Negotiated Services

Table of Contents

Related Policies

Experimental and Investigational Services and Devices
Guidelines for Utilization Management Policy Development & Revision

Policy Number	**477**
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Current Approval Date:	4/23/20
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Category:	Administrative

Policy Statement

1. Negotiations with non-participating healthcare providers on behalf of eligible health plan members are supported when geo-access standards are not met as determined by Optum* by OptumHealth Care Solutions, LLC.

2. Negotiations with specialist non-participating healthcare providers are supported, when **all** of the following criteria are satisfied:
   - The service meets a defined healthcare requirement for the member
   - The service falls under the jurisdiction of the healthcare provider's professional scope of practice as currently written
   - The healthcare provider has demonstrated competency by successfully completing an in-service certification program offered by an accreditated professional educational institution.
   - There is a reasonable expectation that the delivery of negotiated healthcare services will result in superior relevant health outcomes and/or affords less risk in achieving equivalent health outcomes associated with services rendered by participating providers within the geo-access standard.

3. Member requests for the negotiation of services are **not** supported for any of the following circumstances:
   - The member's health plan benefit does not include coverage for the negotiation of services with non-participating healthcare providers
   - There are participating providers, who offer the same or similar services, identified as accessible to the member.
   - The services to be rendered are solely for the comfort and convenience of the member
   - The request for negotiation of services is based primarily upon service technique preference e.g., a specific manipulative technique, specific exercise approach
   - Services have been determined to be investigational, experimental, and/or unproven
   - There is a reasonable expectation that equivalent health outcomes i.e., effectiveness and safety would be achieved with similar services performed by an accessible participating provider
   - The service is not medically necessary

Purpose

This policy has been developed to describe the criteria that Optum uses to conduct the negotiation of health care services with non-participating healthcare providers, when requested by client health plan members.

Key Policy Question

What are the circumstances that support the approval of the negotiation of services with nonparticipating healthcare provider on behalf of enrolled health plan members?

Summary

- Certain health plans have established procedures that provide for the negotiation for healthcare services on behalf of plan members with non-participating healthcare practitioners when access to participating (network) healthcare providers is unavailable
- Healthcare technology assessment standards can be adapted and applied to inform judgments pertaining to the negotiation process
- The clinical evidence is insufficient (sparse and low quality) to make informed judgments about which specific manipulative techniques are most appropriate for specific clinical conditions

Scope

This policy applies to programs, products, provider types, and settings where Optum is contractually obligated to provide service negotiation.

Definitions

Negotiation: The process whereby Optum acts at the request and on behalf of a member to receive eligible services, which are subject to reimbursement at a mutually agreed-to schedule, from a healthcare practitioner who does not participate as a network provider

In-service certification program: A program of clinical education and practicum, preferably under the direct supervision of a clinician who meets the requirements for specialist certification in a listed specialty, [Table 1] that is sponsored by an accredited institution, which provides certification following the successful completion of the program.

Description

The negotiation process commences once an eligible health plan member contacts the Optum customer service department either by phone or in writing. A designated customer service specialist 1) confirms member eligibility; 2) determines if geo-access standards are not satisfied; 3) consults with a medical director about the clinical appropriateness/necessity of the proposed service(s); and 4) contacts the non-participating provider on behalf of the member to establish willingness to treat, confirm professional competencies, and to negotiate reimbursement.

Background

Overview:
Optum contracts with healthcare providers (participating providers). The minimum number and/or distribution (geo-access standards) of participating providers are generally mandated by contract. In this manner, health plan members are assured of having access to participating healthcare providers.

Health plan member benefits, as described in their *Certificate of Coverage* or *Summary Plan Description*, typically include language promoting the utilization of participating providers. Occasionally, geo-access standards are not satisfied in meeting individual member healthcare requirements. In these circumstances, certain health plans have established procedures that provide for the negotiation for healthcare services on behalf of plan members with non-participating healthcare practitioners.

Professional Designations:
Geo-access of participating providers takes into account professional degrees (doctor of chiropractic, physical therapist, occupational therapist, and speech therapist). Additionally; certain professional specialty designations have been recognized as providing skilled services that extend competencies well beyond those typically attained via core educational training programs. [Table 1] These competencies may include the use and interpretation of specialized equipment.

Clinical Appropriateness/Necessity:
There are generally accepted standards for the assessment of healthcare technologies concerning their application within clinical settings. [1-5] These standards have been broadly categorized: scope of practice, safety and effectiveness, recognition/educational settings, regulatory status, quality and magnitude of research evidence, competency/training requirements, cost effectiveness/utility & reimbursement coding, and special considerations.

These standards can be adapted and applied to inform judgments about the reasonable expectation that the delivery of negotiated healthcare services will result in superior relevant health outcomes and/or affords less risk than services provided by an accessible participating healthcare provider. Elements of a technology assessment can be framed to be suited to aide in the negotiation process. [Table 2]

Scope of practice considerations can usually be determined by reviewing the rules and regulations of the designated professional oversight entity i.e., Board of Examiners. *Safety and effectiveness* assessments are the product of explicit evidence reviews, where the strength of recommendation is based, in part, on the trade-offs i.e., risks vs. benefits. The *recognition* of a technology across professional disciplines, and the *settings* in which education and training are provided aide in making informed judgments about service negotiation. In some circumstances relating to the negotiation of services (i.e., devices), *regulatory approval* (e.g., FDA) is a basic step in technology assessment. A systematic review of the *research evidence* using an accepted grading scheme provides key input in making judgments about the validity, predictive value, and clinical utility of a service proposed for the negotiation process. Demonstration of *clinical competencies*, which is inherent in the credentialing of participating healthcare providers, is a fundamental requirement for successfully conducting the negotiation of services on behalf of a plan member. The nature and limits of a service can, in part, be described by the reporting of Current Procedural Terminology (CPT) or Health Care Financing Administration's Common Procedure Coding System (HCPCS) codes. Procedures that have been assigned *unique CPT or HCPCS codes* are more likely to be supported for service negotiation. *Special considerations* include the judgments in the context of the negotiation process on the variation among services that broadly viewed as being the same or similar e.g., manipulative approach (technique systems), different specific exercise approaches, etc.

Because of the prevalence of requests by members for service negotiations that are primarily due to manipulative technique preferences, a bulleted summary of the research evidence is included in this section. The cited references provide an in-depth critical appraisal of the evidence on the rating and comparative analysis of manipulative technique systems.

- Systematic reviews and expert panels have reported on the characterization and rating of manipulative (chiropractic) technique procedures for common low back conditions.[6,7]
- Those procedures rated the highest are supported by the highest quality of literature.[7]
- Side-posture manipulation technique has the widest base of evidence support for low back pain.[6]
- There is sparse evidence upon which to make judgments that techniques systems taught as part of the core curricula of chiropractic colleges are safer or more effective than techniques taught in elective or post-graduate programs.[8]
- Very little research evidence published by specific innovators and developers of named techniques, with the exception of distraction techniques, has to do with clinical outcomes.[6]
- The clinical evidence is insufficient (sparse and low quality) to make informed judgments about which specific chiropractic treatment techniques are most appropriate for specific clinical conditions.[6]
- Clinical guidelines typically recommend manipulation without specifying particular technical approaches.[9-16]

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Tables

Table 1 Recognized Specialty Designations *(for the purposes of this policy)*

Professional Degree	Specialty Designation
Physical Therapy Occupational Therapy	Lymphedema Therapist
Physical Therapy Occupational Therapy	Pediatric Therapist
Physical Therapy Occupational Therapy	Neurological Disorders Therapist
Physical Therapy Occupational Therapy	Hand Therapist
Physical Therapy Occupational Therapy	Home-Care Specialist

Table 2 Healthcare Technology Assessment Standards

Category	Elements of Assessment
Scope of Practice	• Does the service (technology) fall under the jurisdiction of the professional's scope of practice as currently written? • Does the service overlap or fall under scope of practice for another profession?
Safety & Effectiveness	• Does the service pose any safety concerns? • Does the scientific evidence permit conclusions concerning the effect of the service on health outcomes? (see *Research Evidence*) • Do the trade-offs i.e., risk/benefit favor the service? o Is the service likely to be more beneficial than any established alternatives (offered by participating healthcare providers)? o Can the service be expected to improve the net health outcome more than established alternatives? • Is the service being used in an original, innovative, unique, or off-label manner that is not presently supported by research evidence? o Has the service been shown to be safe and effective outside the investigational settings?
Recognition/Educational Settings	• Is the service recognized for utilization by other health care organizations? • Is the service recognized as acceptable for utilization by other licensed healthcare professions? • Is the service primarily taught in seminars or programs sponsored by the manufacturer, developer, or promoter? • Is the service *required or recommended* by the accreditation standards of any of the relevant professional educational institutions? • Is the service taught either as part of the core, non-core, or post-graduate curriculum in an accredited professional educational institution?
Regulatory Status	• If applicable, does the service have final approval from the appropriate government regulatory bodies
Research Evidence	• Does the scientific evidence permit conclusions concerning the effect of the service on health outcomes? o The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. o The quality of the body of studies and the consistency of the results should be considered in evaluating the evidence. o The evidence should demonstrate that the service can consistently achieve measurable (i.e., moderate to large) treatment effects involving discrete outcomes, and narrow confidence intervals (CI) for a defined population o Positions and evaluations by national professional associations, consensus panels or other technology evaluation bodies should be evaluated and given consideration according to the scientific quality of the supporting evidence and rationale o Clinical evidence and expert opinion provide the basis for summarizing the potential net health outcome
Competency/Training	• Are examinations offered/required, which assess knowledge or competency in the use of the service, by professional regulatory boards or national/international testing services? • Is there a certificate program that demonstrates professional competency in the use of the service? • Are there plausible other means by which competence in the use of the service can be demonstrated?
Cost Analysis & Reimbursement Coding	• Is there research evidence supporting the cost effectiveness or utility of the service? • Is there a broadly recognized CPT or HPCS code for the service? o Is the CPT or HCPCS code unique for the service?
Special Considerations	• Is the service similar to other established and accessible services? o Is the service a variant of an otherwise established and generally accessible service i.e., variation of manipulative treatment technique? o Is there a substantiated basis for anticipating superior outcomes and/or more favorable trade-offs with the use of the service vs. similar accessible services?

Policy History/Revision Information

Date	Action/Description
3/12/2009	Utilization Management Committee approval
4/30/2009	Quality Improvement Committee approval – origination date
4/08/2010	Policy references (17-19) were updated; Quality Improvement Committee annual review and approval
10/26/2010	Policy rebranded to "OptumHealth Care Solutions, Inc. (OptumHealth)"
4/07/2011	Annual review and approval completed
4/19/2012	Annual review and approval completed
4/18/2013	Annual review and approval completed
4/17/2014	Annual review and approval completed; References updated; Policy rebranded "Optum* by OptumHealth Care Solutions, Inc."
4/16/2015	Annual review and approval completed
4/21/2016	Annual review and approval completed
4/20/2017	Annual review and approval completed; Legal entity name changed from "OptumHealth Care Solutions, Inc." to "OptumHealth Care Solutions, LLC."
4/26/2018	Annual review and approval completed
4/25/2019	Annual review and approval completed; no significant changes made to the document
4/23/2020	Annual review and approval completed; no significant changes made to the document

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: policy.inquiry@optumhealth.com with the word "Policy" in the subject line.

The services described in Optum* by OptumHealth Care Solutions, LLC policies are subject to the terms, conditions and limitations of the Member's contract or certificate. Optum reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Optum's administrative procedures.

Certain internal policies may not be applicable to self-funded members and certain insured products. Refer to the member's Summary Plan Description (SPD) or Certificate of Coverage (COC) to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.