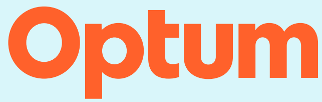
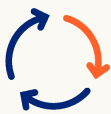


Indiana Medical Management

Quick reference guide

Optum® Medical Management programs ensure members receive appropriate, timely and quality care to address individual healthcare needs. These programs work in collaboration with the member, the family/support system, providers, and key stakeholders to coordinate discharge, health care services, community resources and referrals to the appropriate next level of care.



Medical Management request process

To refer members to Optum Medical Management programs, submit a completed Optum request form via email at OMWcmreferral@optumcare.com. This form can be found as a writable, savable PDF on the Optum Care website under provider resources: https://www.optum.com/business/hcp-resources.html.

Requests will initiate a review within three business days. Urgent referrals will be prioritized and assigned. Members must agree to program enrollment.

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Medical Management services

Transitional care management:

- Dedicated RN case manager
- Telephonic support
- Health goal development
- Coordinate access to community resources and services
- Disease management education and medication review
- Post-discharge 30-day follow-up from inpatient or skilled nursing facility

Complex and high-risk case management:

- Dedicated RN case manager
- Telephonic support
- Patient centered plan of care
- Longitudinal management/coordination of care for medical issues
- Health goal development
- Coordinate access to community resources and services
- Disease management education and medication review

Disease management

Diabetes management:

- Dedicated RN case manager
- Telephonic support
- Patient centered plan of care
- Coordination with PCP and specialist
- Coordinate access to community resources and services
- Evaluate and manage health risk factors
- Disease education (diet, medication management, complications, exercise, and self-management techniques)
- Monitor diabetic wound care

Chronic obstructive pulmonary disease (COPD) management:

- Dedicated RN case manager
- Telephonic support
- COPD treatment assessment
- Patient centered plan of care
- Medication administration coaching
- Coordination with PCP and specialist
- Self-monitoring and interventions follow-up

Congestive heart failure (CHF) management:

- Dedicated RN case manager
- Telephonic support
- CHF treatment assessment
- Patient centered plan of care
- Medication administration coaching
- Coordination with PCP and specialist
- Self-monitoring and interventions follow-up

Licensed social work support

- Supports all clinical programs as well as stand-alone referrals
- Coordination of community resources to address social determinants of health
- Provide education with advance directives and living will documents
- Support members through the emotional adjustments to life changes
- Support with financial resources, housing, transportation, placement, and meal assistance

Special clinical programs

Optum transplant solution:

- Telephonic RN case management
- Pre-transplant identification
- Psychosocial management
- Twelve-month post-transplant coordination

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Renal disease management:

- Manage and improve clinical outcomes for members with Chronic Kidney Disease stage 3b through End Stage Renal Disease
- Renal Care Team includes RNs, social workers, renal dietitians, and nephrologists
- Telephonic and field support
- Dialysis coordination: focus on reduction of infections, anemia, fluid, and electrolyte imbalances
- Management of co-morbid conditions and education related to individual disease progression and medication adherence
- Timely referral for transplant consideration

Additional resources

Optum behavioral health

For direct referrals regarding behavioral health needs. Call behavioral health number on the back of member's card.

Optum nurse line

A 24-hour access hotline for member to reach a nurse to answer questions regarding health concerns. Members can call the number on the back of their insurance card.

HouseCalls

Call to request a visit 1-866-799-5895, TTY 711, Monday–Friday 8 a.m.–8:30 p.m. ET

Referral: Contact your Account Manager. Non-acute, in-home assessment service available to eligible members that includes physical exams, health screenings, medication reconciliation, lab tests and functional/falls/social assessments. HouseCalls helps supplement provider care by reaching patients with access challenges to identify care opportunities, improve performance on key STAR measures, educate patients about their health and reinforce the patient-provider relationship.

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