ALERT® (**AL**gorithms for **E**ffective **R**eporting and **T**reatment)

Certification of Outpatient Benefits and Care Advocacy Processes

As a newly contracted Optum clinician, we anticipate that you will have questions about our standard operating procedures. To that end, we want to make sure that you are aware of our outpatient care advocacy processes.

This insert presents a few of the key elements involved. For additional details, please contact Network Management at 877-614-0484, or go to our clinician website, providerexpress.com, select the "Contact Us" link in the menu bar on the far right of the home page, and scroll down to the Network Management section for additional contact information.

Authorization of Benefits

Authorization of routine outpatient psychotherapy services

When members contact Optum to obtain referrals, they receive a letter containing an Open Authorization number, which is valid for use with any network clinician for routine outpatient services. The Open Auth is valid for a maximum of 12 months from the date of issue up to the benefit limit, subject to the member's continued eligibility and terms of his or her benefit plan.

When scheduling an appointment with a member, you should confirm that the member has obtained an Open Auth. Registered users of our clinician website, providerexpress.com, can verify that an Open Auth exists (or request one if necessary). To register for access, click on the First-time User link on the home page. Some services such as psychological testing, home health visits, and disability treatment are not covered under the open authorization process. You can look up benefit information on providerexpress.com, or you may call the number on the back of the member's insurance card to verify or request authorization. All treatment certified by Optum must be clinically necessary and evidence-based.

Re-Authorization of outpatient services

The initial Open Auth is valid for 12 months, up to the maximum number of sessions allowed by the member's benefit plan, as long as the member's eligibility remains active. If the initial certification expires and the member is still in treatment, request a new authorization on providerexpress.com, or by calling the number on the back of the member's insurance card.

Outpatient Care Advocacy Process

Optum utilizes a nationwide consumer-directed, outcomes-informed and evidence-based care advocacy model called ALERT® (Algorithms for Effective Reporting and Treatment). A questionnaire called the Wellness Assessment (WA) is used, along with claims data, to obtain standardized clinical information about each of our members in outpatient treatment. The WA was initially developed in collaboration with the National Institute of Mental Health, and screens for psychiatric symptoms, substance use conditions, and functional impairments. Copies of the WA are available for both adults and youth, in English and Spanish, on the Forms page of providerexpress.com. As well, network providers can access a pre-populated form by logging in and clicking on ALERT. You may also obtain copies by calling the Forms Hotline at 1-800-888-2998, ext 5759. Please note that over time, photocopying diminishes our ability to

successfully process WA responses. Therefore, it is recommended that you download WA forms on a regular basis.

Member outcomes will be reported back to you in aggregate (in addition to any member-specific follow-up you may receive), and will become part of your quality profile with Optum. Clinician participation rates in administering the WA are included in reviews of clinician performance.

Please note that for Optum clinicians who are licensed at the Masters and Doctoral level, compliance with the ALERT process is a contractual obligation. Psychiatrists and advanced practice nurses with prescriptive privileges are encouraged, but not required, to participate in this process.

If you have questions about Optum's outpatient care advocacy practices, please visit the ALERT page on www.providerexpress.com for more information.

ALERT: Routine Outpatient Care Advocacy Process

- Member calls Optum or accesses www.liveandworkwell.com, our member website, to request authorization (when the benefit plan requires it for outpatient treatment). If the benefit plan does not require prior authorization for outpatient services, member will still be able to call for referrals.
- Optum provides referrals to in-network clinicians based on clinical and geographic needs. An Open Auth is generated, if necessary, allowing the member to see any Optum-contracted clinician for routine outpatient psychotherapy services.
- Member calls the clinician directly to schedule an appointment. When applicable, member brings a copy of the authorization letter to the initial appointment. If member does not bring the letter or has not already obtained authorization (and auth is required), clinicians should contact Optum to obtain a copy or to initiate an Open Auth. Registered users of providerexpress.com may use the Auth Inquiry and Auth Request functions. Or clinicians may call the number on the back of the member's insurance card.
- Clinician provides the one-page Wellness Assessment (WA) to each new member, or to the parent/guardian of a child or adolescent patient.
- Clinician promptly returns each completed WA to Optum as instructed on the form.
- A second WA is administered, preferably at session 3, but may be administered at session 4 or 5 instead.
- Optum reviews the WA and alerts the clinician if a targeted risk is identified. The treating clinician will either be notified by letter, or contacted by a Care Advocate to discuss the case or assist in coordinating additional services.
- Some targeted risk factors identified after the review of the second WA may result in the clinician being asked to administer a third WA at a later point in treatment.
- A follow-up WA will also be sent by Optum directly to the member approximately four months after the initial evaluation.