Optum | UnitedHealthcare Community Plan

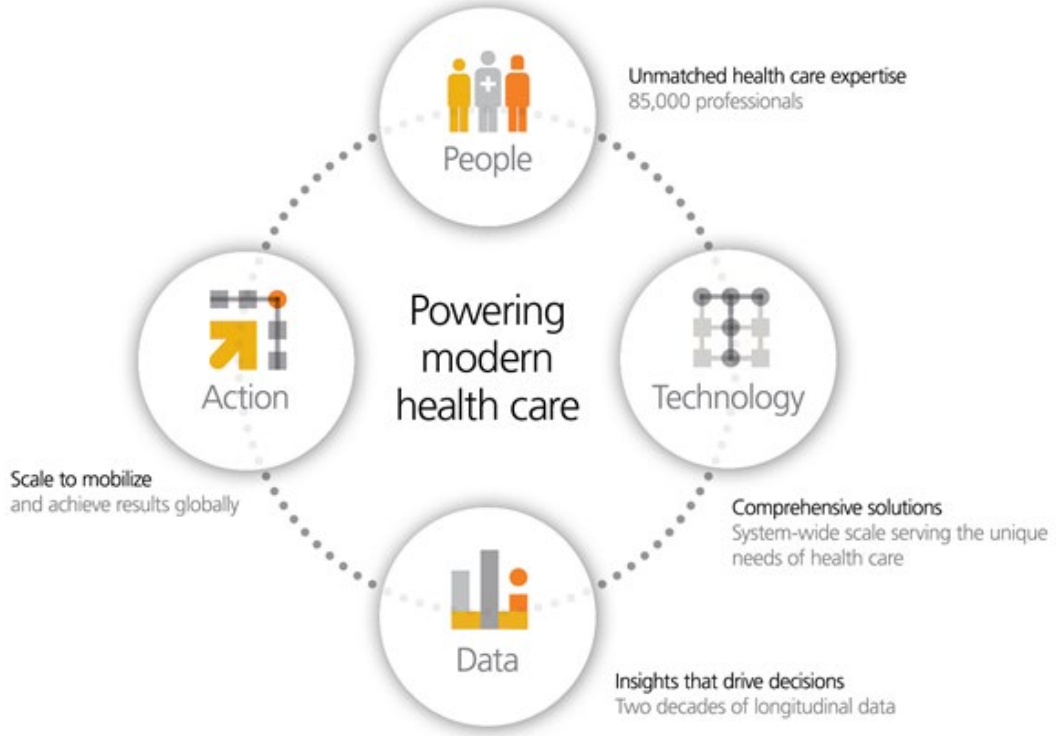
Outpatient Care Engagement

Arizona Provider Training

Optum with UnitedHealthcare

Who is Optum?

- Optum is a collection of people, capabilities, competencies, technologies, perspectives and partners sharing the same simple goal: to make the health care system work better for everyone
- Optum works collaboratively across the health system to improve care delivery, quality and cost-effectiveness
- We focus on three key drivers of transformative change:
  - engaging the consumer
  - aligning care delivery
  - modernizing the health system infrastructure



Optum and You

Achieving our Mission:

- Starts with Providers
- Serves Members
- Applies global solutions to support sustainable local health care needs

From risk identification to integrated therapies, our mental health and substance abuse solutions help to ensure that people receive the right care at the right time from the right providers.

Outpatient Care Engagement: Program Overview

What is Outpatient Care Engagement?

- Optum is tasked with providing utilization management for routine outpatient and community-based services.
- This program engages in utilization management using claims analysis to identify cases for which treatment intensity is higher than average. Members with higher treatment intensity often have more complex clinical needs.
- The purpose of Outpatient Care Engagement utilization management processes is to ensure that covered members are receiving the most effective, efficient, and necessary care to meet the member's individual needs.
- The goal of the Outpatient Care Engagement utilization management program is to facilitate a discussion between Optum and the treating provider for those cases outside the typical range of utilization.
- Outpatient Care Engagement decreases provider administrative burden by removing prior authorization. In addition, up to 90% of all routine and community-based outpatient cases proceed forward without any interaction between the treating provider and Optum staff.
- When Outpatient Care Engagement identifies a case as having high or frequent utilization, a licensed clinician will call the treating provider to initiate a clinical case discussion. These discussions are designed to be collaborative, with the purpose of ensuring that the member is receiving evidence based and medically necessary treatment.
- In situations where treatment does not appear to meet the Optum Clinical Criteria, Optum staff will schedule a conversation between the treating provider and an Optum licensed peer reviewer.
- Based on member clinical needs and Optum Clinical Criteria, the peer review discussion may result in continued payment of services or in a partial or full denial of further routine outpatient treatment.

Outpatient Management

In Scope Services: Individual/Group/Family Therapy; Individual Counseling (H0004), Peer Support (H0038), Skills Training and Development (H2014), Psychoeducational Service (H2027), Home Care Training (S5110), Case Management (T1016)

The Process:

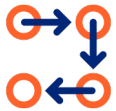
For Outpatient as well as home and community-based services, outpatient analytics enable targeted interventions at the case level.

Inputs

Claims Data

Analysis

Outpatient analytics identify cases for targeted intervention



Actions

- Outreach to provider to ensure evidenced based practice
- Clinician to clinician telephonic review
- Ensure care meeting clinical guidelines

Results

- Improved clinical outcomes
- Improved clinical systems

Outreach to Providers

No more than 10 cases per outreach for each provider unless otherwise agreed upon

A provider will not be outreached to more than 3 times week

Outpatient Care Engagement team will make 2 outreach attempts to the provider within a 14-day period.

If no response has occurred, a Notice of Extension Letter will be sent to the member and the provider allowing an additional 14 days for the provider to respond with the medical documentation. If no response is received, the case will be referred to the internal peer review team.

Outpatient Review: Key Components

Clinical Status of the Member

- Diagnosis
- Symptoms that support the diagnosis
- Degree of impairment that results from the symptoms
- Existence of risk issues
- Environmental Stressor
- Medical co-morbidity

Appropriateness of Treatment

- Length of treatment
- Frequency of sessions
- Type of therapy/treatment approach
- Nature of treatment goals
- Appropriateness of treatment goals for the stage of treatment
- Special Interventions used to achieve the treatment goals
- Incorporation of adjunctive treatments into the treatment plan
- Progress made in treatment
- Obstacles to progress
- Projected future course of treatment

Medical Necessity: Care Advocacy Intervention Script

1. Authenticate Caller with caller's name and two pieces of member's personal identifying information

2. Discuss reason for call: "This call is part of the Optum Outpatient Care Engagement Program. As a part of managing this member's benefit plan, we contact you when our records indicate you have seen a client for outpatient mental health and we will need to do a clinical review in order to discuss the medical necessity of his/her continued care."

3. Clarify Current Mental Health Status
   - Presenting issue
   - Diagnosis and supporting symptoms
   - Risk issues including suicidal or homicidal concerns and substance abuse
   - Risk and/or history of higher level of care

4. Discuss Functional Impairments over Time (FIT); Not intended to ask every question. Use questions as applicable to the specific clinical story

Functional Impairment Over Time				
Functional Areas	Over Lifetime	Start of Episode/Treatment	Progress (Based on FIT)	Goal
Work/School Social/Play Family/Relationships Activities of Daily Living Other Other	• How long have they experienced these problems? • How old were they when they had their first problem in this area? • Has this ever been an issue in their past? • How do they usually function in this area? • Have there been times they were doing better? • When this happened in the past, what worked to get them back on track? • Have they ever received treatment for these issues?	• How were the symptoms impacting their <functional area> when they started treatment? • Were any issues at <functional area> the main reason they sought treatment? • Were they having any problems in the area of <functional area>? • Were there any changes in how they normally perform <functional area>? • Were there concerns from others around them? • What did the member identify as their concerns?	• How has it gotten better or changed? • How much has this increased or decreased? • How has the progress been? Any Set Backs? • How are they doing now? • Does the member feel like they have made progress? • What has helped them to make this progress? • What types of interventions have worked well? • Are they taking any medications that help? • How do they utilize their support system? • What types of skills are they learning?	• So what do you see as the outcome of treatment in terms of this issue? • What is the member hoping that will happen? • What will this look like at the end of treatment? • What do you anticipate the progress going forward? • How long to you anticipate this will take? • Have they ever received treatment for these issues?

5. Discuss provider's intervention plan including verification of best practices including:
   - Intervention type & modality
   - Community supports
   - Current medications and/or psychiatric consult

Questions & Answers

1	**What are the possible outcomes of the care advocacy review?**	• Close the intervention as meeting medical necessity • Recommend modifications to the treatment plan for the member to support evidenced based practices • Refer for peer review
2	**What are the possible outcomes of the peer review?**	• Treatment is determined to meet medical necessity • Agreement to modify the treatment plan for the member based on evidenced based practices • Clinical determination that services either partially or fully do not meet clinical guidelines for coverage
3	**Are Optum Care Advocates and Peer Reviewers licensed in the state of Arizona?**	• All Care Advocates are licensed MFT, LPC, LCSWs licensed in the state of Arizona • Peer Reviews are completed by or review and signed by an Arizona licensed Psychiatrist
4	**Will the provider and the individual receive documentation on any denials/reduction in services from Optum?**	• Verbal notification is given at the time of the decision to the treating provider. • Documentation of denials/reduction of services are also mailed to the provider and the member. Appeals and AZ Grievance process are included.

Questions & Answers

5	**What if the provider does not respond to the outreach attempt?**	• After the 2nd outreach attempt, the Care Advocate will forward the case for peer review to determine medical necessity based on available clinical information • Non-response may result in an adverse benefit determination due to lack of ability to substantiate medical necessity
6	**What if the member has an exacerbation of symptoms or clinical presentation changes?**	• Please call the Outpatient Care Engagement team at 1-855-469-7622 to inform of a change in clinical presentation • The Optum Care Advocate will review the change and refer to peer review or remove any claims stop for the services needed
7	**Is there anything that can be done to reduce the amount of time it takes to complete reviews?**	• Reviews should average 15 to 20 minutes • Providers should review the member's chart, applicable clinical coverage guidelines and slides 8 & 9 of this power point deck • Please contact stem.ca.admin@optum.com with any issues regarding longer than typical reviews and/or care advocate feedback
8	**How can we obtain a copy of the Care Advocate scripts?**	• Please contact your network manager who can send a copy of the care advocate scripts or see slides 8 & 9 of this presentation

Questions & Answers

9	**What is the appeals process?**	• For Arizona there are two levels of appeals; the initial level and then the State Fair Hearing Process • Appeals and AZ Grievance process are included with the denial letter. For more information, please see Chapter 14 in the AZ-Provider Manual: https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/AZ-Provider-Manual.pdf
10	**Does the OP Care Engagement process limit the number of units approved?**	• A peer review determination may limit the number of units based on the clinical presentation • In all other cases, CMHCs should provide services based on members' individual needs

Q&A