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index ____ DASH ____ ____ (other)

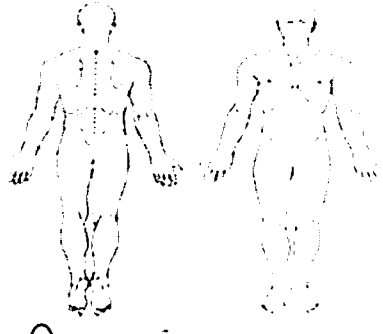
Back Index ____ LEFS ____

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ **Date:** _____