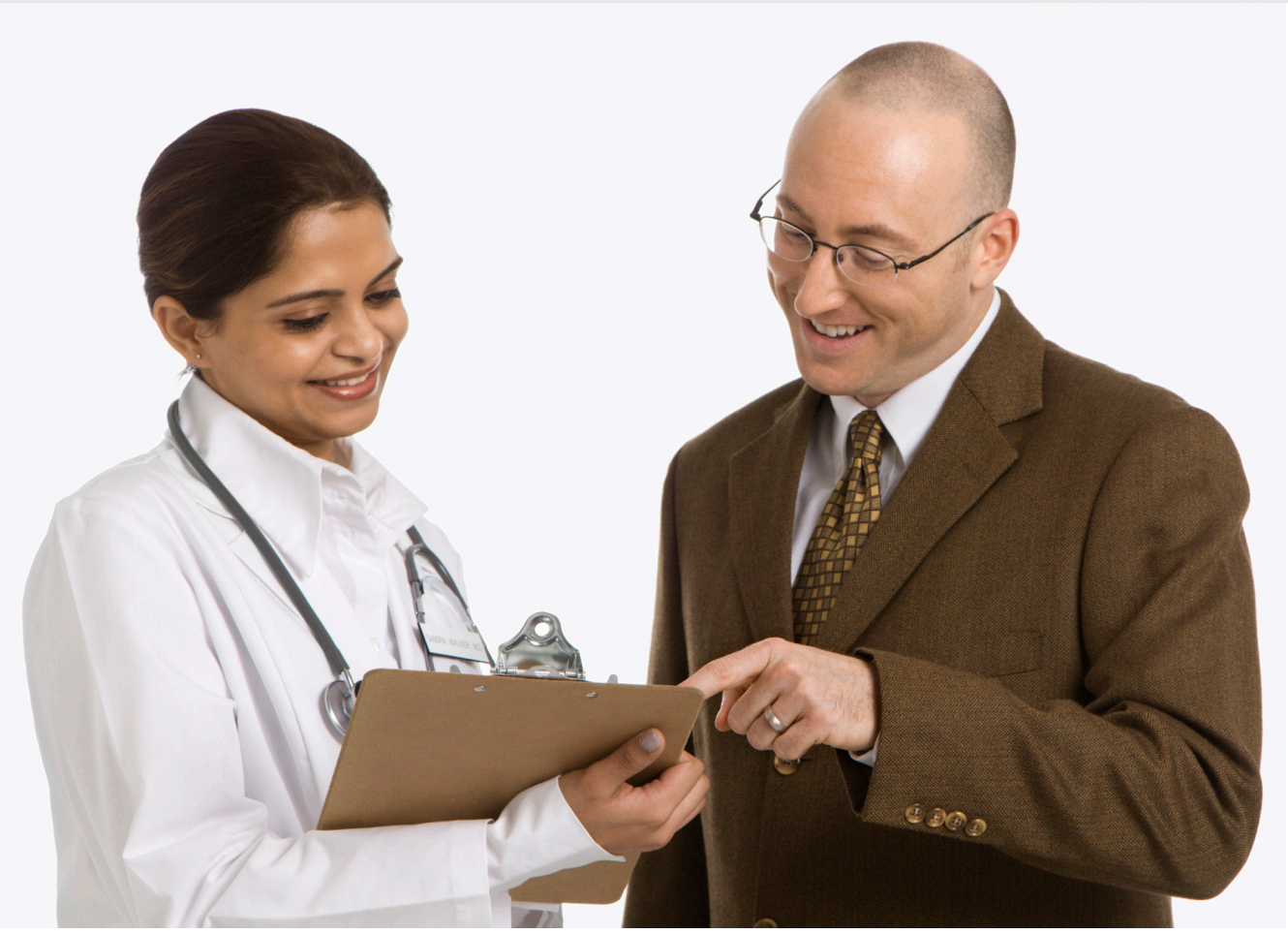
OPTUM®

Instructions for the Healthcare Quality Patient Assessment Form (HQPAF)/Patient Assessment Form (PAF) Programs



The Healthcare Quality Patient Assessment Form (HQPAF) and Patient Assessment Form (PAF) programs promote early detection and ongoing assessment of chronic conditions for our clients' Medicare Advantage members. The goal of the HQPAF/PAF program is to help providers perform a complete and comprehensive annual assessment for their patients. The information on the HQPAF/PAF should be used to assist you in addressing care opportunities during the patient encounter. Nonetheless, providers remain responsible for performing medical diagnostic functions and setting treatment procedures. The information on the HQPAF/PAF should not be used to substitute for the medical judgment of a physician or qualified health care professional.

Key elements of the HQPAF program:

- The information on the HQPAF/PAF is intended to be used at the time of the patient encounter.
- Timely submission of the HQPAF/PAF, and supporting documentation within 60 days of the latest date of service (DOS), allows for early recognition of remaining care opportunities and supports additional outreach to maximize quality of care.
- Submit supporting documentation including current year dates of service, as well as prior year evidence for multi-year care opportunities (for example, breast cancer screenings, colorectal screenings).

Instructions for completing the HQPAF/PAF

1. **Schedule** a comprehensive annual assessment for the patient listed on the HQPAF/PAF or review the document during the patient's next office visit. It is important that you utilize your patient's HQPAF/PAF prospectively during a comprehensive exam to allow enough time to assess all gaps in care and screenings identified on the form. **Review and return the HQPAF/PAF, along with supporting medical record documentation, within 60 days of the latest DOS.** On some forms, patient information may extend to the second page. In these instances, you must submit both the first page and the second page. *Note: Certain types of procedures, including screenings and labs, may result in out-of-pocket expenses for the patient, depending on health plan benefits.*

2. **Document** in the progress note meeting CMS requirements, including clear provider signature and credential(s), patient name and DOS. Results, referrals and any applicable exclusions must be documented in progress notes and returned with the HQPAF/PAF. *Note: Forms are only eligible for DOS within the calendar year. Some HEDIS screenings may occur outside the eligible DOS.*

3. **Submit** the applicable pages of the form and progress note(s) to support all chronic conditions and comorbid factors, documented to the highest level of specificity within 60 days of the latest DOS. Submission options:

Traceable Carrier (*any carrier, such as UPS or FedEx, that provides a tracking number*):
Optum Prospective Programs Processing - 15458 North 28th Avenue, Suite G - Phoenix, AZ 85053

PAF Uploader:
To get started, please visit: optumupload.com

Secure Fax: 1-877-889-5747

4. All providers that qualify for HQPAF/PAF administrative reimbursement must receive their reimbursement via direct deposit. *Administrative reimbursement is completely paperless.* To ensure that you do not experience delays in reimbursement, please visit optum.com/HQPAF or contact Electronic Payments & Statements (EPS) directly at 1-877-620-6194 to enroll.

Instructions for completing individual sections of the HQPAF/PAF
Ongoing Assessment & Evaluation

The "Ongoing Assessment & Evaluation" section provides potential diagnosis and related ICD-10-CM codes for the patient. These potential diagnoses are indicated by risk factors or comorbid conditions identified for the patient based on claims from multiple data sources and may also include lab and pharmacy data. The provider performing the assessment should assess all reported conditions and document in the progress note meeting CMS requirements. At times, potential diagnoses identified are no longer active (as they may have been triggered by an acute condition or because the comorbid condition may not have manifested itself) or cannot be confirmed during the assessment and may require a referral to a specialist (as other providers may be treating the patient for which you have no record). The provider must check the disposition of each condition, if any, on the HQPAF/PAF as it applies at the time of the encounter. *To qualify for the Comprehensive Gap Assessment Program (CGAP), all conditions for which the disposition is 'Yes', if any, must be documented to the highest degree of specificity in the medical record/progress note. Further information on the CGAP is detailed throughout this tool.*

Preventive Medicine Screening *(this section applies to HQPAF only)*

Screenings are included if data indicates that screenings are either due or overdue for the patient or triggered based on patient history.

Screening	Criteria for inclusion
Breast cancer screening*	Screening is recommended for female patients age 50–74 who have not had a mammogram in the 27 months prior to 12/31 of the current year.
Colorectal cancer screening*	Screening is recommended for patients age 50-75, who have not had any of the following: • FOBT in the current calendar year • Flexible sigmoidoscopy in the current or 4 previous calendar years • Colonoscopy in the current or 9 previous calendar years • CT Colonography during current or 4 prior calendar years • FIT-DNA test (Cologuard) during current year or 2 prior calendar years
Body mass index (BMI and weight required)*	Screening is recommended for all patients age 18-74. *Documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year.*

*Denotes quality measure included in CGAP.

Managing Chronic Illness(es) *(this section applies to HQPAF only)*

Conditions included in this section have been identified through claims data. Providers should complete the suggested actions or send in medical record documentation that confirms the screening was already completed within the HEDIS specified timeline.

Condition	Suggested action	HEDIS specification
Controlled blood pressure*	Blood pressure evaluation	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Diabetes mellitus*	Nephropathy screening	Medical attention to nephropathy to occur annually, such as a urine microalbumin test, referral to a nephrologist and/or an ACE/ARB prescription. Screening is recommended for patients with diabetes, age 18-75, who have not had a diabetic nephropathy screening in the current calendar year. *Patients seeing a nephrologist are excluded.*
	Diabetic eye exam If referred, check "Yes" on the HQPAF	Exam is recommended for patients with diabetes, age 18-75, who have not had a dilated or retinal eye exam by an optometrist or an ophthalmologist in the current calendar year.
	HbA1c testing	Test is recommended for patients with diabetes, age 18-75, who in the current calendar year: • Have an HbA1c result over 8% or • Have not had an HbA1c test Star Ratings measure defines HbA1c levels >9.0% as poorly controlled.
Osteoporosis management	Bone density test (BDT) and/or prescription treatment	BDT for females 67-85 to check for osteoporosis. For those who experience a fracture, Bone Mineral Density (BMD) test within 6 months or a dispensed prescription to treat osteoporosis.
Rheumatoid arthritis	Prescription treatment	Those diagnosed with rheumatoid arthritis who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) during the measurement year.

*Denotes quality measure included in CGAP.

Medication Management

The conditions listed in this section are suspected as an indicated condition as a result of a prescribed medication. If the medication is being prescribed for a condition other than the suspected condition, check "No" and document in the patient's medical record the condition for which the patient is taking the medication. In some cases, a prescription has many indicated conditions. When this occurs, the potential diagnosis will state; "Supply indicating diagnosis". When responding in this situation, check "Yes" and document the actual condition being treated in the medical record and submit the medical record with the HQPAF/PAF.

Early Detection

The "Early Detection" section provides recommendations for screenings or chronic illness(es) based on previously reported risk factors and/or comorbid conditions. Providers should consider screening for the listed conditions and confirm in in the patient's medical record.

Care for Older Adults *(this section applies to Special Needs Plan members only)*

Measure	Suggested action	HEDIS specification
Advanced care planning*	Discussion with patient	Recommended during the calendar year for adults 66 years and older. Evidence of advance care planning during the measurement year. The advanced care plan or documentation of discussion with patient (including date) should be included in medical record. Providers should document in medical record if a patient previously executed an advanced care plan.
Medication review*	Annual review of medications	Recommended that adults 66 years and older have an annual review of all medications (prescriptions, OTC, herbal/supplemental therapies) and a documented medication list
Functional status assessment*	Assess activities of daily living (ADL); instrumental activities daily living (IADL); other standardized assessment	Recommended that adults 66 years and older have at least one functional status assessment during the measurement year. Assessments of ADL or IADL should be documented in medical record. Examples of other standardized assessment includes: SF-36, Assessment of Living Skills and Resources (ALSAR), Barthel ADL Index Physical Self-Maintenance (ADLS) Scale, Bayer Activities of Daily Living (B-ADL) Scale, Barthel Index. Notation that at least 3 of the following 4 were assessed is compliant: cognitive status, ambulation status, sensory ability (hearing, vision, speech must be assessed) or other functional independence (that is, exercise, ability to perform a job).
Comprehensive pain screening*	Comprehensive pain assessment	Recommended that adults 66 years and older have at least one pain screening. Documentation should include a result of pain assessment using a standardized assessment tool.

*Denotes quality measure included in CGAP.

Medical History Reported to Health Plan

This section is to be retained for your records and is populated based on data received from all providers, including specialists and pharmacies.

Screening	Criteria for Inclusion
Office visits	A list of the providers the patient has seen at least twice over the course of the previous 24 months is included (outpatient office visits only and some specialties excluded).
Date of last annual exam _____/_____/_____	Allows immediate identification of patients who are overdue for an annual exam by providing the date of the patient's last annual exam as well as the name of the treating provider. *Note: Annual Exam identified using Optum's definition.*
ER visits	List of dates the patient visited an emergency room during the previous 24 months; visit did not result in an admission.
Hospitalizations	A history of hospitalizations the patient has had over the course of the previous 36 months.
Three-year condition list	Provides a list of chronic and non-chronic conditions that have been submitted based on claims for the patient within the previous three years. A legend is provided that shows whether diagnosis came from inpatient, provider office or a combination of provider types.
High-risk medications *(this section applies to HQPAF only)*	A list of medications according to Pharmacy Quality Alliance that are considered to have a high risk of serious side effects for patients 65 and older. Please consider whether a safer drug choice is available. *Note: The medication list is 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 *(this section applies to HQPAF only)*	Medications monitored for adherence will be flagged with "GAP" when two or more fill dates present and total "Days Supply" is less than 80% of the total days on the medication type. Consider engaging patient to discuss barriers to taking medication as directed.
Other prescriptions	Any other prescription medications not in the aforementioned sections.

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The Comprehensive Gap Assessment Program (CGAP) (Select health plans only)

The goal of the Comprehensive Gap Assessment Program (CGAP) is to promote a complete and comprehensive annual assessment of your patient. Use of the information on the HQPAF/PAF at the time of the patient encounter helps to address care opportunities. Groups participating in this program have the opportunity to receive additional reimbursement for meeting the criteria set by the client. Please refer to your HQPAFs/PAFs, Optum's HQPAF website, your local healthcare advocate, or the Provider Support Center to learn more about this program and receive health plan specific program requirements. *Note: If a section that is listed below is not on an individual HQPAF/ PAF, that section will not apply to the CGAP.*

Section (as applicable)	Eligible Response	Non-eligible Response
Ongoing Assessment & Evaluation *(All potential diagnoses listed must be assessed.)*	✓ Yes, No, Referred	☒ Not Assessed
Preventive Medicine Screening *(All screenings must be completed)*	✓ Completed, Exclusion or Referred	☒ Refused
Managing Chronic Illness *Controlled Blood Pressure and Diabetes Mellitus measures only)*	✓ Yes or N/A	☒ No
Care for Older Adults *(All screenings must be completed)*	✓ Completed or Previously Executed	☒ Did not complete

How can we help you?

Our goal is to help healthcare professionals facilitate and support accurate, complete and specific documentation and coding with an emphasis on early detection and ongoing assessment of chronic conditions. Through targeted outreach and education we help our clients and their providers:

- Deliver a more comprehensive evaluation for their patients
- Identify patients who may be at risk for chronic conditions
- Improve patient care to enhance longevity and quality of life
- Comply with the Centers for Medicare & Medicaid Services (CMS) quality measures and risk adjustment requirements

Call your Optum health care representative to find out how we can help you improve outcomes for your patients.

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