Optum Physical Health Online Determination Letters

National Advisory Forum (NAF)

03/24/2016

Online Accessible Clinical Determination Letters

Overview

In an effort to align with provider preference for receiving clinical determination letters electronically, effective April 22, 2016 the Optum Portal will include provider determination letter view/print self-service capability. Providers may access clinical determination letters via secure login online at www.myoptumhealthphysicalhealth.com.

Exceptions

- "Online waiver" approved providers will continue to receive determinations via fax
- No change to member communication process – **members will continue to receive determination letters via mail**

Benefits

- Decreased provider administrative cost (eliminates fax printing)
- Convenient and secure access to determinations
- Decreased receipt time of determinations
- One stop shop for all Optum related documents and processes (PSF and claim submission, newsletters, plan summaries, fee schedules, policy documents, etc.)

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Provider Communications

Notifications

- Q4 2015 and Q1 2016 PH Newsletter article - posted to Portal and emailed to providers
- November 2015 and February 2016 – emailed and faxed to providers
- Early April 2016 reminder letter – will be emailed and faxed to providers
- March 23, 2016 National Advisory Forum presentation - National call/WebEx
- Submission confirmation will include reminder that determination letter may be accessed online within applicable state turnaround time requirements

Additional Assistance

- Providers may call Optum Provider Services at (800) 873-4575 with questions regarding clinical submission, determination letters, connectivity issues, and waiver review
- Electronic Connectivity Unit (ECU) – offers one-to-one website instruction, providers may email webassistanceoptumph@optum.com for an appointment

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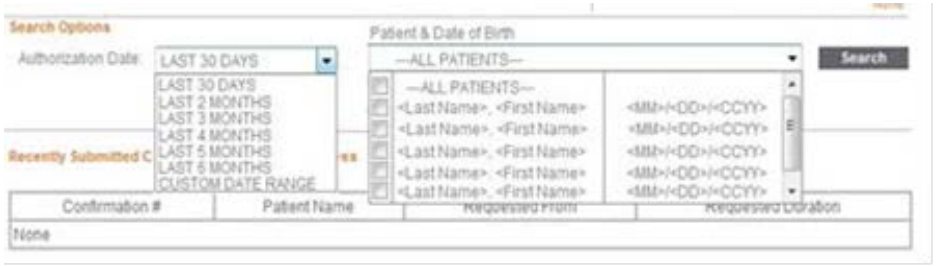
Accessing Clinical Determination Letters Online

The following steps describe how providers may access the Provider Portal and view/print Optum clinical determination letters:

1. Go to www.myoptumhealthphysicalhealth.com
2. Enter your provider ID & password
3. If you need a provider ID or password, click below the login button
4. Click “Clinical Subs & Claims”
5. Click “Clinical Sub Status”
6. **Select applicable search criteria: authorization date(s), patient name(s), DOB**



7. **Click “Letter” to view and/or print clinical determination letter**

Reference Number	Patient Name	Date of Birth	Requested From	Status	Letter
15731737	<Last Name>, <First Name>	DOB <MM/DD/CCYY>	9/10/2014	Completed	Open Letter
15208390	<Last Name>, <First Name>	DOB <MM/DD/CCYY>	5/7/2014	Completed	Open Letter
14681290	<Last Name>, <First Name>	DOB <MM/DD/CCYY>	1/8/2014	Completed	Open Letter

Chiropractic Per Diem Implementation

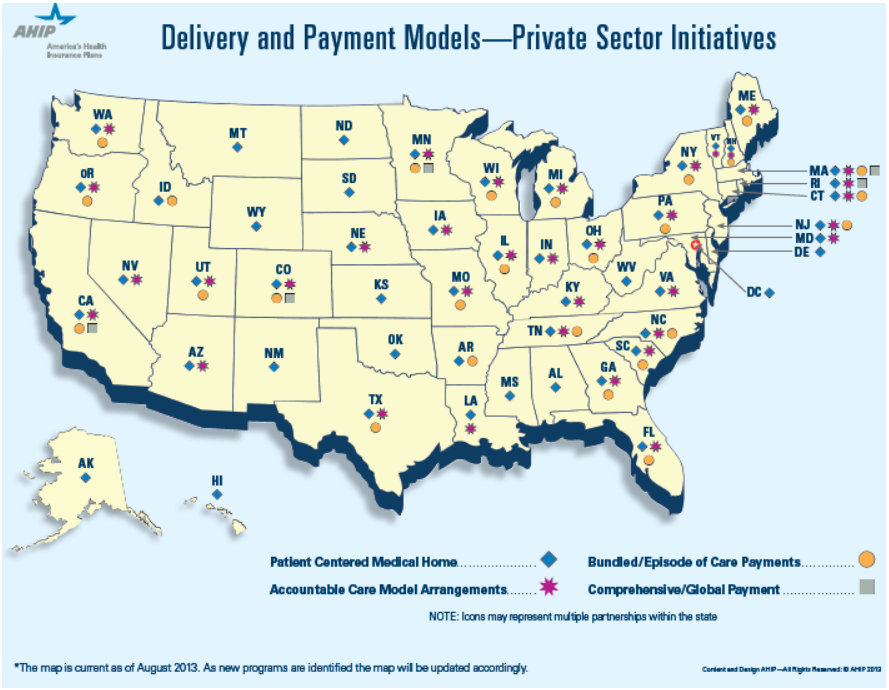
David Elton, DC – Senior Vice President Clinical Products
Amy Wright, PT - Chief Clinical Officer

Industry on Payment Reform

"Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives."

The National Commission on
PHYSICIAN PAYMENT REFORM

March 2013



HBR.ORG
Harvard Business Review
OCTOBER 2013

THE BIG IDEA
The Strategy That Will Fix Health Care

Providers must lead the way in making value the overarching goal by Michael E. Porter and Thomas H. Lee

AHIP
America's Health Insurance Plans

"Fee-for-service couples payment to something providers can control – how many of their services, such as MRI scans, they provide – but not to the overall cost or the outcomes. Providers are rewarded for increasing volume, but that does not necessarily increase value."

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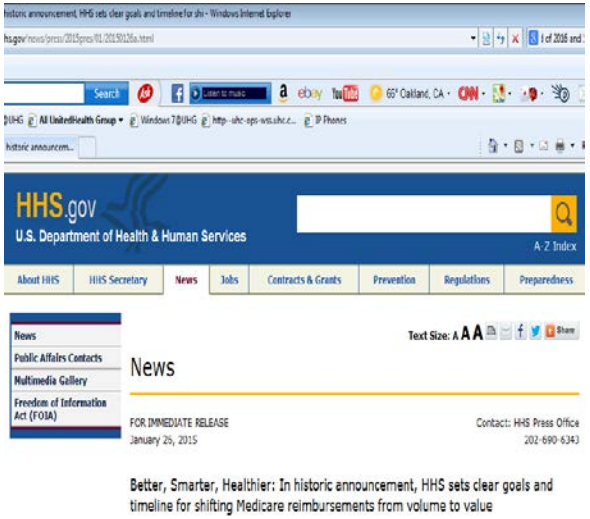
HHS and UnitedHealthcare on Payment Reform

"HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments."



"In just a few short years, debates on provider payment reform have emerged from technical obscurity to national prominence. Payment reform is now seen as self-evidently fundamental to U.S. health reform, quality improvement and cost containment. No national health policy prescription is complete without the exhortation to move from a health care system that pays for volume to one that pays for value."

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Continuum of Health Care Payment Methods

Limited provider financial risk;
Risk of patient over-treatment

High provider financial risk;
Risk of patient under-treatment

FFS | Per Diem | Episode of Care (single-provider) | Episode of Care (multi-provider) | Capitation (condition-specific) | Capitation (full)

Source: Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

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Benefits of Alternative Payment

Simplified administration

Increased Tier 1 Advantage and Tier 1 participation

- Tier 1 Advantage (T1A)
  - No clinical submission required
  - 3600 providers moving to T1A
- Tier 1 (T1)
  - Clinical submission required with minimal UR process
  - 3000 providers moving to T1
- Tier 2 – Participate in a current UR process
  - Clinical submission required with current UR process

- **Decreased CPT coding policy/change impact**
- **No aggregate reduction in reimbursement**

Chiropractic Per Diem

Incremental step toward industry transition away from FFS payment models

A flat rate payment made to a chiropractor

- Includes all covered services within scope provided on a single date of service
- Includes evaluation & management and radiology
- Select DME procedures reimbursed separately
- Applies to the majority of UnitedHealthcare commercial programs; Providers may confirm via current Plan Summary available on the Optum Provider Portal
- Medicare Advantage is *not* impacted

Deployment implemented in phases throughout 2015 and 2016

- Provider notification letter
- Sent via mail 90 days prior

Fee schedules, Plan Summaries and Optum Tiering Methodology accessible

- www.myoptumhealthphysicalhealth.com

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Understanding the Chiropractic Per Diem Fee Schedule

OptumHealth Care Solutions, Inc. (Optum)

UnitedHealthcare® Commercial & Medicare Chiropractic Fee Schedule

Effective Date:

Description	Commercial Per Visit Fee
Per visit fee: Initial evaluation/visit and subsequent visits. Per visit fee represents payment in full for all services provided, including, but not limited to, professional fees, supplies, radiology, and laboratory services. Certain DME covered under the member's commercial benefit plan may be reimbursed separately from the per visit fee schedule.	$XX.00

Medicare Fee Schedule		
CPT Code	Description	Fee
98940	CMT; spinal, one to two regions	$XX.00
98941	CMT; spinal, three to four regions	$XX.00
98942	CMT; spinal, five regions	$XX.00

Reimbursement rates for Covered Services will be the lesser of: (a) the Customary Charges for Covered Services that a provider would ordinarily charge another person regardless of whether the person is a Member, or (b) this fee schedule.

UnitedHealthcare commercial products include: UnitedHealthcare benefit plans issued and administered by UnitedHealthcare or its affiliates, including, but not limited to United One, United Medical Resources and Definity, unless otherwise noted in the Plan Summary.

This fee schedule is not a guarantee of coverage; final coverage will be determined by each member's benefit contract.

The date this fee schedule will be effective.

Reimbursement for all covered services provided within a single visit for all UHC commercial plans.

Reimbursement for the covered services for UHC Medicare Advantage plans. Per diem does *not* apply.

Reimbursement for the majority of commercial plans will be the Commercial Per Visit Fee – OR – provider's billable amount, whichever is less.

Reimbursement for Medicare Advantage plans will be the Medicare Fee Schedule – OR – provider's billable amount, whichever is less.

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Application of a Chiropractic Commercial Per Diem Fee Schedule

Reimbursement rates for Covered Services will be the lesser of: (a) the Customary Charges for Covered Services that a provider would ordinarily charge another person regardless of whether the person is a Member, or (b) this fee schedule.

UHC Commercial Per Visit Example

- **99201:** New patient evaluation
  billed amount $40*
- **98940 :** CMT to one or two regions of the spine
  billed amount $40*
- "Per Visit" would apply and reimbursement would be the "per visit fee"

UHC Commercial "Lesser of" Example

- **99201:** New patient evaluation
  billed amount $40*
- "Lesser of" would apply and reimbursement would be the "billed amount"

** billed amount will vary by provider. The amounts used in the example are only used for the purpose of illustration*

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Leveraging Survey Feedback to Improve The Provider Experience

National Association Forum

March 24, 2016

Vic Feldman, D.C. | MGR Provider Designation, Optum Consumer Solutions Group | victor.feldman@optum.com

Survey Overview – Current and Future

Current

Audience: Providers with:

- **≥10** patients within calendar year
- Email address on file

Process: Vendor emails invitation with a link, username and password to a Web site where provider completes the survey

Questions:

- 24 (27 for California)
- 6 open-ended

Cadence: **Annual**

Future

Audience: Providers with:

- **≥5** patients within calendar year
- Email address on file

Process: Vendor emails invitation with a link, username and password to a Web site where provider completes the survey

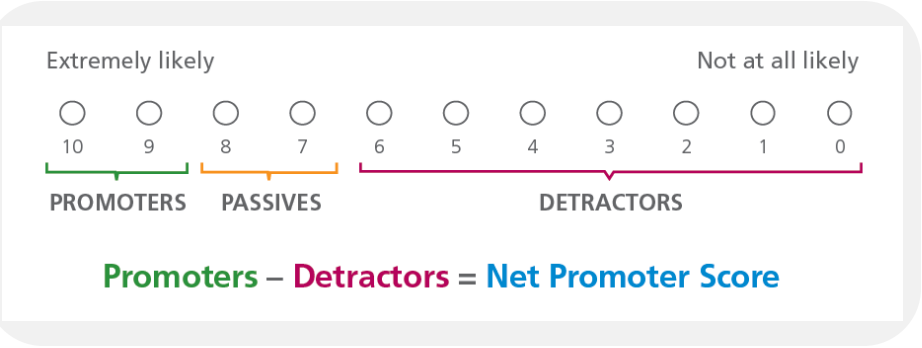
Questions:

- Under review (likely will reduce)
- 7 open-ended

Cadence: **Bi-Annual**

Survey Focus:

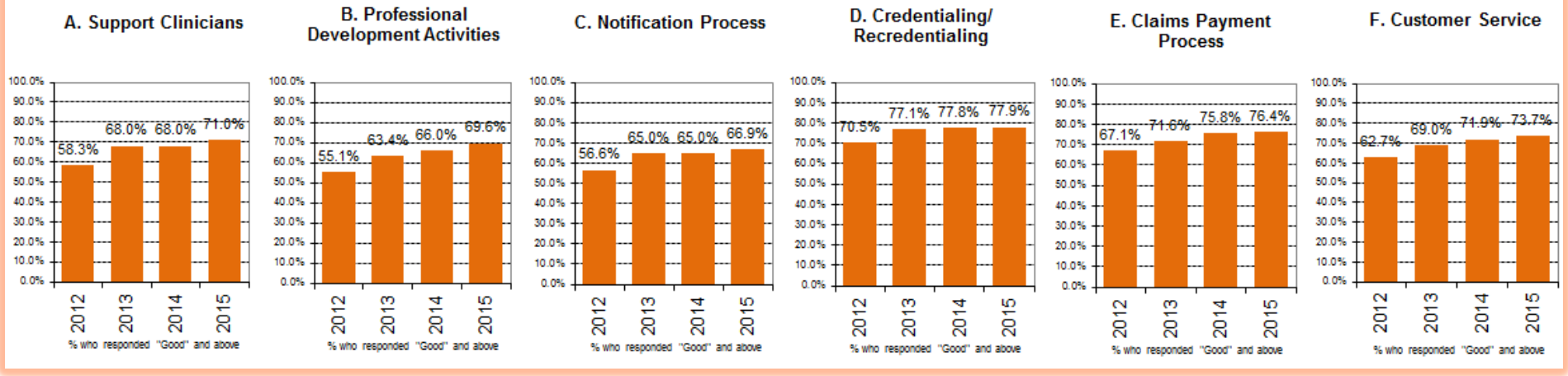
- Support Clinicians
- Professional Development Activities
- UR/Notification Process
- Credentialing
- Claims Payment Process
- Customer Service



Satisfaction Trends

Overall how would you rate the following aspects of Optum:

National

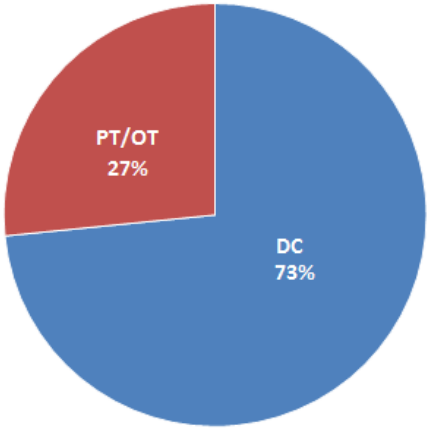


Overall satisfaction – All Tier All Specialty (DC/PT/OT)

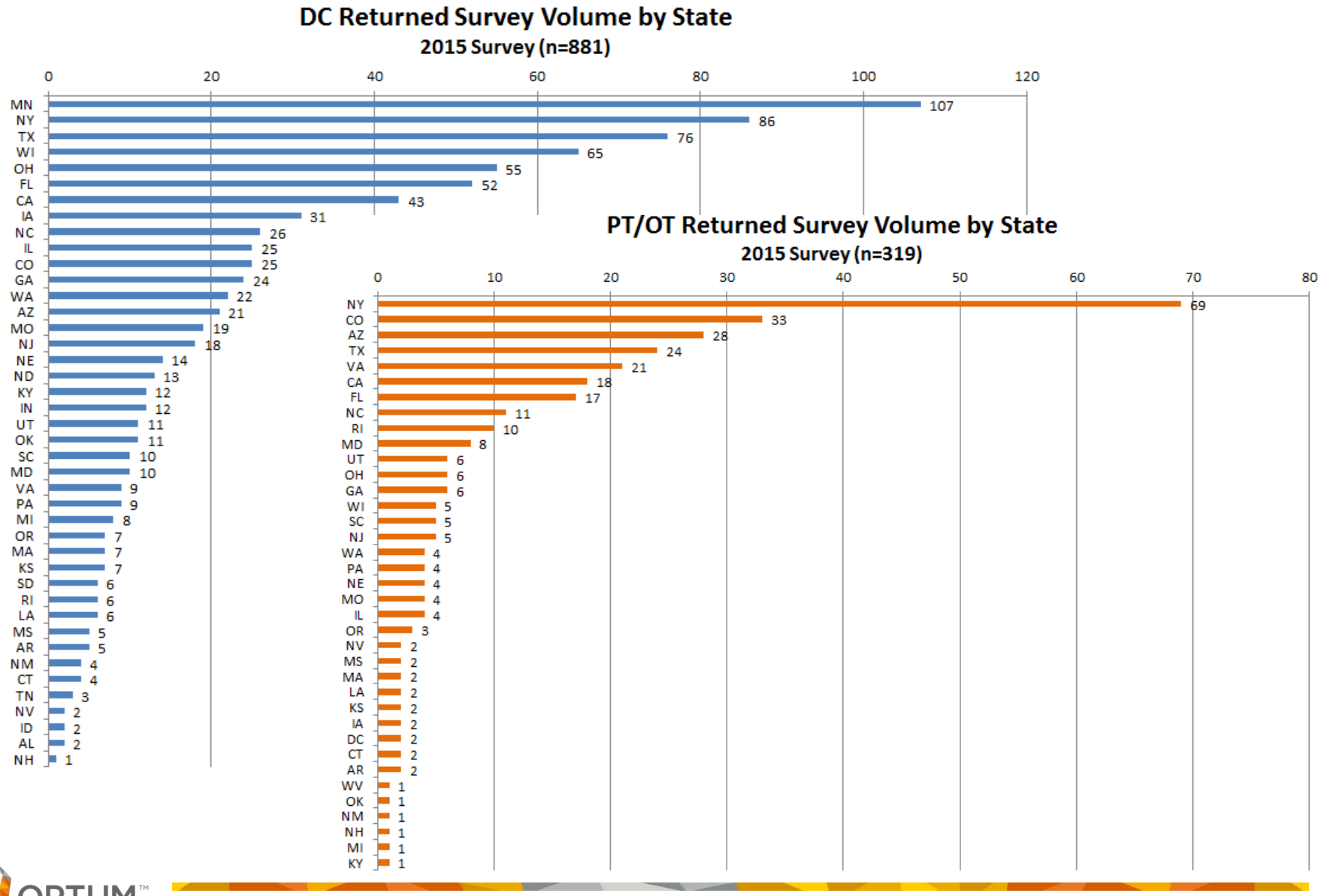
- Increased trend in satisfaction over time
- Minimal differences between specialties
- 10-20% higher ratings with Tier1/Tier1A providers

Distribution of Returned Surveys by Provider Specialty

2015 Survey (n = 1,200)



State Participation



Thank You.

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Modified By: V. Feldman