OPTUM™

Patient Assessment Form (PAF) and Healthcare Quality Patient Assessment Form (HQPAF) Checklist & Frequently Asked Questions

PAF/HQPAF CHECKLIST FOR YOUR MEDICARE ADVANTAGE PATIENTS

Getting started

- ❑ Locate the patient name towards the top of each PAF/HQPAF.
- ❑ Locate the run date on the bottom right corner of each PAF/HQPAF.
- ❑ Search the medical records to identify the patient's most recent visit.
- ❑ If the patient was seen within the past 60 days of the PAF/HQPAF run date, you may submit that progress note.
- ❑ Print or copy the progress note and submit with the completed PAF/HQPAF following the instructions. Depending on your program, the PAF/HQPAF or attached reference sheet will indicate the information that needs to be completed and returned with the progress note.
- ❑ If the patient has not been seen within 60 days prior to the PAF/HQPAF run date, file the PAF/HQPAF in the patient's chart to be reviewed during the next visit or schedule an appointment for an annual assessment.

Preparing Progress Notes

- ❑ Please include the progress note for the most comprehensive visit that took place on or after the 60 day lookback. You can use a progress note from any acute visit or wellness visit between the date range on the PAF/HQPAF. Please include the most comprehensive progress note during the allowed time period.
- ❑ If you are unable to attach a progress note for the specified Date of Service (DOS) time frame, then please utilize one of the check boxes located under Patient Status Exceptions section of the PAF/HQPAF. A progress note is not required if you have checked one of the exclusions.
- ❑ If submitting more than one progress note as supporting documentation, please make sure that at least one of the progress notes falls within the DOS parameters outlined above.

Submitting PAFs/HQPAFs

Before submitting PAFs/HQPAFs, follow these guidelines to avoid rejected PAFs/HQPAFs:

- ❑ Attach the progress note and all supporting medical record documentation and submit with all completed pages of the PAF/HQPAF. Corresponding claims sent to the health plan for the same date of service should include all appropriate diagnosis codes as documented for the visit.
- ❑ Ensure the most recent DOS does not exceed 60 days prior to the run date. If it does, you have 14 months to schedule a patient for an annual assessment and to complete/submit the PAF/HQPAF.
- ❑ Ensure the provider's signature is legible and included on the progress note. PAFs/HQPAFs are rejected for noncompliant / illegible signatures. If using an EMR, ensure the signature on file has been authenticated and is Centers for Medicare & Medicaid (CMS) compliant.
- ❑ Submit a signature log to Optum for your group, even if using an EMR. This proactively assists in validating the signers credentials. We can not process PAFs/HQPAFs if credentials are not present on the EMR and/or if a digital signature is used on the EMR.
- ❑ Ensure the DOS is written legibly on the first page of the progress note. Check to make sure it is not cut-off in the margins if faxing.

The PAF/HQPAF program can help providers identify and address chronic conditions that may otherwise go undiagnosed and/or untreated.

How do I submit PAFs/HQPAFs?

Please submit the PAFs/HQPAFs and all supporting documentation via:

- Secure fax server at:
  1-877-889-5747
- Traceable carrier to:
  Optum
  Prospective Programs Processing
  7105 Moores Lane, Suite 200
  Brentwood, TN 37027

Frequently Asked Questions

How does Optum pull patient data to populate PAFs/HQPAFs?
PAFs are pre-populated for each patient based on past claims data including primary care visits, specialists visits, hospitalizations and Rx claims.

All PAFs/HQPAFs are unique to each patient based on risk factors, emergency room visits, suspected conditions and whether or not a patient is due for a Healthcare Effectiveness Data and Information Set (HEDIS)* specific screening.

Does the PAF/HQPAF need to be filled out at the time of visit?
The PAF/HQPAF was created to act as a prospective tool. We encourage the provider to review the PAF/HQPAF prior to or during the patient's office visit to help address, assess and document all pertinent diagnoses and referrals. If a "yes" box is checked for a chronic condition in the Ongoing Assessment & Evaluation section, it must be documented in the progress note within the date of service."

What is a 60-day lookback?
This is a requirement to ensure outdated tests/assessments are not included in the PAF/HQPAF. Visits should not exceed 60 days before the run date at the bottom right of the form.

What happens if we can't schedule an appointment with the patient?
If you are unable, or unwilling, to schedule an appointment with the patient, please return the PAF with the Patient Status Exceptions section completed, indicating why an assessment could not be performed for that patient.

What other tools does Optum offer that support the HQPAF/PAF program?
Optum wants to encourage and support your success with the HQPAF/PAF program. We offer additional reports, clinical and coding tools, a monthly PAF eBlast and more - all of which may help you with the PAF/HQPAF program. These reports and tools also support other programs related to the identification, treatment and appropriate coding and documentation of services for your patients that have chronic conditions.

Ask your Optum Healthcare Advocate how we can support your practice.

What is the Patient Assessment Form (PAF) program?

The PAF program is designed to help providers ensure that all chronic conditions are being addressed and documented to the highest level of specificity at least once per calendar year for all Medicare Advantage and Medicaid Managed Care Plan patients.

What is the Healthcare Quality Patient Assessment Form (HQPAF) program?

The HQPAF includes all content in the PAF plus sections to address patient quality of care (Preventive Medicine Screening, Managing Chronic Illness, and trifurcation of Prescriptions for monitoring of High Risk Meds and Medication Adherence) and Care for Older Adults when generated for a Special Needs Plan (SNP) member.

Additional PAF/HQPAF Tools

Talk to your local Optum Healthcare Advocate for additional tools on the PAF and HQPAF program. This includes the HQPAF Provider Instructions and the HQPAF Provider brochure.

Who can I contact if I have questions?

For questions, please contact the Optum Provider Support Center at 1-877-751-9207 or your local Healthcare Advocate.

For additional information as well as publications and products available for HEDIS, please visit the National Committee for Quality Assurance (NCQA) website at www.ncqa.org

www.optum.com

11000 Optum Circle, Eden Prairie, MN 55344

This guidance is to be used for easy reference; however, the ICD-9-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. This tool supplies general information regarding HEDIS and Stars, but NCQA administers HEDIS and CMS administers the Stars measures and you should consult the NQCA and CMS websites for further information. Lastly, on April 7, 2014 CMS announced a revised CMS-HCC risk adjustment model that differs from the proposed Medicare risk adjustment model. For more information see: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2015.pdf, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf, and http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html.

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