



Utilization Management Policy

Denial of Services Not Covered By the Health Plan

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Policy Statement

Services will be denied if they are a non-covered Health Plan benefit. A reference source which lists non-covered services for the plan will be cited where possible.

Purpose

To state the criteria supporting coverage denials that provide no criteria for the denial other than the service is not covered.

Scope

All in and out of network programs, involving all provider types, where utilization review (UR) and coverage determinations are performed.

Background

Health plans benefit documents may include specific exclusions and/or limitations. These documents take precedence over delegated UM programs. Services that are not explicitly covered by a member's benefit document will be administratively denied. Examples of services that may not be covered include but are not restricted to those where visit limits and/or reimbursement limits have been exceeded.

*Optum™ Physical Health (“Optum”) includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.



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References

1. Consensus – Utilization Management Committee

Policy History/Revision Information

Date	Action/Description
9/20/2002	Original effective date
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
1/27/2011	Background section added
4/08/2010	Annual review and approval completed
10/26/2010	Policy rebranded to “OptumHealth Care Solutions, Inc. (OptumHealth)”
4/07/2011	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 rebranded “Optum* by 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.”
4/26/2018	Annual review and approval completed
4/25/2019	Annual review and approval completed
4/23/2020	Annual review and approval completed; no significant changes made to the document
4/22/2021	Annual review and approval completed; no significant changes made to the document
5/03/2022	Annual review and approval completed; no significant changes made to the document
6/29/2022	Updated legal entity name “OptumHealth Care Solutions, LLC.” to *Optum™ Physical Health (“Optum”) includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.
4/27/23	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 .

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: phpolicy_inquiry@optum.com with the word “Policy” in the subject line.

The services described in Optum* by OptumHealth Care Solutions, LLC policies are subject to the terms, conditions and limitations of the Member's contract or certificate. Optum reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Optum's administrative procedures.

Certain internal policies may not be applicable to self-funded members and certain insured products. Refer to the member's Summary Plan Description (SPD) or Certificate of Coverage (COC) to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies.

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If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.