Optum Physical Health

Clinical Forms Instruction Manual

OptumHealth Care Solutions – Physical Health includes OptumHealth Care Solutions, LLC, ACN Group IPA of New York, Inc., Managed Physical Network, Inc., and ACN Group of California, Inc.

REVISED: 7/01/2015 OptumHealth – Physical Health. UM Dept.

Overview

The OptumHealth Care Solutions, LLC (OptumHealth) forms are communication tools. They are the vehicle by which a provider reports critical case elements and communicates these and the treatment plan for a patient to OptumHealth.

The change in a patient's status as a result of treatment is the outcome from treatment. From a patient's perspective, this is the benefit of care. Treatment goals are important in that they represent the projected outcomes, or benefits, of care. Measuring the outcomes and benefits of care is the primary method of evaluating the effectiveness of a treatment plan.

The following pages provide useful information that explains the role of each form and expands upon the meaning of each element.

The forms can be submitted online at www.myoptumhealthphysicalhealth.com. Please reference your plan summary and Operations Manual for further information and for information regarding filing requirements. If you have any questions regarding these forms or the clinical submission process, please contact your Support Clinician or Provider Services at (800)873-4575.

This packet includes instructions on the following forms:

- **Patient Summary Form (PSF-750)**
- **Back Index**
- **Neck Index**
- **DASH (Disability of Arm, Shoulder and Hand) Questionnaire**
- **LEFS (Lower Extremity Functional Scale)**
- **Patient Status Report**

Patient Summary Form (PSF-750)

The Patient Summary Form is used by providers to document the status of the patient and the need for services.

OptumHealth uses this form to review patient eligibility and to enter demographic and clinical data in to our Clinical Information System. The information contained on the form may also be used by the OptumHealth Support Clinician to evaluate the treatment approach and expectations of the provider.

In the pages that follow, the form will be broken down into sections and the most important areas will be explored in detail.

Patient Summary Form
PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name Last | First | MI | ◯ Female ◯ Male | Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s) | 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ——

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode
1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery
1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ______

Diagnosis (ICD codes)
Please ensure all digits are entered accurately
1°
2°
3°
4°

Nature of Condition
1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level
◯ 98940 ◯ 98942
◯ 98941 ◯ 98943

Current Functional Measure Score
Neck Index | DASH | (other FOM)
Back Index | LEFS

Patient Completes This Section:
(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:
Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**
Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

4. How often do you experience your symptoms?
(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?
(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is…
(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X ______________________ **Date:** ____________

Patient Summary Form – Administrative Sections

The Administrative section contains the demographic, insurance and referral information used by the administrative staff of both OptumHealth and the provider. Please fill out completely to avoid delay in processing.

Patient Summary Form
PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless other-wise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name Last | First | MI

◯ Female
◯ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Some health plans benefit programs may require the patient to obtain a referral for care. If the Plan's benefit requires a referral, and if the plan summary indicates a referral is required, please complete the referral information.

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

The next portion of the form is used to identify the provider and practice location. Please be sure that this is completed fully and legibly so that your submission can be effectively processed. Please indicate the credentials of the provider who is performing the service.

We encourage you to submit online at www.myoptumhealthphysicalhealth.com, however if no internet access is available, then you may fax us your Patient Summary Form.

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s) | 1 MD/DO | 2 DC | 3 PT | 4 OT | 5 Both PT and OT | 6 Home Care | 7 ATC | 8 MT | 9 Other ____

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section

This section comprises some significant elements that give the case unique characteristics. All fields are required to be completed except for the Functional Outcome Measure Score – please see below for further information on the Functional Outcome Measure Score tools.

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode
1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery
1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ________

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Nature of Condition
1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level
98940 98942
98941 98943

Current Functional Measure Score
Neck Index DASH (other FOM)
Back Index LEFS

The date you want THIS submission to begin: - This is the starting date for the episode being documented on this Patient Summary Form.

For Clinical Submissions with start date before 10/1/2015 please use ICD-9 codes.
For Clinical Submissions with start date on/after 10/1/2015 only ICD-10 codes will be accepted.

Note: Submissions are subject to timely filing requirements. Please contact our Provider Services Department at (800) 873-4575 for questions regarding timely filing.

Date you want *THIS* submission to begin:

Patient Type

1. **New to your office** – A patient who has not been seen by you or someone of a similar specialty within your office within the preceding three years.

2. **Established, new injury** – An "Established Patient" for which a clinical submission has previously been sent that is experiencing symptoms related to a new injury or complaint.

3. **Established, new episode** – An "Established Patient" for which a clinical submission has previously been sent that is experiencing a new occurrence/episode related to the injury or complaint on the previous submission.

4. **Established, continuing care** – An "Established Patient" for which a clinical submission has previously been sent that continues to ongoing treatment for the same condition.

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition - Important in determining the phase of care and stage of healing.

1. **Initial onset -** A condition whose onset is recent (within the last three months) and that is not recurrent (see definition below).

2. **Recurrent** - A condition characterized by multiple episodes, where symptoms persist for less than three months duration, and are separated by intervals during which no symptoms are present.

3. **Chronic -** A condition characterized by a continuous duration of symptoms longer than three months.

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

Cause of Current Episode - Assists in defining the origination of patient's need for treatment.

1. **Traumatic:** The complaints are due to injury caused by an identifiable external force/agent.

2. **Unspecified:** The complaints occurred insidiously or spontaneously without apparent cause.

3. **Repetitive:** The complaints are a result of repeated actions/use.

4. **Post-surgical:** The complaints are a result of a surgical procedure. Please list the date of surgery and indicate the type of surgery

5. **Work related:** Complaints related to involvement in a reported work related accident.

6. **Motor vehicle:** Complaints related to involvement in a reported auto accident.

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ______________

Diagnosis (ICD 10 code) - The diagnosis should include a clinical primary diagnosis using current ICD 10 diagnosis codes

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°							
2°							
3°							
4°							

Functional Outcome Measure Score

- Scores from the **Back and Neck Index, DASH, LEFS**, or other functional outcome measurement tool can be entered into the appropriate boxes on this Patient Summary Form. Further information regarding scoring is available in the Functional Outcome Measurement section of this document.

Current Functional Measure Score

Neck Index		DASH		(other FOM)
Back Index		LEFS		

DC ONLY - Anticipated CMT Code Level - This field is for use for chiropractors only.

The patient's current complaint and the provider's current medical records must support the number of spinal and/or non-spinal regions represented in the billed Chiropractic Manipulative Treatment (CMT). Support for the 98941 (3-4 spinal regions) and 98942 (5 spinal regions) CMT codes require documentation of a patient complaint and a diagnosis in all affected spinal regions. Support for the 98943 requires documentation of a patient complaint and a diagnosis for an extraspinal region.

For further information regarding coding, please contact your Support Clinician or review coding information on our website, www.myoptumhealthphysicalhealth.com.

DC ONLY

Anticipated CMT Level

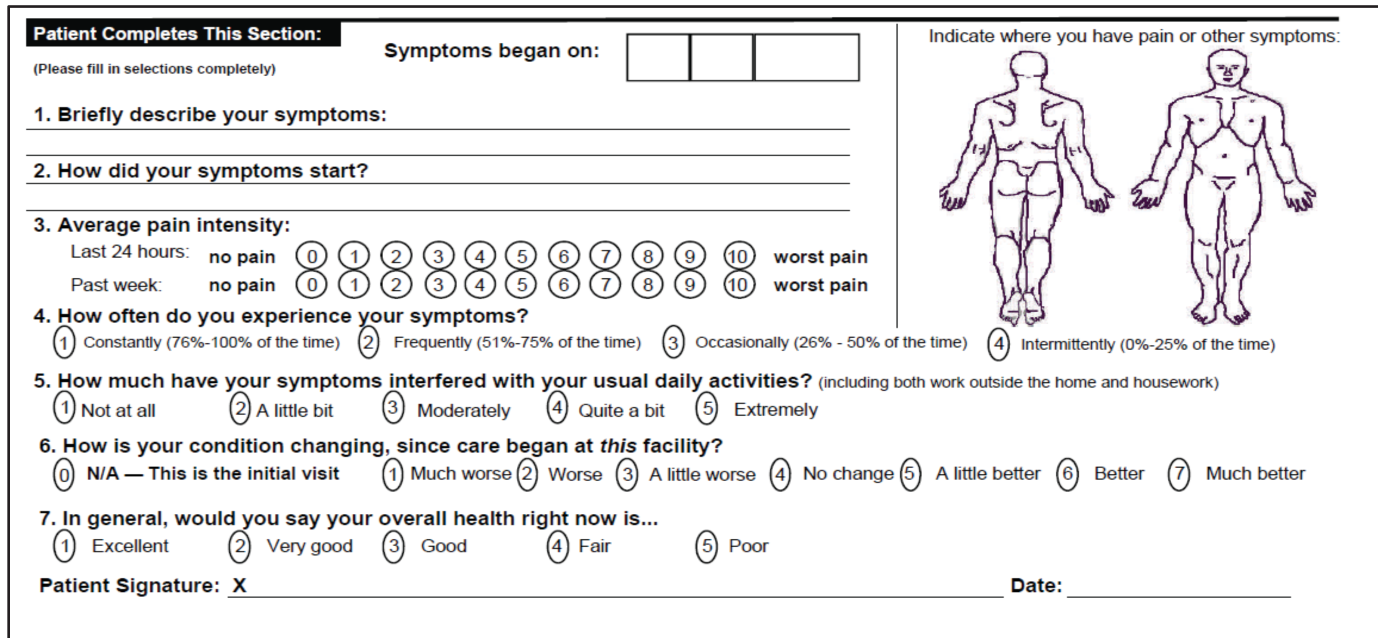
◯ 98940 ◯ 98942
◯ 98941 ◯ 98943

Patient Completes This Section

The next section is completed by the patient.

These questions were developed as a time management tool to help the provider efficiently gather information that is routinely collected during the patient history. By capturing this information using a standardized format, the provider is able to then expand upon the information by asking more detailed questions in follow-up to the patient's responses.

Patient compliance and satisfaction with the paperwork is significantly enhanced if, when presenting the patient with the OptumHealth forms, he or she is told that the forms are used to help the practitioner in gathering important information about the patient's condition.



Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

6. How is your condition changing, since care began at *this* facility?

0 **N/A — This is the initial visit** 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better

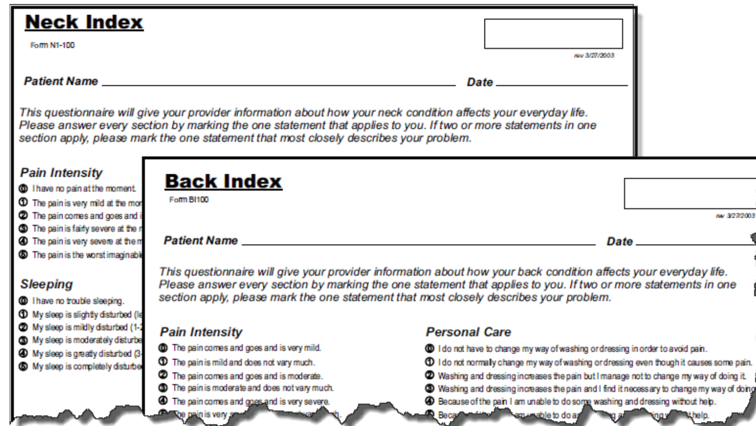
7. In general, would you say your overall health right now is…

1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Patient Signature: X ______________________ **Date:** ____________

Indicate where you have pain or other symptoms:

Back and Neck Index



Neck Index

Form N1-100

rev 3/27/2003

Patient Name ______ *Date* ______

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the
② The pain comes and goes and
③ The pain is fairly severe at the
④ The pain is very severe at the
⑤ The pain is the worst

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed
② My sleep is mildly disturbed
③ My sleep is moderately
④ My sleep is greatly disturbed
⑤ My sleep is completely

Back Index

Form BI100

rev 3/27/2003

Patient Name ______ *Date* ______

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing
④ Because of the pain I am unable to do some washing and dressing without help.

The Back and Neck Indexes are valid and reliable questionnaires completed by the patient and used to obtain data regarding a patient's tolerance for activities of daily living (ADL).

When administered prior to and at the completion of treatment, the change in the index score is used to objectively document the outcome of treatment.

To aid in scoring, the provider website contains a Back and Neck Index scoring utility.

Scoring the Neck and Back Indexes

Both indexes use the following scoring procedure:

The index consists of 10 sections. The heading of each section contains an ADL or pain descriptor. Beneath the heading of each section are 6 statements describing increasing levels of disability or severity of pain. A value ranging from 0 (no disability or pain) to 5 (total disability or severe pain) is assigned to each statement. The raw score out of 50 is obtained by adding the values of the statements selected in all of the sections.

If the patient has answered all 10 sections the raw score can be multiplied by 2 to obtain the % Disability.

For those cases where the patient does not respond to every section, the index score is calculated by adding the values of the statements selected in all of the sections, dividing this total by the maximum possible value of the sections and multiplying the result by 100:

$$\textbf{Index Score} = \frac{\text{Total value of all statements selected}}{\text{Maximum possible value (\# of sections with a statement selected x5)}} \times 100$$

Example 1A: A patient selects a statement in each of the 10 sections of the index and these add up to 16. Since the patient chose a statement in each section you can just multiply this score by 2 to get the % Disability:

Index Score = 16 (total scored) x 2 = 32% disability

Example 1B: Given the same situation in example 1A you can also use the formula to calculate the % Disability as follows: the patient selects a statement in each of the 10 sections of the index and these add up to 16. Since the patient chose a statement in each section the maximum possible value of the sections is 50 (10 sections x 5). Therefore:

$$\textbf{Index Score} = \frac{16 \text{ (total scored)}}{50 \text{ (total possible)}} \times 100 = 32\% \text{ disability}$$

Disability of the Arm, Shoulder, and Hand (DASH)

The DASH is a 30-item self-report questionnaire designed to measure physical function items, six symptom items, and three social/role function items. The DASH is designed to measure physical disability and symptoms in a heterogeneous population that includes both males and females; people who place low, moderate, or high demands on their upper limbs during their daily lives (work, leisure, self-care); and people with a variety of upper-limb disorders.

Scoring

Patients are asked to answer all sections and respond based on their ability to perform activities over the past week; only one answer per question.

At least 27 of the 30 items **must** be completed for scoring.

The assigned values are summed and divided by the number of questions answered. This value is transformed to a score out of 100 by subtracting 1 and multiplying by 25.

DASH = { (sum of *n* responses) / *n* - 1} x 25   ***n* = total number of questions answered**

$$\text{DASH} = \left\{ \frac{\text{sum of } n \text{ responses}}{n} - 1 \right\} \times 25$$

Minimum detectable change (MDC): 12.7 points; current literature holds 12.7 points to be the minimal change in score to be statistically significant at the 95% confidence interval. [2]

Minimum clinically important difference (MCID): 15 points; this represents the change in score needed to be considered clinically significant. [2]

Example

Patient completed the entire 30 items on the DASH and when the items are summed they total 73. When the tool is scored the value of the DASH is 35.8%

$$\text{DASH} = \left\{ \frac{\text{sum of } n \text{ responses}}{n} - 1 \right\} \times 25$$

$$\text{DASH} = \{ (73 / 30) - 1 \} \times 25 = 35.8\ \%$$

Lower Extremity Functional Scale (LEFS)

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below b
Problem for which you are currently seeking attention. Please provide an answer for eac

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2
2	Your usual hobbies, re creational or sporting activities.	0	1	2
3	Getting into or out of the bath.	0	1	2
4	Walking between rooms.	0	1	2
5	Putting on your shoes or socks.	0	1	2
6	Squatting.	0	1	2
7	Lifting an object, like a bag of groceries from the floor.	0	1	2
8	Performing light activities around your home.	0	1	2
9	Performing heavy activities around your home.	0	1	2
10	Getting into or out of a car.	0	1	2
11	Walking 2 blocks.	0	1	2
12	Walking a mile.	0	1	2

The LEFS is easy to administer and score and is applicable to a wide range of disability levels and conditions and all lower-extremity sites. It is a functional measure that can be used by clinicians as a measure of patients' initial function, ongoing progress, and outcome as well as to set functional goals. It is a self-report condition-specific measure that has been proven to yield reliable and valid measurements.

Scoring

LEFS is scored via summation of all responses (one answer per section) and compared to a total possible score of 80. **(Score = sum of responses / 80)**

The LEFS **raw score is the final score** and should be compared to the total possible score of 80 as a reference

Error +/- 5 points; an observed score is within 5 points of a patients "true" score.

Minimum detectable change (MDC): 9 points; change of more than 9 points on the LEFS represents a true change.

Minimum clinically important difference (MCID): 9 points; "Clinicians can be reasonably confident that a change of greater than 9 points is… a clinically meaningful functional change."[1]

Example

Patient completed the entire 20 items on the LEFS and when the items are summed they total 31.
When the tool is scored the value of the LEFS is 31/80. For OptumHealth forms please enter the sum of response, do not actually divide the sum by 80.

$$\text{Score} = \frac{(\text{sum of responses})}{80} = \text{Score} = \frac{(31)}{80}$$

Patient Status Report (PSR)

The Patient Status Report (PSR) is used to document the outcome of treatment for OptumHealth patients. The request to complete the monthly PSR is generated and distributed to providers at the end of each month. It contains a list of all patients whose treatment is scheduled to end the following month. The form includes the patient name, the clinical submission reference number, the last scheduled date of treatment, and the initial scores of the Back Index and the Neck Index.

For example, the PSR that is distributed the last week of February contains a list of all patients whose treatment plans are scheduled to end in March.

As patients complete their treatment plans, providers and/or clinic staff record the patient's final status using the final status categories on the report, and rate the patient's adherence to the provider's treatment plan using a 0-10 point scale. In addition, providers should attempt to have the patient complete a Functional Outcome Measure (FOM) at, or near, the end of the treatment plan. The score from the final FOM should be recorded on the PSR. Comparing the initial index score on the PSR with the score achieved at the end of the treatment provides an objective measure of the patient's change in functional status during the treatment plan.

The report can be completed each month by accessing the provider website at www.myoptumhealthphysicalhealth.com. By the end of each month, the PSR should be completed online.

Patient Status Report from PT PT

When you have completed as many PSRs as you would like please click

Submit for Review

Instructions | December 2013 | January 2014 | February 2014 | March 2014 | April 2014 | May 2014

			Initial Score							Ending Score				
Patient Name	Ref #	Tmt End Date	Back	Neck	DASH	LEFS	Other	Patient Status	Adherance w/Plan	Back	Neck	DASH	LEFS	Other
[illegible]	[illegible]	3/17/2014				19				?	?	?	?	
[illegible]	[illegible]	3/18/2014				65				?	?	?	?	
[illegible]	[illegible]	3/3/2014								?	?	?	?	
[illegible]	[illegible]	3/17/2014				13				?	?	?	?	
[illegible]	[illegible]	3/10/2014	24							?	?	?	?	
[illegible]	[illegible]	3/11/2014		8	14					?	?	?	?	
[illegible]	[illegible]	3/20/2014								?	?	?	?	
[illegible]	[illegible]	3/21/2014				23				?	?	?	?	
[illegible]	[illegible]	3/5/2014			46					?	?	?	?	
[illegible]	[illegible]	3/25/2014								?	?	?	?	
[illegible]	[illegible]	3/19/2014				67				?	?	?	?	

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