



Optum* by OptumHealth Care Solutions, LLC.
2020 Utilization Management Program

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Section 1 - Introduction

The purpose of the Utilization Management Program is to provide clinical support for providers in the provision of evidence-informed treatment of plan members. For this reason, Optum will refer to its application of Utilization Management as Clinical Support. The scope of Optum’s UM Program is physical medicine services, including but not limited to chiropractic, physical therapy, speech therapy and occupational therapy.

The UM Clinical Support Program provides guidance to health care providers in the evaluation, documentation, and treatment of their patients covered under a client health plan. It will meet the standards set by the National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and other accreditation organizations which our clients may require, including but not limited to:

- Timely assessments that are clinically sound and consistent
- Clear, explicit communications to providers and members.
- Simplifying, minimizing or eliminating all unnecessary reporting

Optum will comply with applicable state, federal, and Medicare/Medicaid utilization management regulations, and member health plan benefit coverage documents and clinical policies, which may differ from NCQA or health plan requirements.

1.1 Overview of Clinical Support Program

The Optum “Clinical Support Program” has been designed to assist in the delivery of effective and efficient services emphasizing evidence-informed care. The goal of Clinical Support is to assist providers in delivering, and patients in obtaining optimal outcomes from care, while minimizing inefficiencies and unsupported clinical variance from evidence-informed care. The Clinical Support Program is built upon four core principles:

- **Practice According To Current Best Evidence:** Defining "best practices" in physical medicine and continually setting the information standard.
- **Accountability:** Encouraging providers to be accountable for their services and assisting patients to be knowledgeable health care consumers.
- **Education and Communication:** Engaging providers and patients, where delegated, in a learning culture, supplying them with evidence-informed health and well-being information.
- **Affordable Care:** Keeping costs manageable by streamlining processes and using communication, information and education to lead providers and their patients to a “best practice” health care experience.

The main elements of the Clinical Support Program are described below.

Education and Support

Optum is committed to providing ongoing educational resources to its provider community that promotes the adoption of "best practice" physical medicine care. Clinical education is provided in a variety of ways including local seminars, one-on-one Support Clinician interaction, aggregate data reporting and review, internet resources and newsletters. Communication and education are delivered to health care providers as a means to enhance the process and the quality of care (i.e., care that is effective and efficient resulting in optimal treatment outcomes and high patient satisfaction).

Profiling and Data Sharing

Optum uses data collected from claims and the clinical submissions to create reporting that summarize the processes of care and clinical outcomes of each provider. This reporting is useful to Optum for:

- Recognition of superior provider outcomes and/or efficiencies
- Communication to the Plan of network outcomes.
- Promotion of Physical Medicine inclusion in benefit structure.
- Selection of providers that may benefit from additional educational opportunities.
- Identification of providers with 'unsupported clinical variance', who haven't effectively adopted "best practice" approaches to delivering care.

This information regarding performance is made available to participating providers on a 24/7 basis.

Fundamental to achieving the triple aim^{1,2} of improved experience, health and affordability is:

- timely, valid and reliable point in time and longitudinal measurement of individual provider clinical, administrative, cost, outcomes and consumer ratings performance
- comparison of individual provider point in time and trended performance with that of same specialty colleagues and best clinical evidence
- distribute data via secure portal enabling convenient 365/24/7 provider self-service access to the data resources
- prioritized and collaborative outreach from same specialty Optum Physical Health peers to identify, discuss and facilitate provider improvement in effectiveness and efficiency
- leverage data asset to designate providers into "tiers" which support a variety of initiatives to optimize effectiveness and efficiency of programs focused on improving quality and affordability

1. Berwick, Donald M., Thomas W. Nolan, and John Whittington. "The triple aim: care, health, and cost." *Health Affairs* 27.3 (2008): 759-769.
2. Stiefel, Matthew, and Kevin Nolan. "A guide to measuring the triple aim: population health, experience of care, and per capita cost." *IHI Innovation Series white paper*. Cambridge, MA: Institute for Healthcare Improvement (2012).

To achieve the above, Optum Physical Health aggregates clinical, cost, outcomes, consumer ratings, demographic and administrative data into comprehensive provider data sharing resources that are distributed 365/24/7 via secure data sharing portal. Clinical, outcomes, and demographic data are derived from standardized medical record used by all Optum Physical Health providers. Consumer rating and reviews are derived from the Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

survey³ and a convenient no/low cost acquisition process Optum has developed with a third party survey vendor. At established time intervals business rules are applied against the provider level summarized data to identify, in prioritized order, providers exhibiting performance warranting the investment of clinical resources to initiate outreach to review performance data and to discuss/agree on improvement actions.

3. The CAHPS Clinician & Group Survey (CG-CAHPS). Agency for Healthcare Research and Quality; U.S. Department of Health & Human Services: <https://www.cahps.ahrq.gov/>

Clinical Submission/Notification

The standardized clinical submission or notification process provides Optum with the information necessary for the execution of the UM Program. Clinical data that are consistent, reliable, valid, and clinically-relevant are necessary for making informed judgments about individual patient evaluations, care management, outcomes, and utilization review determinations. From a population-level perspective, data can be aggregated to identify opportunities to improve healthcare quality and value.

1.2 Overview of Utilization Management

Optum uses information established by NCQA and state, federal, and Medicare/Medicaid utilization management regulations, as applicable, which may differ from health plan requirements. For guidelines in ensuring timelines are met, appropriately qualified healthcare professionals are involved in making determinations, and relevant clinical information is consistently gathered. These standards also serve as guidelines for ensuring that members are informed of the clinical rationale for adverse determinations and are apprised of their appeal rights. Federal and state-specific utilization management laws will be followed when they include more stringent requirements than Optum policies and procedures. No aspect of Optum's Utilization Management Program or Quality Improvement/Quality Management initiatives, including Utilization Review, shall contain any financial basis or incentive based on the amount or type of care not authorized. Utilization Management includes the following processes:

- Concurrent, preservice and retrospective service determination
- Clinical review
- Communication of findings
- Management of the appeal process

The scope of the Utilization Management Program consists of a continuum of processes associated with utilization management. These processes include the review of relevant UM metrics and data, actions taken as result of the review including the development of quality improvement projects (QIPs). Results of QIPs are reported to the Quality Improvement Committee.

1.2.1 Clinical Submission and Associated Forms

Optum providers are contractually required to comply with the Optum programs and procedures, including the Utilization Management processes. Optum conducts two forms of Utilization Management:

- *Utilization Review* – for contracted clients where submission of the Patient Summary Form is required i.e., where Optum renders adverse determinations and where appeals rights are provided.

- *Notification* – for contracted clients where the submission of the Patient Summary Form is not required for payment i.e., feedback from Optum is purely informational, and no adverse determinations are made.

The *Utilization Review* process requires contracted health care providers to submit the Patient Summary Form at the beginning of a treatment plan (generally within the first 10 days). Utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review meet plan benefit coverage criteria. The patient may not be billed for covered services not reimbursed due to the health care provider's failure to properly follow Optum's Utilization Review requirements.

Prior to submission of the Patient Summary Form and while the clinical submission is being processed, the health care provider is obligated to provide necessary services to the patient.

The *Notification* process recommends but does not require contracted health care providers to submit the Patient Summary Form at the beginning of a treatment plan. The information submitted is typically used to identify opportunities for focused clinical outreach and support.

1.2.2 Administrative Compliance Assessment

Upon receipt of the clinical submission form (Patient Summary Form), Optum performs various administrative compliance assessments primarily concerning timeliness of submission and compliance with forms instructions, including required elements.

If the submission is missing required information, documented, reasonable attempts to obtain the missing information from the patient's health care provider may be made prior to denying services on lack of information. A response will be sent to the provider indicating the area of non-compliance.

In an effort to keep the member informed, the member also receives a response indicating that the provider did not make a compliant submission and informing them that they cannot be held financially responsible for the provider's omission/non-compliance.

Unless specific regulation requires more stringent timeframe and notification standards, the following will apply to responses regarding non-compliant provider clinical submissions.

The response will be provided within five (5) calendar days of receipt of the Patient Summary form. The written response is sent to the health care provider either by U.S. Mail, facsimile or is available online at <https://www.myoptumhealthphysicalhealth.com> and to the patient by U.S. Mail. In these instances, the Clinical Submission Response includes, but is not limited to, the following information:

- Instructions and telephone number for reaching Optum or the patient's health plan, as appropriate;
- Description of the reason for non-compliance;
- Instructions and timelines for submission of missing information (if applicable) needed to process the request.
- In occasional cases where it is determined that additional information is needed from the patient, the response to the patient will identify the information that is required and will provide instructions to the patient regarding submission of such information. The patient will have, at a minimum, 45 days to submit this information.

1.2.3 Clinical Assessment

Optum has determined that certain cases do not require specific assessment by a Support Clinician. The cases that meet the established conditions are provided with standard recovery milestones based upon the clinical information submitted by the provider. The conditions and milestones are evaluated annually.

For cases requiring clinical assessment, the Support Clinicians conducting reviews are clinical peers of the same specialty as the treating provider. Clinicians use Optum review criteria, their clinical judgment, experience and problem solving skills applied to the patient's unique clinical information to evaluate and render a decision. Optum uses one standard process that applies to both pre-service and post-service clinical assessments. Optum completes all assessments within the established turnaround time of no more than fifteen (15) calendar days or as required by state-specific or CMS regulations.

Clinicians use the following hierarchy of evidence to inform clinical decision making:

1. Specific Health Plan Benefit Coverage, Medical Policy or Clinical Guidelines
2. Optum UM Policy
3. National/Specialty Guidelines and Reports (e.g., AHRQ, USPSTF, ACR)
4. Evidence-Based Health Technology Assessments (developed from evidence-based sources i.e., clinical research publications health plan guidelines specific to area, etc.)

Adverse Determinations (Utilization Review Process)

An adverse determination is a determination that certain services are not covered under the member's benefit contract, including a denial due to a limitation in benefit coverage or an exclusion of benefit coverage. Adverse determinations may be categorized as either administrative or clinical and are rendered by UM staff who have authority to deny coverage. Administrative adverse determinations are benefit denials based upon the member's benefit contract, which require no clinical interpretation (i.e., the patient no longer has medical coverage). Clinical adverse determinations are denials based upon the member's benefit contract that involve a clinical determination regarding appropriateness, necessity and/or efficacy.

It is the responsibility of the Support Clinician to adequately and clearly document the clinical rationale for all adverse clinical determinations. The provider and member both receive a response notifying them of the adverse determination. Unless specific state, federal, or CMS requires other timeframe and notification standards, the following will apply to adverse determinations.

The response will be provided within fifteen (15) calendar days of receipt of the Patient Summary Form or as required by state-specific or CMS regulations. The written response is sent to the health care provider either by U.S. Mail, facsimile or is available online at <https://www.myoptumhealthphysicalhealth.com> and a written response is sent to the patient by U.S. Mail. Notice of Adverse Determination Responses include, at a minimum, the following information:

- Instructions and telephone number for reaching an Optum Support Clinician, or the patient's health plan, as appropriate;
- Description of the action taken and the complete explanation of the grounds for the denial written in plain language that a layperson would understand and which do not include abbreviations or acronyms that are not defined or health care procedure codes that are not explained.

- A reference to the benefit provision, protocol or criteria used to make the determination;
- Notification that the clinical review criteria utilized in rendering the adverse determination is available upon request by the insured or their designee.
- Description of appeal rights including the right to submit other information relevant to the appeal, an explanation of the appeals process including right to member representation, right to submit comments, documents or other information relevant to the appeal, timeframes for deciding appeals and Expedited, External or Independent Review rights, as applicable.

Non-Adverse Determinations

For clinical determinations that support treatment, a date and/or visit milestone is established. If the provider believes that care is necessary beyond the established milestone, the provider is then obligated to use the Patient Summary Form to supply Optum with updated clinical information.

The provider and member both receive a response detailing the re-submission date and/or visit and/or service milestone. Unless specific state, federal, or CMS law requires a more stringent response timeframe and notification standards, the following will apply to cases where a recovery milestone was established.

The response will be provided within fifteen (15) calendar days of receipt of the Patient Summary form or as required by state-specific or CMS regulations. The written response is sent to the health care provider either by U.S. Mail, facsimile, or is available online at <https://www.myoptumhealthphysicalhealth.com> and a written response is sent to the patient by U.S. Mail. In these instances, the response includes, but is not limited to, the following information:

- Instructions and telephone number for reaching an Optum Support Clinician, or the patient's health plan, as appropriate;
- Re-submission in terms of date and/or specified visits and/or specified services.

1.2.4 Reconsideration Determinations

For most plans, when a clinical adverse determination has been made, the physician/provider has the opportunity for a reconsideration i.e., a peer-to-peer review by telephone. The reconsideration process provides an opportunity for the treating physician/provider to discuss the case by telephone with the Support Clinician, who made the adverse determination. Additional or new information exchanged during this conversation may lead to a change in the established recovery milestones (treatment duration and/or number of visits and/or number of services).

The physician/provider will request telephonic reconsideration within 30 days of the clinical adverse determination. Reconsideration related to peer-peer review will occur within 1 business day of the request by the treating provider. An attempt will be made to make available the same Support Clinician, who made the adverse determination. If the original Support Clinician is not available within this time frame, another designated Support Clinician will be involved in the reconsideration request. The designated Support Clinician will make an autonomous determination based on the merits of the current and newly acquired clinical information. If the adverse determination is not reversed upon reconsideration, a first level appeal review may be requested by the provider. A written response with the reconsideration determination will be transmitted within 15 days or in accordance with timeframes specified in state, federal, or CMS regulatory requirements to the treating physician/provider, facility, member or authorized member representative.

1.2.5 Urgent Care/Emergency Services

Although rare within the scope of conditions treated by Optum providers, should a treatment submission meet the definition of Urgent Care as defined by state, federal, or CMS regulations, a verbal notification will be provided to the treating provider within 24 hours of receipt of the request.

If Optum is unable to make a determination on urgent care due to lack of necessary information, we may extend the notification timeframe once, up to 48 hours. Within 24 hours of receipt of the urgent request, we will notify the provider, member or member's authorized representative of what specific information is necessary to finalize the treatment plan, as well as the time period in which to provide the information. The provider, member or the member's authorized representative will be given at least 48 hours to provide the information. Optum will finalize the treatment plan within 48 hours of receiving the information, even if the information is incomplete, or within 48 hours of the end of the specified time period given to the provider, member or the member's authorized representative to supply the information, whichever is earlier.

Emergency services are rare within the scope of conditions treated by Optum providers. Prior authorization is not required.

Section 2 – Governance, Committee Structure, and Staffing

The Optum Senior Executive Management has appointed a Quality Improvement Committee (QIC) which has oversight, in conjunction with the Senior Director, of the UM Program, process, guidelines, appeals and outcomes. The QIC will annually review and evaluate the UM Program and recommend revisions as necessary to assure that utilization processes, guidelines, and initiatives are accurately described in the program and goals and objectives are met. During the annual review, the QIC will also review and analyze data on member and provider satisfaction to identify and recommend action on any improvement opportunities. The QIC is responsible for approving all policies enforced by UM.

The Chair of the UM Committee has responsibility for the oversight and implementation of the UM Program and for the management of support resources in conjunction with the Senior Director.

2.1 Utilization Management Committee

2.1.1 Composition

The UM Committee is a peer review Committee comprised of at least one (1) participating health care provider (non-staff), Utilization Management staff, a Compliance representative and a UM Director who functions as UM Chair. Regional representation of participating health care providers is added as necessary. Professional, licensed specialists serving as consultants may be called as needed for unusual or difficult issues/cases. These specialists may be Chiropractic, Physical Therapy, Occupational Therapy, Medical or other Clinical Providers. Membership selection will give preference to providers who have UM or QM experience. Each member is re-appointed annually by QIC. Selection of the Committee will be made by nomination from the QIC, CCO or Senior Executive Leadership, based on academic background, clinical and professional experience, review experience and managed care

experience. Seventy-five percent of members present at meetings will constitute a quorum. Decision-making will occur through voting on motions made by a simple majority of members present at the meeting.

2.1.2 Responsibilities

The UM Committee is responsible for:

- Oversight and analysis of the UM Program scope, structure and performance
- Annual UM Program description and review.
- Training and assessment for support clinicians.
- Procedural guidelines for support clinicians and appeals process.
- UM decision protocols.
- Timely UM and appeals decisions.
- Consistency of review decisions.
- Compliance with established policies.
- Monitoring of over and underutilization.

The meeting will be held once per year or as frequently as necessary to meet the objectives and requirements of the UM Program objectives. The UM Committee reports to the QIC at each meeting about its oversight and analysis activities and presents proposed new policies, procedures, quality management and improvement activities and issues for consideration.

2.1.3 Program Development and Approval

The UM Program shall be developed by the UM Committee and will be reviewed and approved annually by the QIC. The UM Annual Evaluation will be incorporated into the Annual QI Evaluation. All UM policies, initiatives and procedures will be reviewed by the QIC at their regular meetings. The UM Program leadership will annually evaluate the program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity. It will also annually evaluate the level of involvement of the Senior Director in the UM program. Member and provider satisfaction data will be considered when evaluating the UM program.

2.1.4 UM Program Evaluation

The UM Committee oversees and reviews the UM Program Evaluation under the direction of the UM Chair. The UM Program is monitored through review of the following:

- Member and provider satisfaction survey results.
- Appeal and complaint data
- Utilization initiatives
- Regulatory compliance data

2.2 Staffing and Qualifications

The UM Program is administered through the following positions:

- UM Chair
- UM Director
- UM Senior Director
- Support Clinicians
- Clinical Operations Director
- Administrative Services
- QM Department

Optum will maintain reasonable staff levels to meet quality standards and afford appropriate time for training and development.

UM Chair

The Chair of the Utilization Management Committee is a licensed health care provider who is charged with responsibility for all aspects of the Utilization Management Plan and Program, including:

- Review and approval of Utilization Management Program, policies and procedures at least annually
- Utilization Management Committee activities
- Coordination, review and approval of written clinical criteria
- Conduct annual meetings
- Monitor appeals and complaint data to assess effectiveness of and satisfaction with the UM Program
- Interact with Optum's Credentialing and Risk Management (CRM) program regarding provider performance
- Oversight of clinical administrative staff and approval of administrative policy and procedure
- Oversight and implementation of the UM Program
- Communicate regularly with CCO on UM activities
- Assure adequate resources are available to meet program goals

UM Director

- Manages daily activities of the UM Program
- Is licensed in the practice of specialized field (DC, PT, OT) and authorized to provide the specialty health care service by a state licensing agency in the United States
- Supervisory responsibilities for the UM Clinical staff, including Support Clinicians
- Coordinates Support Clinician selection, training, performance monitoring and auditing
- Oversight of clinical staff
- Monitor for consistent application of criteria by UM clinical staff
- Monitor documentation for adequacy.
- Available to UM staff on site or by telephone.
- A degree in specialized field (DC, PT, OT) from an accredited college or university.
- Minimum of five years clinical practice experience preferred. Prior leadership role, either professional or civic is desirable.

Senior Director

- The Senior Director is a licensed chiropractor or physical therapist who has responsibility for the implementation, supervision, oversight and evaluation of the UM program.

- The Senior Director is also responsible for reviewing the results of the annual projects and UM processes.
- Oversee UM compliance activities - develop expertise, plan operations to ensure compliance with CMS and 50 states' regulatory requirements, approve UM letter language, work with clients to meet UM regulatory expectations, analyze operational impact of law changes, develop policies and procedures to ensure compliance with standards and regulations
- Oversee UM - direct audit prep, represent Physical Health in client, accreditation and regulatory audits, draft response to findings, create/implement solutions to address gaps, work with clients on ongoing issues; monitor issue resolution
- Plan/direct operations to support efficiency and quality in UM administrative processing
- Oversee approval of IT business requirements, direct staff who perform IT request analysis and UAT for clinical operations
- Plan/direct the UM department training program
- Plan/direct UM performance monitoring and reporting activities
- Oversee writing, review, approval of administrative UM policies, procedures, and job aides
- Create and provide ongoing input into FTE model for new business implementations, determine staff needs, plan for increase/decrease in staff, approve job descriptions
- Lead department Vital Sign activities
- Active clinical licensure, ideally in PT or DC. BS, MBA preferred, in health care, or information technology related field

Support Clinician

Clinical assessments are completed by support clinicians licensed within the same specialty as the treating provider. Support clinicians undergo regimented training that results in a clear understanding of the vital component involved in providing clinical support. Clinical support requires a broad understanding of evidence-informed care resources. These resources are used in Optum's clinical review applications to expand the knowledge of current evidence-informed literature and competence in the use of the electronic review tools.

Support clinicians have responsibilities for an extensive level of clinical and administrative tasks including but not limited to:

- Reviewing clinical submissions in a timely manner with appropriate and consistent responses.
- Distribution of clinical support documentation.
- Educating providers regarding healthcare alternatives and applicable benefits.
- Completion of provider interventions to assist participating providers to attain performance expectations.
- Making determinations of medical necessity for managed indemnity and PPO insured individuals.
- Focusing on the complexity, intensity and expected outcomes of the services implemented (not just on diagnosis or claim expenditure).
- Complying with the member's benefit plan design and customer-specific account instructions, as well as state, federal, and CMS mandates.
- Providing network education and negotiation of services rendered by non-network providers.
- Conduct review for Out-of-Network programs.
- Participation in Optum clinical committees.
- Participation in Optum provider education activities.
- Provide assistance to supporting department regarding clinical issues.
- Positions in this function require an active professional license as DC, PT, OT, SLP.

- Unrestricted and unencumbered license in one or more states
- The practitioner must have at least 5 years of clinical experience in the field they have their licensure.

Clinical Operations Director

The Clinical Operations Director is responsible for oversight of the administrative functions associated with UM. Clinical Operations Director responsibilities include but are not limited to:

- Manages administrative services staffing and execution
- Ensures regulatory compliance with processing and notification turn-around-times
- Ensures response letters meet regulatory compliance requirements
- Manages administrative services adherence to accreditation standards and requirements
- Develops administrative policy and procedure

Administrative Services

All administrative personnel involved in the UM process are instructed, evaluated and required to receive periodic training concerning confidentiality of information, policies and procedures of data collection. Audit reports reflecting performance of non-clinical UM staff will be generated and reported. Non-clinical administrative personnel will not render any clinical decisions. They may enforce plan benefit provisions and administrative policy.

Non-clinical staff provide administrative services that support the UR process. These functions include but are not limited to:

- Complete administrative processing/assessment of submissions and notifications
- Update patient health plan information used for administrative and clinical assessment, claims payment, and applying appropriate appeal rights
- Prepare data and records for internal and external audits
- Manage response letter content, generate letters, and coordinate delivery to patients and providers
- Collect, assemble, and disseminate data related to UM Program performance and characteristics

QM Department

Optum QM Department:

- Assists UM in identifying and implementing those processes required by NCQA, CMS or other accreditation or regulatory bodies.
- Develops a systematic reporting process that meets all UM Committee and Program requirements, primarily related to over- and under-utilization and the consistency of the clinical assessment decisions.

2.3 Training Program

All personnel working within the UM Program participate in training to ensure compliance with regulatory requirements and excellence in executing their responsibilities. Training includes:

- Knowledge and application of the UM Program

- Knowledge of plans administered by Optum and any requirements specific to those plans
- General understanding of relevant Optum administrative processes
- Regulatory requirements
- In-depth overview of systems and applications used to perform review processes, including CRS and CDCM
- NCQA and CMS standards
- Integrity, compliance, and confidentiality awareness

Additionally, Support Clinicians receive the following training:

- Review of the Clinical Support Manual and reporting requirements contained within
- Application of the treatment algorithms that have been developed for the management of acute, subacute, chronic, and supportive cases
- Implementation of UM policies and guidelines to assist in adjudication of treatment submissions
- Familiarity with all clinical response codes and their appropriate application

Additionally, Support Clinicians will receive orientation in the principles and procedures of NCQA standards, CMS standards, Integrity and Compliance as well as administrative training to ensure comprehensive understanding of processes and procedures.

2.4 Evaluation Program for Support Clinicians

The Director of Utilization Management is responsible for ensuring that evaluations are conducted at least annually. Opportunities to improve consistency are continuously acted upon. Support Clinicians evaluations are comprehensive in scope, objective, and address the areas listed below:

- Working policies and guidelines affecting Clinical Support and the Utilization Management program.
- Consistent application of Optum Treatment Algorithms and UM criteria.
- Timeliness of the review as measured by turnaround times.
- Appropriate use of notification response codes.
- Compliance with administrative processes.
- Communication skills and issue resolution by review of Communication Logs, complaints, appeals or other pertinent information.
- General review of the employee's performance, including interpersonal issues, work quality/accuracy and productivity.

Section 3 – Confidentiality

Optum's confidentiality policies and guidelines incorporate and comply with the following:

- State, federal, and CMS Regulations
- National Committee for Quality Assurance (NCQA)
- Optum's corporate standards and criteria for health care delivery systems
- Health Insurance Portability and Accountability Act (HIPAA)

Optum's confidentiality policy encompasses all aspects of clinical and administrative operations. All medical and other private information regarding clients, patients, customers, and/or insured persons must be maintained as confidential. Information regarding the claims, medical history and medical condition of plan participants or their dependents must be preserved accordingly. Confidential medical information includes information that identifies, or can be used to identify, any medical condition or type of treatment pertaining to a covered person; this includes information requiring security clearance. Such information is confidential and should never be used or disclosed to others except as required to administer the Plan and not without proper written authorization as required by law. The individuals with job responsibilities involving payment of claims, maintenance of medical records, or the administration and/or audit of benefits may have access to confidential medical information.

Clinical information submitted is accessible to Optum Support Clinicians or other clinical officers, and as necessary, support staff. Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients.

In circumstances where disclosure of confidential medical information is required due to specific business transitions, e.g., a change in the business relationship with the customer, or an outside auditor requests access to specific information, special hold harmless agreements may be required prior to the release of any confidential medical information. Disclosure is otherwise permissible only where required by law.

The UM program will also incorporate the Optum confidentiality policy. Protected Health Information (PHI) will be shared only within Optum on a need-to-know basis. Employees and committee members will sign a confidentiality statement. A breach of this policy may result in corrective/disciplinary actions. Confidentiality monitoring and support of confidential policies related to the UM process are the responsibility of all management staff.

Requests from individuals for PHI will be processed and provided in accordance with applicable state, federal, and CMS laws and Health Insurance Portability and Accountability Act regulations. PHI will not be disclosed or published without the written consent of the individual or as otherwise required by law. Such reference must be dated and contain the signature of the individual who is the subject of the personal or confidential information requested and must have been obtained one year or less prior to the date of the disclosure.

Provider-specific information, that is information wherein a provider's name and professional status and title are stated, is not disclosed to the general public or to entities outside of Optum except as required to administer the Plan. Such disclosure requires prior written notice to the health care provider. Provider-specific information is treated as confidential information and shared within Optum on a need to know basis only within utilization management and quality management and credentialing. The release of any provider-specific data will be in compliance with applicable state, federal, and CMS laws.

Section 4 – Clinical Review Criteria

4.0 Overview

Throughout the utilization management process, Optum utilizes explicit clinical review criteria, in the form of clinical policies, based on sound clinical principles and processes. Optum clinical review criteria are developed to assist in administering plan benefits. These criteria neither offer medical advice nor guarantee coverage. Clinical criteria are reviewed and revised on at least on an annual basis.

Clinical review criteria represent the basis for non-certification utilization review determinations. Upon request, Optum discloses to the patient and/or treating provider the criteria (policy or policies) upon which a non-certification decision was based.

Written clinical review criteria consist of utilization management (clinical) policies that take into consideration plan documents, nationally recognized standards of care established by government regulatory agencies, scientific evidence in peer reviewed literature, evidence-based guidelines, the positions of relevant professional organizations, health technology assessments, broadly accepted care pathways, decision support tools, local delivery system accommodations, and internal utilization data.

Clinical review criteria are applied in conjunction with the specific circumstances applicable to each patient's condition. Along with explicit criteria, decisions and determinations are also based upon the support clinician reviewer's knowledge and judgment on a case by case basis. Clinical reviewers use their clinical judgment when:

- Assessing and evaluating care and services outlined in the health care record.
- Interpreting or applying clinical review criteria.
- No applicable clinical review criteria are available.

Support Clinicians are encouraged to use all available criteria required in making the most appropriate clinical determinations about medical necessity and/or appropriateness of health care services in accordance with the specific benefit plan design.

4.1 Development of Written Clinical Review Criteria

4.1.1 Oversight & Approval

The Utilization Management Committee and Quality Improvement Committee oversee the development and approval of all clinical review criteria utilized by Optum. Initially, development of clinical policies and other criteria takes place under the direction of the Utilization Management Committee. Advisory Councils, and/or ad-hoc work groups designated by the Quality Improvement Committee provide subject matter expertise informing the development of clinical criteria. The Quality Improvement Committee provides final approval of all clinical review criteria. Practicing health care providers are included as members of each of the committees involved in the development and approval of clinical review criteria and policies.

4.1.2 Process

Utilization management (clinical) policies are developed using transparent processes including descriptions of the methods employed to identify evidence, critically appraise research evidence, and rate the evidence. The basis for each policy statement is explicitly derived from information provided by the literature review, pragmatic judgments (whenever the research evidence is sparse, inconclusive, or inconsistent), and the

appraisal of the positions and policies of relevant professional societies and other health care organizations. An explicit methodology is used to align evidence review findings with the terminology stipulated in benefit documents.

Details of the process steps are described in Policy 429 - Guidelines for Utilization Management Policy Development & Revision.

4.2 Dissemination

Approved policies are communicated to providers using various media. Summaries and/or notices about recently approved policies are included in the *provider newsletter*. Policies are posted in an open-access *web portal*. Recently approved policies are communicated to representatives of professional organizations, who are members of the *Optum Advisory Councils*. Providers may request a copy of approved policies at any time via the Provider Support phone line or requesting from a Support Clinician.

Providers can supply feedback about policies on a 24/7 basis via a dedicated email box, which is recorded on each policy.

Plain Language Summaries, appended to key policies, are intended to inform health plan members about the clinical review criteria using straightforward terminology.

4.3 Review and Updating of Written Clinical Review Criteria

The review and updating of clinical review criteria used by Optum is conducted under the oversight of the Utilization Management Committee and Quality Improvement Committee on at least an annual basis.

The review process includes the appraisal of relevant information identified subsequent to the most recent approval of a policy (clinical review criteria). The search strategy, which is described in detail in policy 429 - Guidelines for Utilization Management Policy Development & Revision, employs computer-aided searches of biomedical databases and registries. These include databases that are specific for physical therapy, chiropractic, and complementary and alternative medicine. The identification of ongoing trials and searches of consumer-oriented websites are also components of the literature search.

Documents and information that are identified in the search strategy and are used in the review and updating of clinical review criteria include but are not limited to:

- Research evidence e.g., systematic reviews, experimental and observational studies
- Evidence-based guidelines
- Technology assessments and evidence reports
- The positions and policies of relevant professional societies
- The policies of other health care organizations

Additionally, the consideration of new regulatory requirements and the analyses of internal data contribute to the review and updating of clinical review criteria.

4.4 Application of Clinical Review Criteria

Clinical review criteria are applied in the context of individual patient care management and benefit coverage. Standardized clinical forms submitted by the health care provider and/or patient health care records are evaluated by a qualified clinical peer reviewer (support clinician). Clinical review criteria are employed in conjunction with support clinician judgment to arrive at determinations regarding the medical necessity of the requested services, the appropriate level of the requested services, and the outcome of care (for continuing care).

Section 5 – Appeals

5.0 Appeal Rights

Optum shall comply with those standards established by governmental regulatory bodies and accreditation organizations to ensure the right of the insured, the insured's designee and/or the insured's health care provider to appeal an adverse decision. Optum shall not take any action with respect to a patient or a health care provider, that is intended to penalize the insured, the insured's health designee, or the insured's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse decision.

5.1 Standard Appeals

Provider appeals may be filed in writing, or by telephone, and must be filed within the timeframe specified by the applicable state or federal guidelines, and must include all necessary information to file the appeal from said determination.

Member appeals may be requested by the member, member's authorized representative, or a provider acting on behalf of a member; and will be allowed at least 180 days after notification of the denial to file an appeal or as allowed by state, federal, and CMS requirements. The member is also given the opportunity to submit written comments, documents, records and other information relevant to the appeal. First level clinical appeals will be reviewed by a Support Clinician not involved in the previous reviews and not a subordinate of the original reviewer. The review process will include the following:

- Appeal determination will be made and written notification of the appeal decision will be sent to the health care provider and patient and/or the patient's designee within fifteen (15) (pre-service) or thirty (30) (retrospective) calendar days of receipt of the request for appeal or as allowed by state, federal, and CMS requirements;
- Notification shall include, if the original adverse determination is upheld, the clinical rationale for such decision and
- Notification of the right to appeal all first level appeal decisions, including the enrollee's right to external appeal (when appropriate in accordance with state, federal, and CMS regulations) and instructions on how to do so.
- Failure on the part of Optum to make an appeal determination within the applicable time periods in accordance with state, federal, and CMS regulations shall be deemed to be a reversal of the original

adverse determination. Written notification of the appeal determination will be sent to the health care provider, and patient and/or the patient's designee.

If additional information is required in order to conduct the appeal, the following guidelines are followed:

- Clinical information will be requested of the provider and shall include only that information needed to make the appeal determination.
- All requests for additional/necessary information will be made at the same time, if possible.

If, as a result of the level one appeal, the original determination is upheld, in whole or in part, a second level appeal review may be requested in writing or by telephone, as allowed by state and federal guidelines. Second level appeals, when delegated to Optum, will be reviewed by a clinician who has not made a previous determination regarding the care being appealed and who is not subordinate to a clinician whose determination is included in the appeal. For those states that require a panel determination in a second level appeal, one will be provided. Appeals must be filed within thirty (30) calendar days of the receipt of the level one appeals determination or as allowed by state, federal, and CMS requirements. The review process will include the following:

- Appeal determination will be made within and written notification of the appeal decision will be sent to the health care health care provider, and patient and/or the patient's designee within fifteen (15) (pre-service) or thirty (30) (retrospective) calendar days of receipt of the request for appeal or as allowed by state, federal, and CMS requirements
- Notification shall include, if the original adverse determination is upheld, the clinical rationale for such decision.
- Notification of the right to appeal all first level appeal decisions, including the enrollee's right to external appeal (in accordance with state, federal, and CMS regulations) and instructions on how to do so.
- Failure on the part of Optum to make an appeal determination within the applicable time periods in accordance with state regulations shall be deemed to be a reversal of the original adverse determination. Written notification of the second level appeal determination will be sent to the health care provider, and patient and/or the patient's designee.

5.2 Expedited Appeals

Where the health care provider believes that the clinical condition of the patient warrants an expedited appeal for continued, extended or additional services, requests for an expedited appeal may be made by telephone, via facsimile or by mail. Procedures followed for an expedited appeal include:

- A clinical peer reviewer other than the Support Clinician who rendered the original adverse determination shall review the expedited appeal
- Optum Support Clinicians will be accessible within 24 hours of receiving notice of the expedited appeal.
- Notification of determinations on expedited appeals will be made by telephone to the provider and/or member, as required, within 24 hours of the decision or as allowed by state, federal, and CMS requirements. Written notification of determinations on expedited appeals will be provided to the health care provider, and the patient and/or the patient's designee within 3 calendar days of our receipt of the request for review of an adverse benefit determination or as allowed by state, federal, and CMS requirements. The expedited appeal decision may be appealed through the standard appeals process if the expedited appeal has not resolved the difference of opinion for continued treatment.

- Failure on the part of Optum to make an expedited appeal determination within the applicable time periods in accordance with state, federal, or CMS regulations shall be deemed to be a reversal of the original adverse determination. Written notification of the appeal determination will be sent to the health care provider, and the patient and/or the patient's designee.

5.3 External Appeals

When appropriate and in accordance with applicable laws, Optum has implemented an external appeals process to meet state, federal and CMS requirements.

An external appeal is a request for an independent review or reconsideration of services denied by a health insurance carrier for medical necessity or experimental and investigational reasons. Reviews are conducted by external appeal agents that are certified by the state and have a network of medical experts to review the denial.

If Optum receives notice that an external appeal has been requested, Optum will provide all requested information to the independent reviewer that is conducting the review as required.

When Optum is informed of the outcome of the independent review, if the original denial is overturned, Optum will update our systems accordingly to allow for additional payment of services that were previously denied.

Section 6 – Availability

Optum maintains a telephone system and toll-free telephone numbers for patient and health care provider telephone communications. The system has the capability to receive and process all telephone calls received. These calls are directed to the appropriate personnel or are forwarded to a specific individual's voice mail. After hours telephone calls include instructions for the use of the voice mail system and handling of emergency situations. Voice mail is required to be retrieved at least daily and responses made within one business day regarding patient care. Optum provides TDD/TTY and language assistance as needed.

Optum's phone system is maintained Monday through Friday between the hours of 7:00 a.m. and 5:00 p.m. local time. Support Clinicians, the Director of Utilization Management and the Senior Director are available a minimum of 40 hours per week during normal business hours to discuss patient care and to respond to telephone requests. In addition, all peer reviewers have voice mail 24 hours per day, 7 days per week and are required to monitor it and respond within one business day regarding patient care.

Optum Support Clinicians are available to discuss any aspect of Optum's Utilization Management Program with patients, where delegated, the patient's authorized representative, or the health care provider. Optum staff members are trained in telephone etiquette to identify themselves by name and title when answering a call and by name, title and company name when placing a call.

Section 7 – Delegation

Not Applicable. Optum does not delegate any UM functions or processes.

Section 8 – Member/Subscriber Contract

Health Plans delegate utilization management to Optum. The Health Plan is responsible for disclosures to patients and prospective patients. Optum will assist Health Plans in developing disclosures and is contractually obligated to comply with Health Plan requirements.

Section 9 – Definitions

Authorized Member Representative: An authorized member representative is a person who the member has authorized to represent their health interests and to act on their behalf. Optum may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of the member. In the case of a request involving urgent care, a health care professional, with knowledge of a member's condition is permitted to act as the authorized representative of the member.

Clinical Support Program: The overall goal of the Optum Clinical Support Program (CSP) is to provide collegial feedback to providers to support the current Best Practice treatment protocols for health care members. The primary focus is on education and support. The Clinical Support Program places the focus on provider accountability. Case clinical submission is required within the program and the provider receives a written response. Additional hallmarks of the CSP are peer-to-peer interactions in regard to aggregate practice data, as well as case-specific data.

Expedited Appeal: an appeal of an adverse determination in a case involving urgent care

Medical Necessity: Optum applies the definition of medical necessity that exists under the patient's medical benefit plan unless specific state, federal, or CMS law requires other specific language.

In general, medical necessity is defined as health care services and supplies that Optum defines as:

- Necessary to meet the basic health needs of the covered person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health service.

- Consistent with scientifically based guidelines of national, professional, research, healthcare coverage organizations or government agencies.
- Consistent with the diagnosis of the condition.
- Demonstrated through prevailing peer-reviewed medical literature to be either:
 - * Safe and effective for treating or diagnosing the condition for which their use is proposed.
 - * Safe with promising efficacy in a clinically controlled research setting and using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.

Medical Appropriateness: Medically appropriate means that:

- The expected health benefits from a medical service are clinically significant, and exceed the expected natural history of recovery, and the expected health risks by a sufficient margin.
- The service is demonstrably worth doing and is superior to other health services, including no service.
- Expected health benefits include: improved level of function and meaningful relief of pain.

Routine service decisions for determining medical necessity and/or appropriateness follow standard protocol and the Support Clinicians, the Directors of Utilization Management and the Senior Director, or their designee, are available to discuss patient care and respond to phone calls.

Support Clinician: a clinical peer licensed in the same specialty area as the treating provider who has an active, unrestricted license.

Urgent Care: Urgent care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Section 10 – State Specific Addenda

Optum maintains state, federal, and CMS specific addenda to the UM Program.

Section 11 – Revision and Approval History

Date	Action	Description
11/11/1996	Origination date	
5/21/1997	Update and approval	
9/22/1997	Update and approval	
3/24/1998	Update and approval	
6/18/1998	Update and approval	
1/28/1999	Update and approval	
2/23/2000	Update and approval	
6/15/2000	Update and approval	
3/07/2001	Update and approval	
9/04/2001	Update and approval	
9/20/2002	Update and approval	
1/31/2003	Update and approval	
11/11/2003	Update and approval	
3/30/2004	Update and approval	
5/26/2004	Update and approval	
10/18/2004	Update and approval	
2/14/2006	Update and approval	<ul style="list-style-type: none"> - Multiple edits incorporated to reflect the <i>Clinical Support Program (CSP) UM model</i> - SECTION 2 – GOVERNANCE, COMMITTEE STRUCTURE, and STAFFING revised to describe the role and responsibilities of the <i>National Director of Utilization Management</i> and the <i>Senior Executive Leadership</i> - The role and responsibilities of the <i>Support Clinicians</i> were explicitly described - Sub-section 5.1 – <i>Standard Appeals</i> was revised to include adherence to state and federal regulatory requirements - Section 9 – DEFINITIONS: the definition for <i>Clinical Support Program</i> was added - Section 10 – STATE-SPECIFIC ADDENDA: GA and KY added
12/04/2006	Update and approval	<ul style="list-style-type: none"> - Page 13 – Revised last paragraph in Section 5 - APPEALS to indicate review by a clinician and use of a panel when necessary by state law. - Additions to Section 10 – STATE ADDENDA: New Jersey and Rhode Island

4/10/2008	Update and approval	<ul style="list-style-type: none"> - Sub-section 1.2.1 – <i>Clinical Submission and Associated Forms</i> revised to reflect changes in forms’ titles
11/11/2008	Update and approval	<ul style="list-style-type: none"> - Rebranded: OptumHealth Care Solutions – Physical Health; amended section 5.1 and 5.2 in compliance with CT-DOI
3/12/2009	Update and approval	<ul style="list-style-type: none"> - Revised timelines in sections 1.2.4 and 5.2 to reflect NCQA and URAC compliance - Revised section 2.2: Clinical Operations Manager and Administrative Services descriptions amended to reflect more integral role of operations department in supporting UM/UR; removed references to National UM Director - Revised section 2.3: Training Program description now includes both clinical and administrative operations training details - Removed footer section with limited revision history and added section 11 with full revision history, Revision and Approval History - Removed references to “Patient Health Questionnaire” to reflect new 1 form process
7/30/09		<ul style="list-style-type: none"> - Added date and signature field to page 22
3/11/10		<ul style="list-style-type: none"> - Changed the term “evidence-based” to “evidence-informed”. - Added bullet points to describe our UM process. - Added language about determination response inclusions – criteria, benefit provision, etc. - Added a 30 day timeframe to reconsideration determinations - Added a sentence about emergency service review. - Made changes to the Appeals section – timeframes and appeal response detail - External Appeal language was updated
9/21/10		<ul style="list-style-type: none"> - Rebranded entire document with new licensed entity name, OptumHealth Care Solutions, Inc. (OptumHealth)
1/27/11		<ul style="list-style-type: none"> - Updated to reflect public sector business application – CMS/Medicare references throughout. - Significant revision of section 4 and correlating

section of the table of contents.

4/7/11	Annual review and approval	<ul style="list-style-type: none">- Changed emergent care TAT from <i>up to 72 hours</i> to <i>24 hours</i>.
12/8/11	Update and approval	<ul style="list-style-type: none">- Added "Physical Health" to the title page- Updated Standard Appeal Section (5.1) with: Member appeals may be requested by the member, member's authorized representative, or a provider acting on behalf of a member; and will be allowed at least 180 days after notification of the denial to file an appeal or as allowed by state, federal, and CMS requirements.
4/19/12	Update and approval	<ul style="list-style-type: none">- Deleted individual state references in the Addenda section and replaced with general Addenda reference.
9/13/12	Update and approval	<ul style="list-style-type: none">- Rebranded document to Optum/OptumHealth,- Added "local delivery system" reference- Deleted retrospective emergency service review paragraph.- Changed UMC meeting frequency from 4x annually to 2x annually
4/18/13	Update and approval	<ul style="list-style-type: none">- Reformatted document – cover page- Added accreditation references- Added "Medicare/state" reference language- Changed Admin oversight lead from Manager to Director
10/17/13	Update and approval	<ul style="list-style-type: none">- Removed NCQA accreditation specific references
3/1/13	Update and approval	<ul style="list-style-type: none">- Replaced all "OptumHealth Care Solutions, Inc." text with "Optum".
3/1/14	Update and approval	<ul style="list-style-type: none">- Replaced "OptumHealth Care Solutions, Inc." text with "Optum by OptumHealth Care Solutions, Inc."- Amended Adverse Determination requirement text to read: "Notification that the clinical review criteria utilized in rendering the adverse determination is available upon request by the insured or their designee »- Added CCO professional credentials
3/1/15	Update and approval	<ul style="list-style-type: none">- Updated table of contents – pg. 2- Added reference to CMS/federal/state – throughout- Added Triple Aim related paragraphs – pg. 4- Added concurrent review – pg. 5- Added new NCQA required health literacy text – pg. 7

		<ul style="list-style-type: none"> - Clarified clinical reconsideration as peer-peer review – pg. 8 - Added review of satisfaction data to QIC responsibility – pg. 9 - Added Clinical Operations Director to staffing list – pg. 11 - Added annual evaluation of UM SCs – pg. 14 - Removed URAC from the confidentiality list – pg. 14 - Added provider ability to request clinical policies – pg. 16 - Removed appeal 30 day language and added applicable state/federal guideline use – pg. 18 - Clarified second level appeal notification – pg. 19 - Added patient/member detail to expedited appeal process – pg. 19
3/1/16	Update and Approval	<ul style="list-style-type: none"> - Added TDD/TTY/language assistance service detail – pg. 19 - Revised Triple Aim text and reference – pg. 4 - Added CAHPS reference and revised clinical sub text – pg. 5
3/1/17	Update and Approval	<ul style="list-style-type: none"> - Replaced OptumHealth Care Solutions, Inc. with OptumHealth Care Solutions, LLC. - throughout
3/8/18	Update and Approval	<ul style="list-style-type: none"> - Added speech therapy to the physical medicine services – pg. 3 - Deleted duplicate word, “survey” – pg. 4 - Added “or is available online at https://www.myoptumhealthphysicalhealth.com” to 1.2.2 Administrative Compliance Assessment – pg. 6, to Adverse Determinations – pg. 7, to Non Adverse Determinations – pg. 8 - Replaced CCO with UM Director who functions as UM Chair – pg. 9 - Added Oversight “and analysis” of the UM Program “scope, structure and performance” to UMC Responsibilities (2.1.2) – pg. 9 - Updated meeting frequency from twice to once per year, “The meeting will be held once per year or as frequently as necessary to meet the objectives ...” – in UMC Responsibilities (2.1.2) - pg. 10 - Added updated NCQA language, The UM Committee reports to the QIC at each meeting about its “oversight and analysis” activities and presents proposed new policies, procedures, “quality management and improvement” activities and issues for consideration - in UMC Responsibilities (2.1.2) - pg. 10. - Added sentence, “The UM Committee oversees and reviews the UM Program Evaluation under the direction of the UM Chair.” to UM Program Evaluation (2.1.4) – pg. 10. - Updated UM Chair responsibilities, Conduct “annual” meetings –in UM Chair (2.2) – pg. 10. - Updated the title of policy 429 to “Guidelines for Utilization Management Policy Development & Revision” – in section 4.1.2 Process – pg. 15 and 4.3 Review and Updating of Written Clinical Review Criteria – pg. 16.
10/4/18	Update and Approval	<ul style="list-style-type: none"> - UMC per electronic vote approved the following updates: Removed sentence, “Clinicians use Optum review criteria, their clinical judgment, experience and problem solving skills applied to the patient’s unique clinical information to evaluate and render a decision.” from section 1.2.3 Clinical Assessment – pg. 6. Added to

section 1.2.3 Clinical Assessment – pg. 7, “Clinicians use the following hierarchy of evidence to inform clinical decision making:

1. Specific Health Plan Benefit Coverage, Medical Policy or Clinical Guidelines
2. Optum UM Policy
3. National/Specialty Guidelines and Reports (e.g., AHRQ, USPSTF, ACR)
4. Evidence-Based Health Technology Assessments (developed from evidence-based sources i.e., clinical research publications health plan guidelines specific to area, etc.)”

10/18/18 Update and Approval - QIC meeting vote approved the following updates:
 Removed sentence, “Clinicians use Optum review criteria, their clinical judgment, experience and problem solving skills applied to the patient’s unique clinical information to evaluate and render a decision.” from section 1.2.3 Clinical Assessment – pg. 6. Added to section 1.2.3 Clinical Assessment – pg. 7, “Clinicians use the following hierarchy of evidence to inform clinical decision making:

1. Specific Health Plan Benefit Coverage, Medical Policy or Clinical Guidelines
2. Optum UM Policy
3. National/Specialty Guidelines and Reports (e.g., AHRQ, USPSTF, ACR)
4. Evidence-Based Health Technology Assessments (developed from evidence-based sources i.e., clinical research publications health plan guidelines specific to area, etc.)”

3/14/19 Update and Approval - Added, "The scope of the Utilization Management Program consists of a continuum of processes associated with utilization management. These processes include the review of relevant UM metrics and data, actions taken as result of the review including the development of quality improvement projects (QIPs). Results of QIPs are reported to the Quality Improvement Committee." – in section 1.2 Overview of Utilization Management – pg. 5
 - Added, “and are rendered by UM staff who have authority to deny coverage.” – in section Adverse Determinations (Utilization Review Process) – pg. 7
 - Added, “The UM Program leadership will annually evaluate the program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity. It will also annually evaluate the level of involvement of the Senior Director in the UM program. Member and provider satisfaction data will be considered when evaluating the UM program.” - in

- section 2.1.3 Program Development and Approval – pg.10
- Added, “ Monitor for consistent application of criteria by UM clinical staff, Monitor documentation for adequacy, available to UM staff on site or by telephone “ – in section UM Director – pg. 11
- Added, “The Senior Director is a licensed chiropractor or physical therapist who has responsibility for the implementation, supervision, oversight and evaluation of the UM program. The Senior Director is also responsible for reviewing the results of the annual projects and UM processes.” – in section Senior Director – pg. 11
- Removed “to providers” from sentence, “Optum provides TDD/TTY and language assistance to providers as needed.” – in Section 6 Availability – pg. 20

3/12/20

UMC Update and approval

- Changed year to 2020 from 2019
- Expanded the Table of Contents to be consistent with other areas of the Table of Contents
- Page 11 UM Director: second bullet inserted in the practice of specialized field (DC, PT, OT). Added 2 bullet points:
 - A degree in specialized field (DC, PT, OT) from an accredited college or university.
 - Minimum of five years clinical practice experience preferred. Prior leadership role, either professional or civic is desirable.
- Page 12 Senior Director – 10 bullet points added:
 - Oversee UM compliance activities - develop expertise, plan operations to ensure compliance with CMS and 50 states' regulatory requirements, approve UM letter language, work with clients to meet UM regulatory expectations, analyze operational impact of law changes, develop policies and procedures to ensure compliance with standards and regulations.
 - Oversee UM - direct audit prep, represent Physical Health in client, accreditation and regulatory audits, draft response to findings, create/implement solutions to address gaps, work with clients on ongoing issues; monitor issue resolution.
 - Plan/direct operations to support efficiency and quality in UM administrative processing.
 - Oversee approval of IT business requirements, direct staff who perform IT request analysis and UAT for clinical operations.
 - Plan/direct the UM department training program.
 - Plan/direct UM performance monitoring and reporting activities.

- Oversee writing, review, approval of administrative UM policies, procedures, and job aides.
 - Create and provide ongoing input into FTE model for new business implementations, determine staff needs, plan for increase/decrease in staff, approve job descriptions.
 - Lead department Vital Sign activities.
 - Active clinical licensure, ideally in PT or DC. BS, MBA preferred, in health care, or information technology related field.
- Page 13 Support Clinician – added 3 bullet points:
- Positions in this function require an active professional license as DC, PT, OT, SLP.
 - Unrestricted and unencumbered license in one or more states.
 - The practitioner must have at least 5 years of clinical experience in the field they have their licensure.

4/23/20

QIC Update and approval

- Changed year to 2020 from 2019
- Expanded the Table of Contents to be consistent with other areas of the Table of Contents
- Page 11 UM Director: second bullet inserted in the practice of specialized field (DC, PT, OT). Added 2 bullet points:
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 - Oversee UM - direct audit prep, represent Physical Health in client, accreditation and regulatory audits, draft response to findings, create/implement solutions to address gaps, work with clients on ongoing issues; monitor issue resolution.
 - Plan/direct operations to support efficiency and quality in UM administrative processing.
 - Oversee approval of IT business requirements, direct staff who perform IT request analysis and UAT for clinical operations.
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DATE: 04/20