OPTUM®

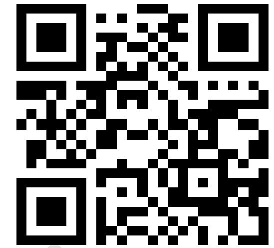
Health Plan Logo

2020 Healthcare Quality Patient Assessment

The Optum in-office assessment program is developed and administered by Optum on behalf of [Client]. **Use for 2020 date(s) of service**; past screening documentation may be outside of this date range.

Participation is eligible for up to $XX when submitted accurately and **timely**.
See ► **Administrative Reimbursement**.

Submit via traceable carrier, Optum Uploader, or secure fax (1-972-957-2145).
See ► **Additional Instructions**



► Patient: MbrLastName, MbrFirstName

Member ID: XXXXXXXX **DOB: MM/DD/YYYY** **Phone: ###-###-####**

▷ Provider Information

Check box to confirm the provider completing the assessment. Enter name/NPI if not populated.

☐ **Provider: PCP Name 1** **NPI:** __ __ __ __ __ __ __ __ __ __

☐ **Provider:** ______________________________ **NPI:** __ __ __ __ __ __ __ __ __ __

▷ Care Priority: 1

ⓘ Emergency Room visits (3), High Risk Medications (3), Medication Adherence Gap (3)

▷ Ongoing Assessment & Evaluation

Check the appropriate box. All conditions 'Assessed and Diagnosed' (which means the condition was evaluated, present and appropriately documented during a 2020 encounter) must be supported in the medical chart provided. If any suspected condition is reported as 'Assessed and Not Diagnosed', the Evaluating Practitioner Name and Date of Service must be reported covering all conditions assessed during the encounter.

HCC	Potential Diagnosis *Designate Specificity*	Risk Factors, Co-morbid Conditions or Screenings	Assessed and Diagnosed	Assessed and Not Diagnosed	Referred	Not Assessed
135	Acute Renal Failure (N17.-)	GFR test value was 57.9	☐	☐	☐	☐
022	Morbid Obesity (E66.01, E66.2, Z68.4-)	Previously Coded: Morbid Obesity (E66.01)	☐	☐	☐	☐
157	Pressure Ulcer w/ Necrosis to Muscle, Tendon, Bone; consider location, laterality & stage (L89.-4, L89.--4)	Previously Coded ICD-10: Aseptic Necrosis (733.XX)	☐	☐	☐	☐

If any suspected condition is reported above as 'Assessed and Not Diagnosed', the Evaluating Practitioner Name and Date of Service must be reported covering all conditions assessed during the encounter.
Evaluating Practitioner Name: ______________________ Date of Service: ______________________

▷ Preventive Medicine Screening

Indicate if screening/referral(s) were completed by checking the appropriate box.

The following screening(s) are due or overdue, as indicated by HEDIS & health plan data. **Evidence of results, referrals, and exclusions must be included in medical record documentation submitted with this assessment.**

Screenings to Consider	Outcome			Exclusion	
Body Mass Index (BMI & Weight required) *Recommended for adults 18-74 at each outpatient visit*	☐ Completed	☐ Unable to weigh	☐ Refused	☐ Age/Sex	☐ Pregnant
Breast Cancer Screening *No claims for breast cancer screening in the current or prior calendar year*	☐ Completed	☐ Referred	☐ Refused	☐ Age/Sex	☐ Bilateral Mastectomy ☐ 2 Unilateral Mastectomies
Colorectal Cancer Screening *No claims for fecal occult screening in the last 12 months; sigmoidoscopy in last 5 years; nor colonoscopy in the last 10 years*	☐ Completed	☐ Referred	☐ Refused	☐ Age/Sex	☐ Colorectal Cancer ☐ Total Colectomy

▷ Managing Chronic Illness

Indicate actions performed by checking the appropriate box.

The following action(s) are due or overdue, as indicated by HEDIS & health plan data. **Evidence of assessment or a referral (where applicable) must be included in medical record documentation submitted with this assessment.**

Conditions	Suggested Action	Yes	N/A	No
Controlled Blood Pressure*	Blood Pressure Evaluation	☐	☐	☐
Diabetes Mellitus*	Diabetic Eye Exam (Yes indicates referral or completed)	☐	☐	☐
	HbA1c Testing	☐	☐	☐
	Nephropathy Screening	☐	☐	☐
Rheumatoid Arthritis	Prescription Treatment	☐	☐	☐

*As of run date, member is not yet eligible for measure per HEDIS specifications; measure triggered based on member history.

This information is a summary of previously reported diagnoses, from multiple sources and is not intended to be used in place of medical diagnosis or treatment.
Any HIV/AIDS and substance abuse conditions, whether present or not, are not part of this assessment.

SAMPLE

PATIENT & PROVIDER INFORMATION

Patient:	MbrLastName, MbrFirstName			Provider:	PCPName1
Member ID:	XXXXXX	DOB:	MM/DD/YYYY		

▷ Early Detection

Consider these conditions & submit medical record documentation if present.

Chronic Illnesses or Screenings to Consider	Risk Factors, Co-morbid Conditions or Screenings	Yes	No	Referred	Not Assessed
Abdominal Aortic Aneurysm	Current or Past Smoking	☐	☐	☐	☐
Depression	Screening using tool such as PHQ-9©	☐	☐	☐	☐

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Patient: MbrLastName, MbrFirstName	Provider: PCPName1
Member ID: XXXXXX DOB: MM/DD/YYYY	

▷ Patient Status Exceptions — No Reimbursement Will Be Made

If you are not able to complete the assessment: complete this section and return this page only.

- ☐ Patient does not respond to contact efforts.
- ☐ Invalid / incomplete contact information.
- ☐ This patient is deceased, as of ____/____/______.
  MM DD YYYY
- ☐ This patient is no longer seen at this practice.
- ☐ I am not interested in contacting this patient.

► Administrative Reimbursement

Completed assessments with progress note(s) that meet CMS documentation requirements are eligible for administrative reimbursement under the following conditions:

2020 DOS Required	Timely: $XX	Late: $XX	After Expiration: $0
Documentation of one or more face to face encounter(s) in 2020	Returned within 60 days of the latest DOS submitted	Returned AFTER 60 days of the latest DOS submitted	Submissions after 01/31/2021 are not eligible for reimbursement.

Timely return will be calculated using the latest date of service submitted. Account Set-up Form (ASF) (available at www.optum.com/in-office-assessment) & W9 a pre-requisite for reimbursement and must be received by the Reject expiration date (03/26/2021) or the administrative reimbursement for the program year will be forfeited.

►Additional Instructions

① **Schedule** a comprehensive exam for this patient's next office visit to allow for enough time to assess all gaps in care and screenings identified on the assessment and complete page one. ***With some assessments, patient information may extend to a second page. In these instances, you must submit both the first page and the second page.***

② **Verify** member eligibility prior to rendering services, as members can be enrolled or disenrolled throughout the year. ***Assessments with ineligible dates of service will not be reimbursed.***

③ **Document** in the progress note meeting CMS requirements, including clear provider signature & credential(s), patient name, and date of service.
***This assessment expires – eligible dates of service for submission limited to 01/01/2020 through 12/31/2020 and can be submitted through 01/31/*2021. Rejected assessments can be resubmitted by 03/26/2021.**

④ **Submit** the applicable page(s) of this assessment and progress note(s) to support all chronic conditions and co-morbid factors, documented to the highest level of specificity within 60 days of the latest date of service. Submission options:

1. **Traceable Carrier** (any commercial carrier with traceable delivery): OPTUM Prospective Programs Processing, 2222 W. Dunlap Ave., Phoenix, AZ 85021
2. **Optum Uploader:** To get started, please visit: optumupload.com
3. **Secure Fax:** 1-972-957-2145

For questions, visit www.optum.com/in-office-assessment or call 1-877-751-9207.

► Keys to Success

✓ Be sure to include the following when submitting an assessment:

1. Page one of the assessment; if patient information extends to a second page, you must complete and return both the first and the second page.
2. All pages of completed progress note for a visit between 01/01/2020 and 12/31/2020.
3. Additional documentation (potentially outside of date range above) supporting past screenings

✓ Progress notes must meet Optum coding standards and CMS Documentation requirements, including:

1. Provider name, credentials and signature must appear at the end of each documented patient visit in the progress note
2. Provider signature log should be on file
3. If printing from EMR, appropriate authentication language, such as "Signed by" or "Authenticated by", must be present
4. Member name and date of birth (on all pages)
5. Date of service

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Member ID:	XXXXXX	**DOB:**	MM/DD/YYYY		

► Medical History Reported to Health Plan

Retain for your records

Information below is based on data received from all providers, including specialists.

Office Visits

2 or more visits in past 24 months or single annual exam

Physician	Specialty	Visits	Last Visit
John Jones, MD	Internal Medicine*	1	02/25/2019
John Jones, MD	Internal Medicine	3	07/15/2018
Margaret Elizabeth Murkowski-Doe, MD	Cardiology	2	05/15/2018

*Optum identified as date of last annual exam

ER Visits

Past 24 months, no admission

Date
01/01/2018
07/04/2018
09/07/2017

Hospitalizations

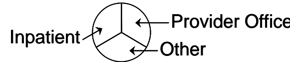
Past 36 months

Admit	Discharge
08/01/2019	08/05/2019
11/01/2018	11/08/2018
11/23/2018*	11/27/2018

*Readmission w/in 30 days

Three-Year Condition List

Place of Service Legend



Chronic

Diagnosis Coded / *HCC if applicable*	Year 19	Year 18	Year 17
250.00 DB W/O COMP TYPE II/UNS NOT UNCNTRL E11.9 Type 2 diabetes mellitus without complications *019 Diabetes without Complication*	Other		
250.02 DB W/O COMP TYPE II/UNS UNCNTRL E11.65 Type 2 diabetes mellitus with hyperglycemia *019 Diabetes without Complication*		Provider Office	
272.4 OTHER&UNSPECIFIED HYPERLIPIDEMIA E78.4 Other hyperlipidemia E78.5 Hyperlipidemia, unspecified			Other
281.9 UNSPECIFIED DEFICIENCY ANEMIA D53.9 Nutritional anemia, unspecified		Other	
285.9 UNSPECIFIED ANEMIA D64.9 Anemia, unspecified			Provider Office
374.30 UNSPECIFIED PTOSIS OF EYELID H02.409 Unspecified ptosis of unspecified eyelid			Other
557.0 ACUTE VASCULAR INSUFF INTESTINE K55.0 Acute vascular disorders of intestine *107 Vascular Disease w/Complications*		Other	Other

Non-Chronic

Diagnosis Coded / *HCC if applicable*	Year 19	Year 18	Year 17
374.87 DERMATOCHALASIS H02.839 Dermatochalasis of unspecified eye, unspecified eyelid	Other		
375.15 UNSPECIFIED TEAR FILM INSUFFICIENCY H04.129 Dry eye syndrome of unspecified lacrimal gland		Provider Office	
401.1 ESSENTIAL HYPERTENSION, BENIGN I10 Essential (primary) hypertension	Other		
401.9 UNSPECIFIED ESSENTIAL HYPERTENSION I10 Essential (primary) hypertension			Provider Office
558.9 UNS NONINF GASTROENTERIT&COLITIS K52.89 Other specified noninfective gastroenteritis and colitis K52.9 Noninfective gastroenteritis and colitis, unspecified			Provider Office
562.10 DIVERTICULOSIS OF COLON K57.30 Diverticulosis of large intestine without perforation or abscess without bleeding		Provider Office	
569.3 HEMORRHAGE OF RECTUM AND ANUS K62.5 Hemorrhage of anus and rectum		Provider Office	
578.1 BLOOD IN STOOL K92.1 Melena		Other	
578.9 UNSPEC HEMORRHAGE GI TRACT K92.2 Gastrointestinal hemorrhage, unspecified		Other	
599.0 UTI SITE NOT SPECIFIED N39.0 Urinary tract infection, site not specified			Provider Office
787.01 NAUSEA WITH VOMITING R11.2 Nausea with vomiting, unspecified	Provider Office	Provider Office	
788.41 URINARY FREQUENCY R35.0 Frequency of micturition	Other		
789.00 ABDOMINAL PAIN, UNSPECIFIED SITE R10.9 Unspecified abdominal pain	Other		

Note: Chronic determination made by reference to Agency for Healthcare Research and Quality - Healthcare Cost and Utilization Project (HCUP) Chronic Condition Indicator File. *All HCCs listed reflect the CMS Medicare Advantage HCC Model.*

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Member ID:	XXXXXX	DOB:	MM/DD/YYYY		

High Risk Medications

The use of HRM can lead to increased morbidity, decreased quality of life, & preventable healthcare costs. The CMS, American Geriatric Society & NCQA CAUTION the use of the following medication(s) found in this patient's profile. Please consider a suitable alternative.

Drug Name	Classification	Filled	Days Supply	Qty
EXAMPLE HIGH RISK DRUG 150 mg	EXAMPLE HIGH RISK CLASS	08/28/2019	30	1
		10/07/2018	30	1
		12/12/2017	30	1
EXAMPLE HIGH RISK DRUG 2 10 mg	EXAMPLE HIGH RISK CLASS	09/01/2018	90	90
		11/24/2017	90	90
EXAMPLE HIGH RISK DRUG 3 2 mg	EXAMPLE HIGH RISK CLASS	11/24/2019	40	120
		03/10/2019	40	120
		02/27/2018	40	120

Note: Medication list limited to prescriptions filled using health plan coverage; self-pay prescription data not available.

ACEI or ARB, Statins, and Oral Diabetes Medications – Monitored for Patient Adherence

The following medications are monitored for adherence, and will be flagged with "GAP→" when two or more fill dates are present and total "Days Supply" is less than 80% of total days on the medication type. Engage patient, discuss barriers & encourage 90 day refills.

Adherence Gap	Drug Name	Classification	Filled	Days Supply	Qty
GAP→	EXAMPLE DRUG 150 MG	SULFONYLUREAS	12/11/2019	30	1
			11/12/2019	30	1
			04/01/2018	30	1
			05/06/2017	30	1
	EXAMPLE DRUG 10 MG	SULFONYLUREAS	08/26/2018	90	90
			11/24/2017	90	90
GAP→	LIALDA TER 1.2 GM	MISCELLANEOUS G.I.	11/24/2018	40	120
			01/27/2018	40	120
			03/30/2017	40	120

Note: Medication list limited to prescriptions filled using health plan coverage; self-pay prescription data not available.

Other Prescriptions

Drug Name	Classification	Filled	Days Supply	Qty
EXAMPLE OTHER DRUG 150 MG	Non-RISKY	11/12/2019	30	3
		12/11/2018	30	3
		04/01/2018	30	3
		05/06/2017	30	3
EXAMPLE OTHER DRUG 10 MG	SULFONYLUREAS	08/26/2018	90	90
		11/24/2017	90	90
HUMALOG MIX 50/50 ING 50/50 U/ML	INSULINS INJ	11/24/2019	40	120
		01/27/2019	40	120
		03/30/2018	40	120

Note: Medication list limited to prescriptions filled using health plan coverage; self-pay prescription data not available.

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