Utilization Management Overview

Optum Health Solutions Musculoskeletal (MSK) Utilization Management Policy
Policy Number: 337

Effective Date: 04/24/2025

Table of Contents

Policy Statement 3
Purpose 3
Scope 3
References 4
Review and Approval History 5

Policy Statement

Utilization Management (UM) policies serve as the clinical criteria for utilization review determinations. When applying the UM policies to make utilization review determinations, the capabilities of the local health care delivery system and their ability to meet the member's specific health care needs are considered. In making a utilization review determination based on the UM policies, consideration is also given to the individual clinical circumstances and needs of the member such as age, co-morbidities, complications, progress of treatment, and (when applicable) psychosocial situation and home environment.

Optum's system and process allows only clinical peers (Optum Support Clinicians) to render clinical decisions regarding denial of services. Adverse determinations are rendered by licensed practitioners in accordance with state, CMS, and accreditation requirements. Determinations, and the rationale for any denial of services, shall be communicated to the provider and the member. Such notification shall include the procedure to appeal any denial of services. Optum shall make available upon request by the insured, or their designee the clinical review criteria utilized in rendering each adverse determination.

Optum will maintain clear documentation of the ordering provider's original request and any negotiation and/or agreement to accept an alternative treatment or modified extension of stay.

In those instances where Optum conducts prospective reviews, Optum will base review determinations solely on the medical information obtained by Optum at the time of the review determination. In the case of retrospective reviews, Optum will base its review determinations solely on the medical information available to the ordering provider at the time the medical care was provided. Optum may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

Optum will not retrospectively deny coverage for services when prior certification has been given unless the certification was based on fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or provider.

Clinical peers are accessible via toll free number at least 40 hours per week during normal business hours to assist the provider, including discussion of adverse determinations. Each Support Clinician is assigned individual voice mail. Voice mail is accessed and responded to at least once each 24-hour period.

Purpose

This policy was developed to describe the required process of utilization reviews used by Optum and essential for compliance with applicable state, federal and agency requirements, or mandates. The process detail is incorporated into the Optum Utilization Management (UM) program. Individual plan requirements supplements the UM program.

Scope

All in and out of network programs, involving all provider types, where utilization review determinations are performed (subject to specific health plan benefit limitations).

References

National Committee for Quality Assurance (NCQA). https://www.ncqa.org

Review and Approval History

Date	Action
3/7/2001	Original effective date
9/20/2002	Annual review and approval completed
11/11/2003	Annual review and approval completed
10/18/2004	Annual review and approval completed
2/14/2006	Annual review and approval completed
4/10/2008	Annual review and approval completed
1/15/2009	Policy reformatted
4/30/2009	Annual review and approval completed
4/8/2010	Annual review and approval completed
10/26/2010	Policy rebranded to “OptumHealth Care Solutions, Inc. (Optum)”
4/7/2011	Annual review and approval completed
4/19/2012	Annual review and approval completed
4/18/2013	Annual review and approval completed
4/17/2014	Annual review and approval completed; Policy statement updated i.e., availability of clinical criteria. Policy rebranded “Optum* by OptumHealth Care Solutions, Inc.” to “OptumHealth Care Solutions, Inc.”
4/16/2015	Annual review and approval completed
4/21/2016	Annual review and approval completed
4/20/2017	Annual review and approval completed; Legal entity name changed from “OptumHealth Care Solutions, Inc.” to “OptumHealth Care Solutions, LLC.”
3/8/2018	Annual review completed by UMC; Policy updated in compliance with UM standards
4/25/2019	Annual review completed by UMC; Policy statement updated in compliance with UM standards
4/23/2020	Annual review completed
4/22/2021	Annual review completed; Deleted URAC from list of references
5/3/2022	Annual review completed; Added, “Optum may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures” to the Policy Statement
4/27/2023	Annual review and approval completed; no significant changes made to the document. Updated contact email from policy.inquiry@optumhealth.com to phpolicy_inquiry@optum.com.
01/10/2024	Annual review; no substantive changes. Document content transitioned to new policy template. Approved by Optum Clinical Guideline Advisory Committee.
4/25/2024	Annual review and approval by Optum Quality Improvement Committee.

10/9/2024	Annual review; no substantive changes. Approved by Optum Clinical Guideline Advisory Committee.
04/24/2025	Annual review and approval by Optum Quality Improvement Committee.