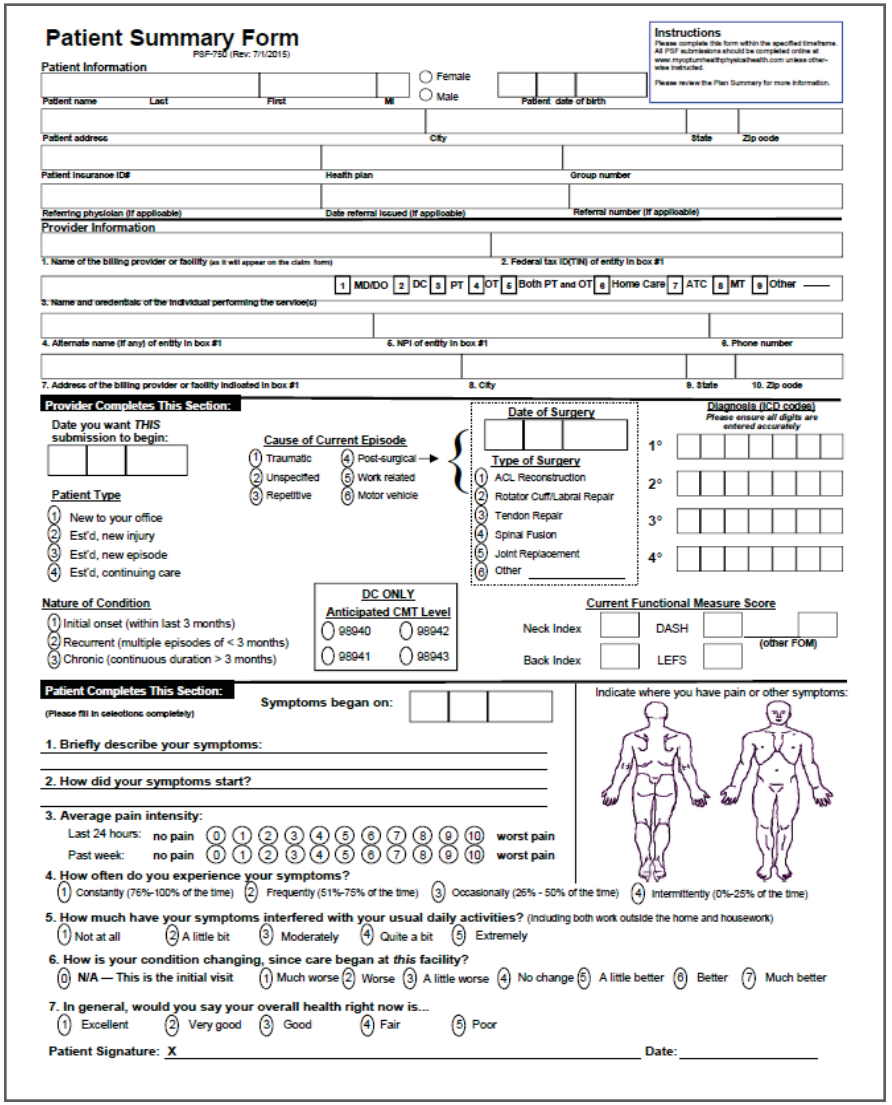
Optum Physical Health
Clinical Submission Process Tutorial

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

Patient Summary Form (PSF-750)

- The simplified one-page form collects clinical and administrative information



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:

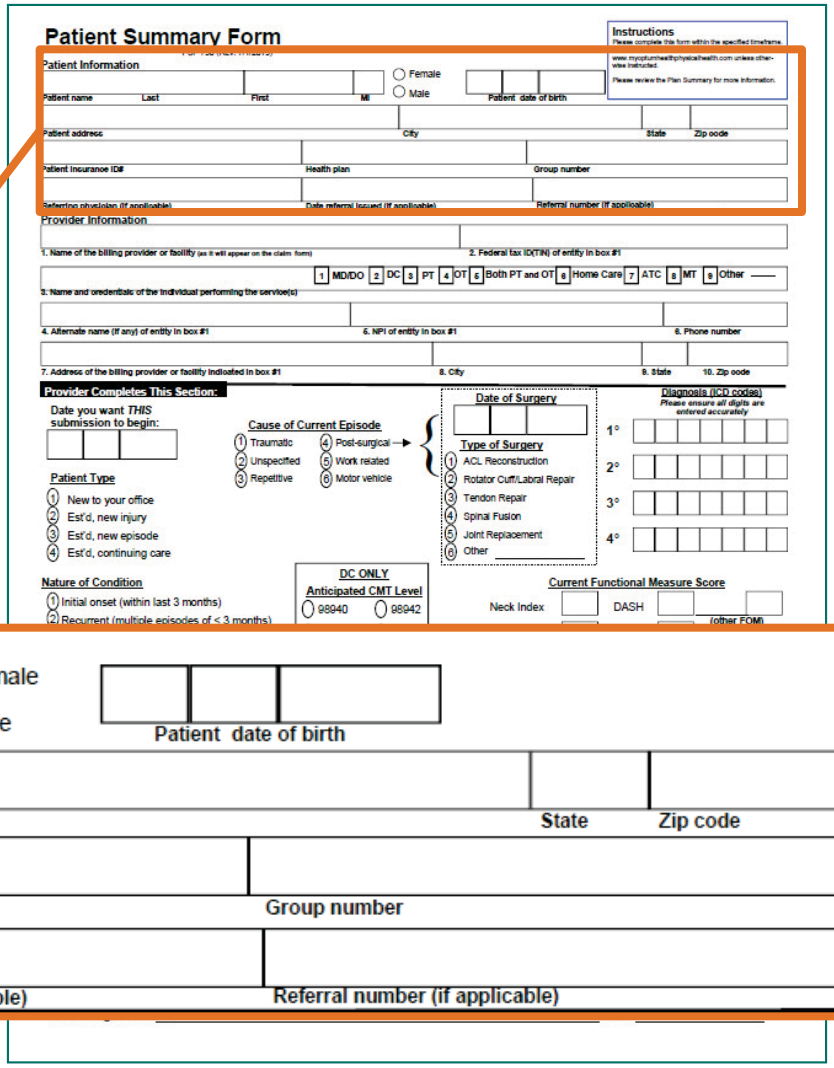
1. Briefly describe your symptoms:
2. How did your symptoms start?
3. Average pain intensity:
   Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
   Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
4. How often do you experience your symptoms?
   1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (25% - 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

Indicate where you have pain or other symptoms:

Patient Signature: X _____ Date: _____

Patient Information

- Please complete the requested patient demographic and administrative information.
- Referral information may not be applicable to all patients.



Patient Information

Patient name Last First MI

Female Male

Patient date of birth

Patient address City State Zip code

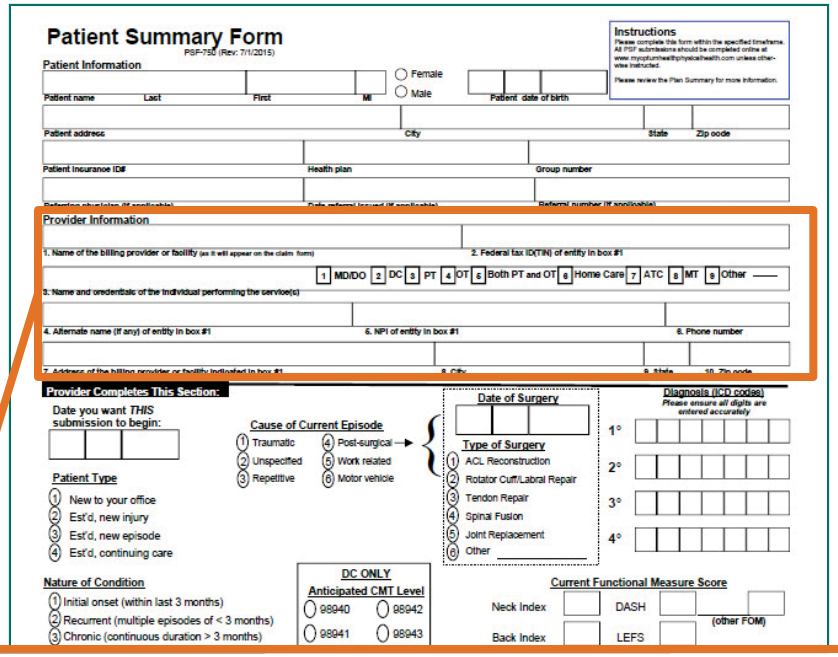
Patient insurance ID# Health plan Group number

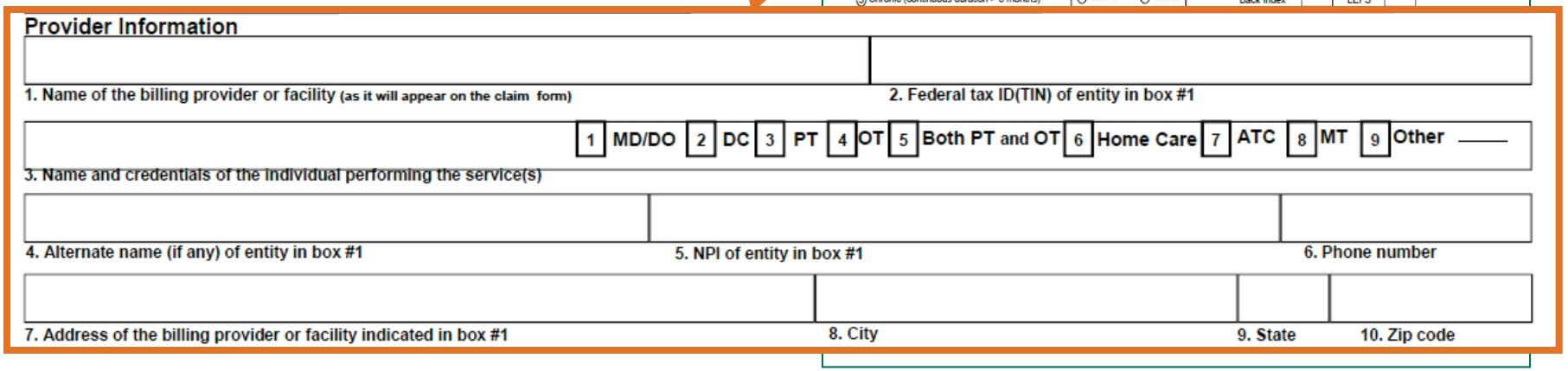
Referring physician (if applicable) Date referral issued (if applicable) Referral number (if applicable)

Provider Information

- Please complete the provider information section.
  - Indicate the primary credential of the provider (s) performing the services.
  - Alternate name and NPI are not required, but can assist in provider identification.
- If the member is receiving multiple services and these services are being billed under multiple providers names, for example a chiropractor and physical therapist, please submit a PSF for each provider.
- If the services are being billed under your clinic name for PT and OT, you may submit one form and select "Both PT and OT".

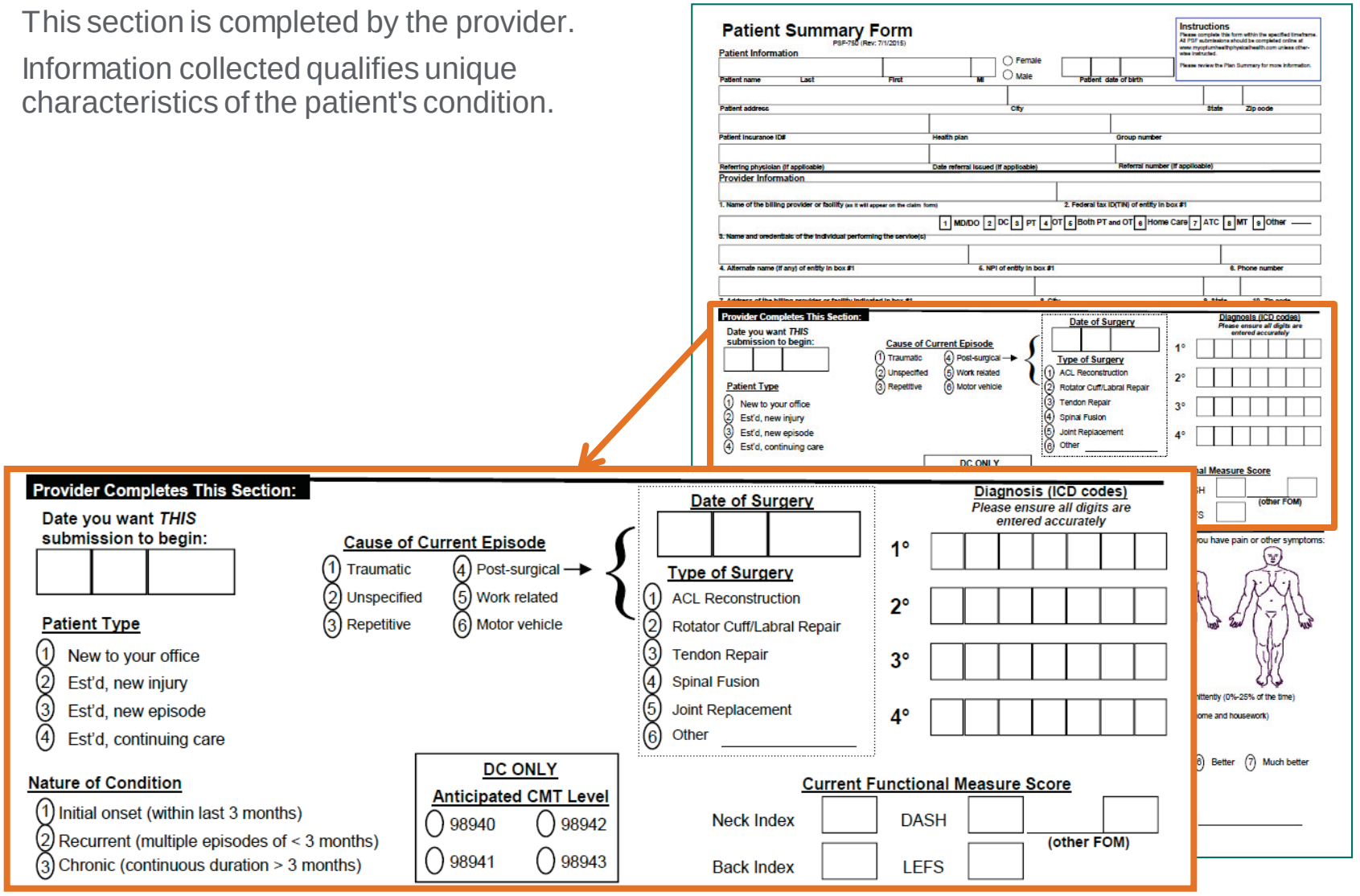
5	Both PT and OT





Critical Case Information

- This section is completed by the provider.
- Information collected qualifies unique characteristics of the patient's condition.



Date you want *THIS* submission to begin

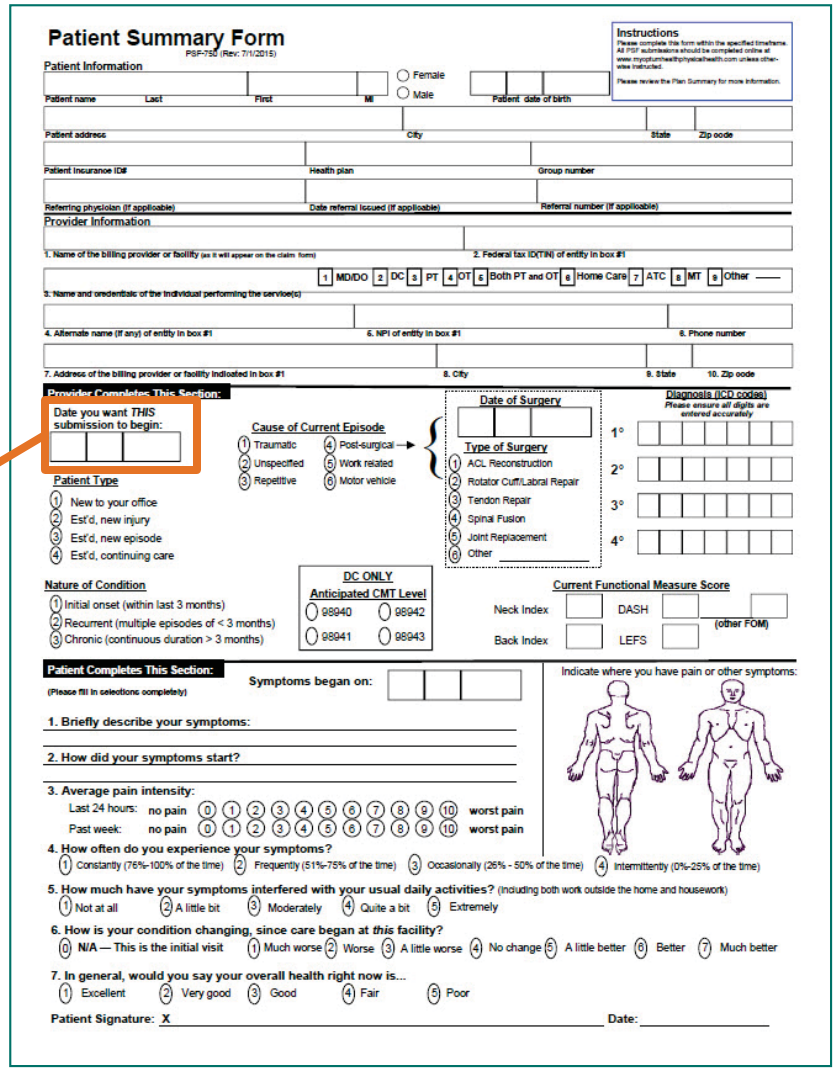
- For an initial submission, enter the date care is initiated, including the evaluation. *(Note: this may not necessarily be the same you complete the form.)*
- For subsequent submissions, please enter the date that the subsequent time frame should begin.
- Resubmit when the timeframe, number of visits, or number of services (services applicable to chiropractic only) expires, whichever occurs first.

Date you want *THIS* submission to begin:

Please note

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.



Patient Summary Form

PSF-75D (Rev: 7/1/2015)

Instructions

Please complete this form within the specified timeframe. All PDF 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

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ——

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 — 6. 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:

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°

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

DC ONLY — Anticipated CMT Level: ○ 98940 ○ 98941 ○ 98942 ○ 98943

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

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

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: _____

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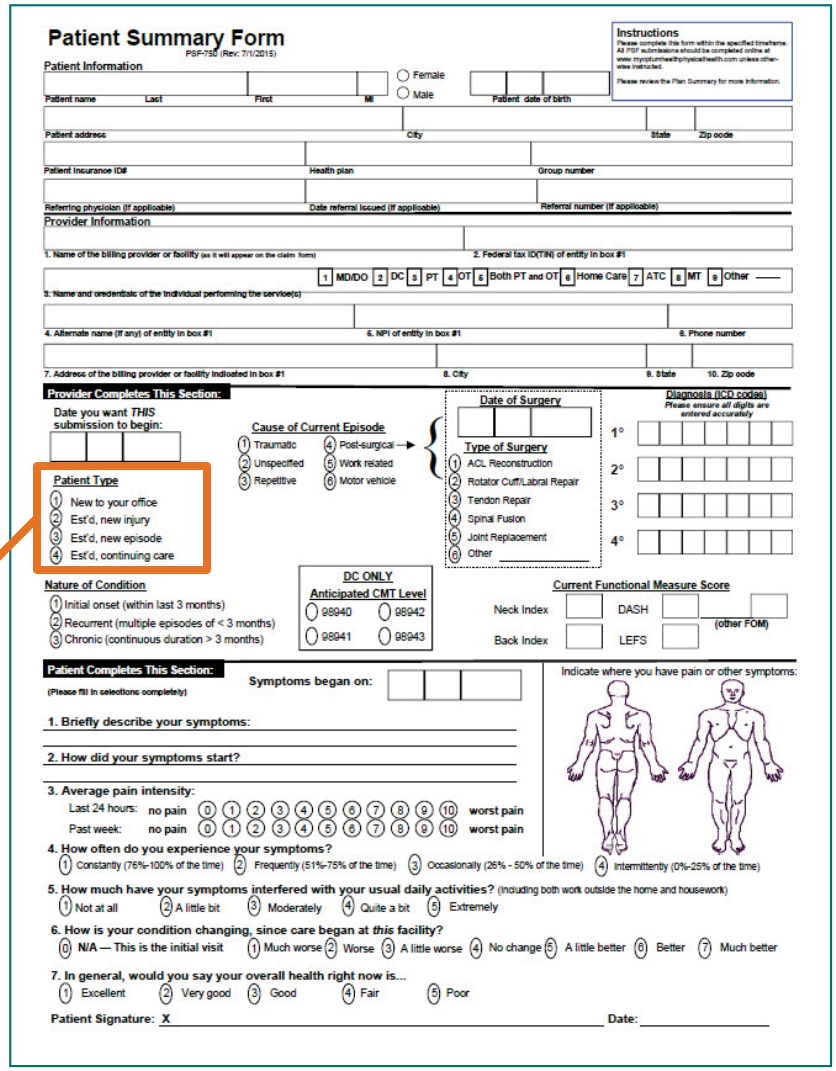
Patient Type

- **New to your office** - A patient who has not been seen by you or a provider of a similar specialty within your office within the preceding three years.
- **Est'd, new injury** - An established patient who is experiencing symptoms related to a new injury or complaint.
- **Est'd, new episode** - An established patient who is experiencing a new occurrence/episode related to the injury or complaint on the previous submission.
- **Est'd, continuing care** - An established patient receiving 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



Patient Summary Form

PSF-75D (Rev: 7/1/2015)

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Please complete this form within the specified timeframe. All PDF 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

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ——

3. Name and credentials of the individual performing the service(s)

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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
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5. Joint Replacement
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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:

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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

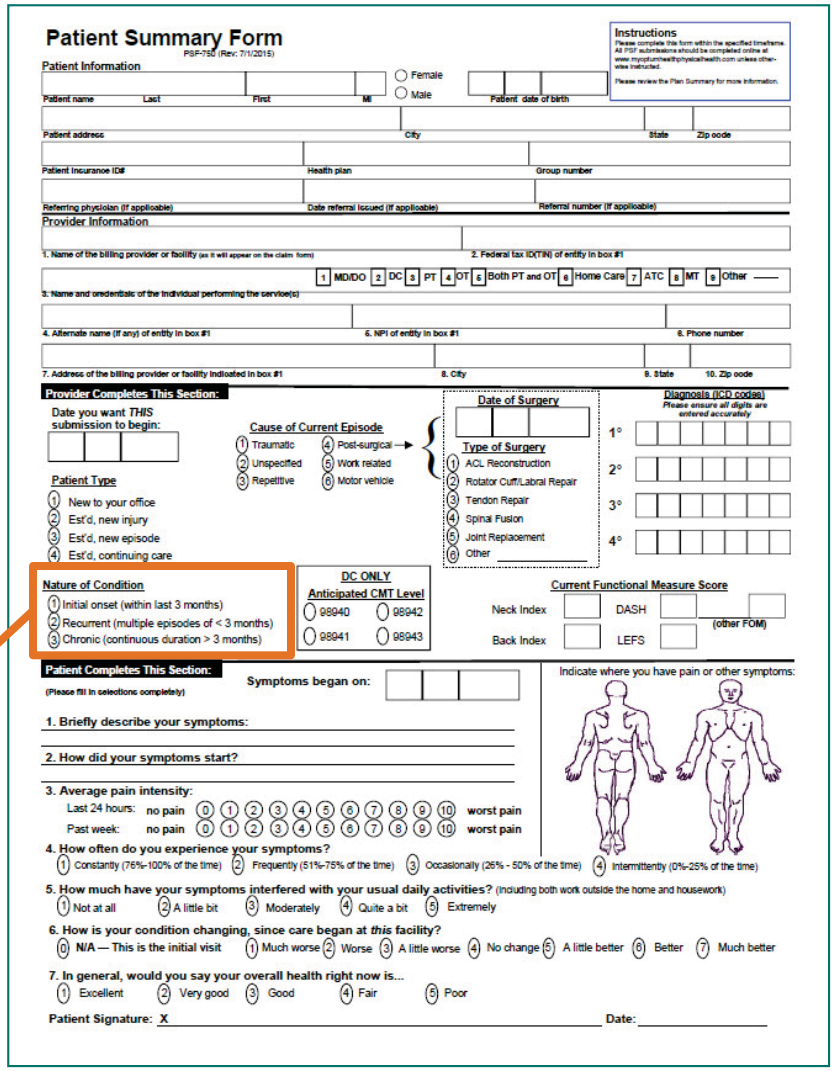
6. How is your condition changing, since care began at *this* facility?
0. N/A — This is the initial visit 1. Much worse 2. Worse 3. A little worse 4. No change 5. A little better 6. Better 7. Much better

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: _____

Nature of Condition

- **Initial Onset** - Recent onset of a condition (within the last 3 months and that is not a recurrent condition).
- **Recurrent** - A condition characterized by multiple episodes, where symptoms persist for less than 3 months duration, and are separated by intervals during which no symptoms are present.
- **Chronic** - A condition characterized by a continuous duration of symptoms longer than 3 months.



Patient Summary Form

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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

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3. Name and credentials of the individual performing the service(s)

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:

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°

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: (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, Back Index, LEFS (other FOM)

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

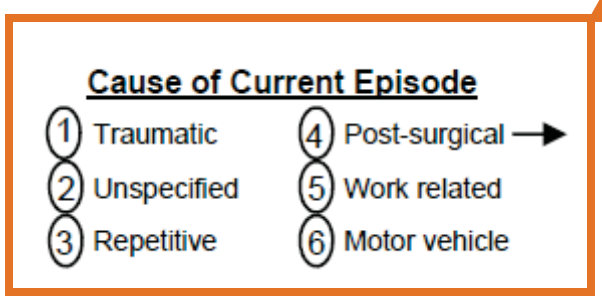
Patient Signature: X _____ Date: _____

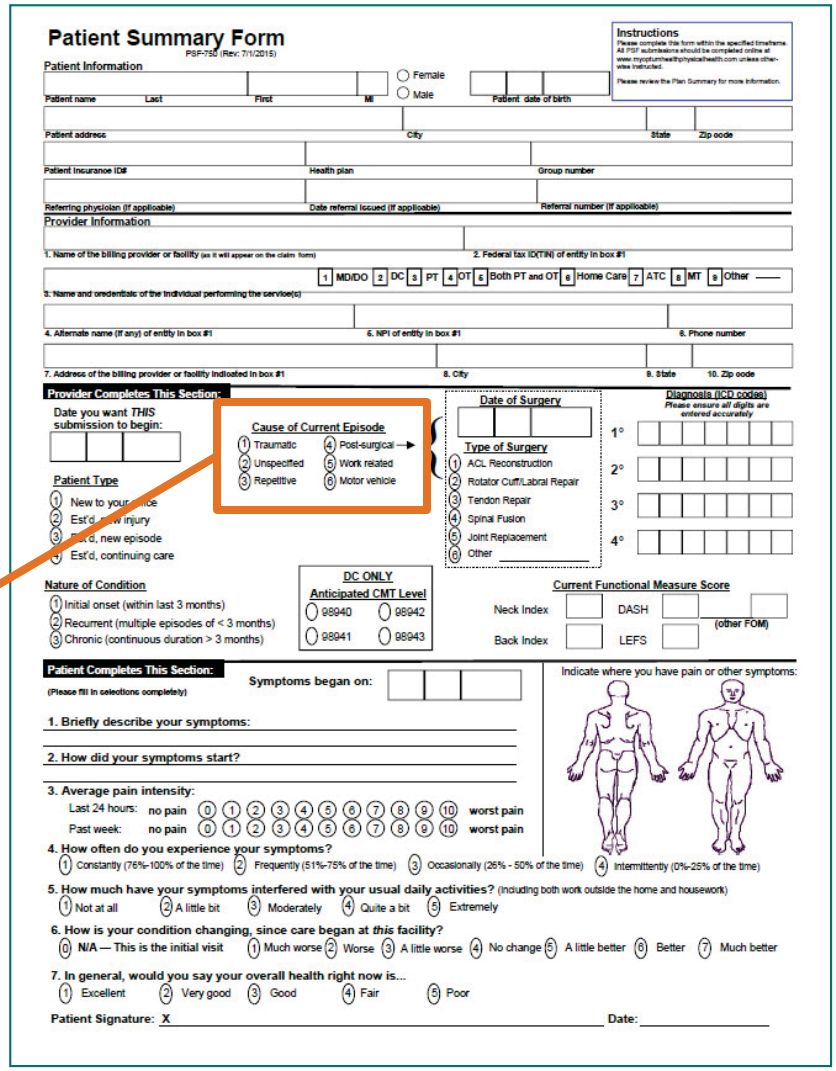
Nature of Condition

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

Cause of Current Episode

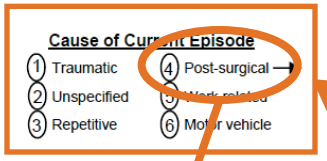
- **Traumatic** - The complaints are due to injury caused by an identifiable external force/agent.
- **Unspecified** - The complaints occurred gradually or suddenly without apparent cause.
- **Repetitive** - The complaints are a result of repeated actions/use.
- **Post-surgical** - The complaints are either due to or a result of a surgical procedure (see following slide).
- **Work Related or Motor Vehicle** - Complaints related to involvement in a work or auto accident.

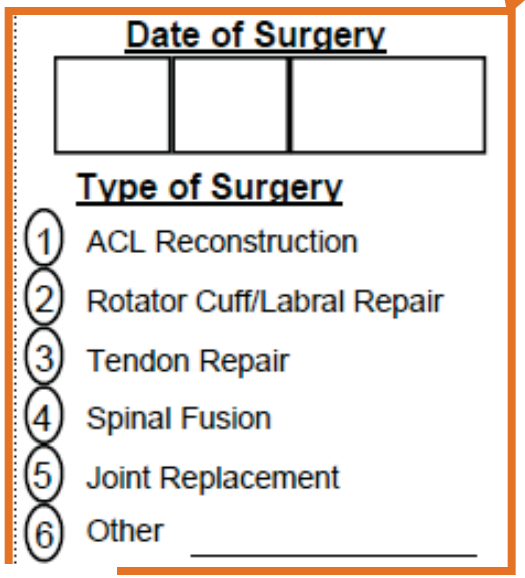


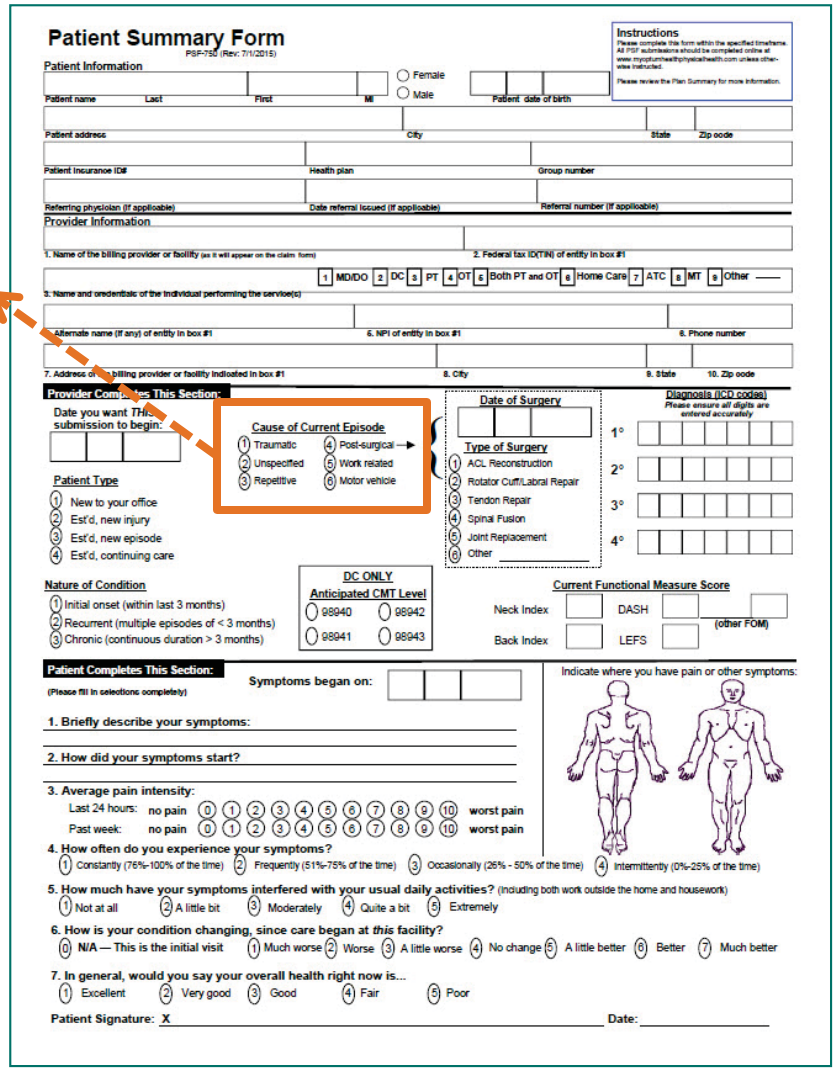


Post-Surgical Cause of Current Episode

- Only select Post- Surgical as the cause of current episode for recent surgeries(typically within the preceding 90 days).

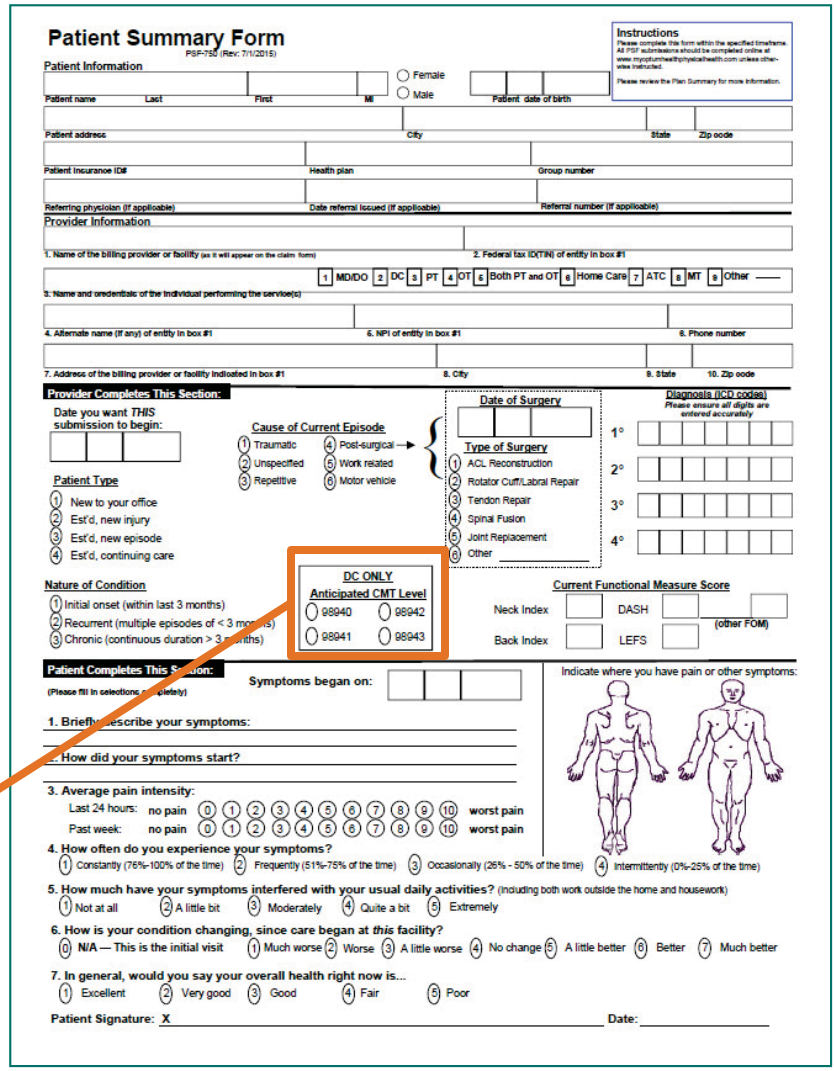


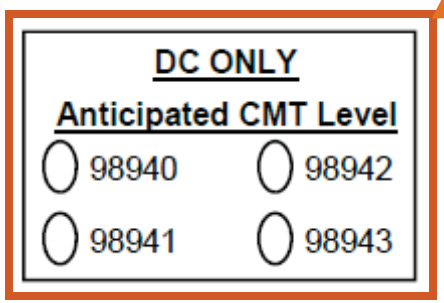




DC Only – Anticipated CMT Level

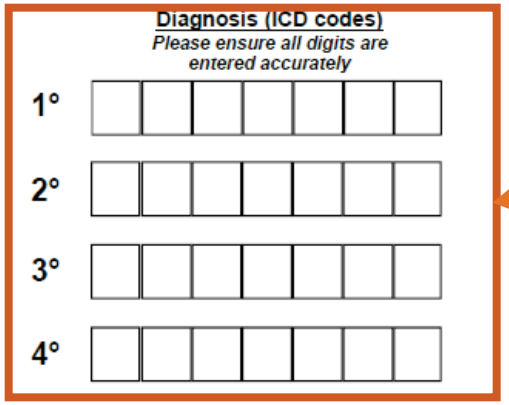
- This item is required for **DC** (Doctor of Chiropractic) providers only. All other health care specialties leave this item blank.
- Select the supported CMT level that meets CMT coding criteria.
  - Consult a coding reference and the OptumHealth policy #71 for further clarification.
- Support for the level of spinal CMT requires:
  - documentation of patient complaints,
  - exam findings, and
  - diagnoses involving the appropriate number of regions:
    - » 98940 – 1 to 2 regions
    - » 98941 – 3 to 4 regions
    - » 98942 – 5 regions

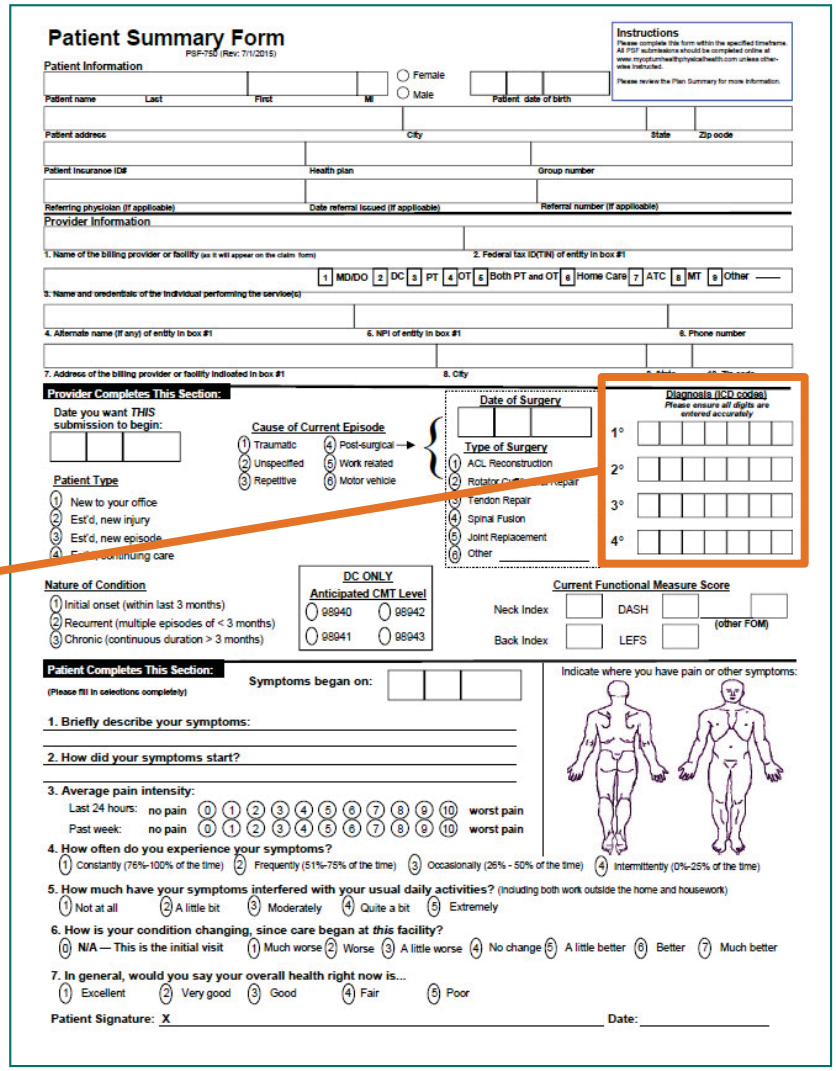




Diagnosis*

- Should include a clinical **primary** diagnosis using current ICD diagnostic codes.
- Utilize the ICD codes that most accurately describes the patient's condition.
- All diagnoses should be documented in your office notes.
- Please ensure that you accurately enter valid codes.





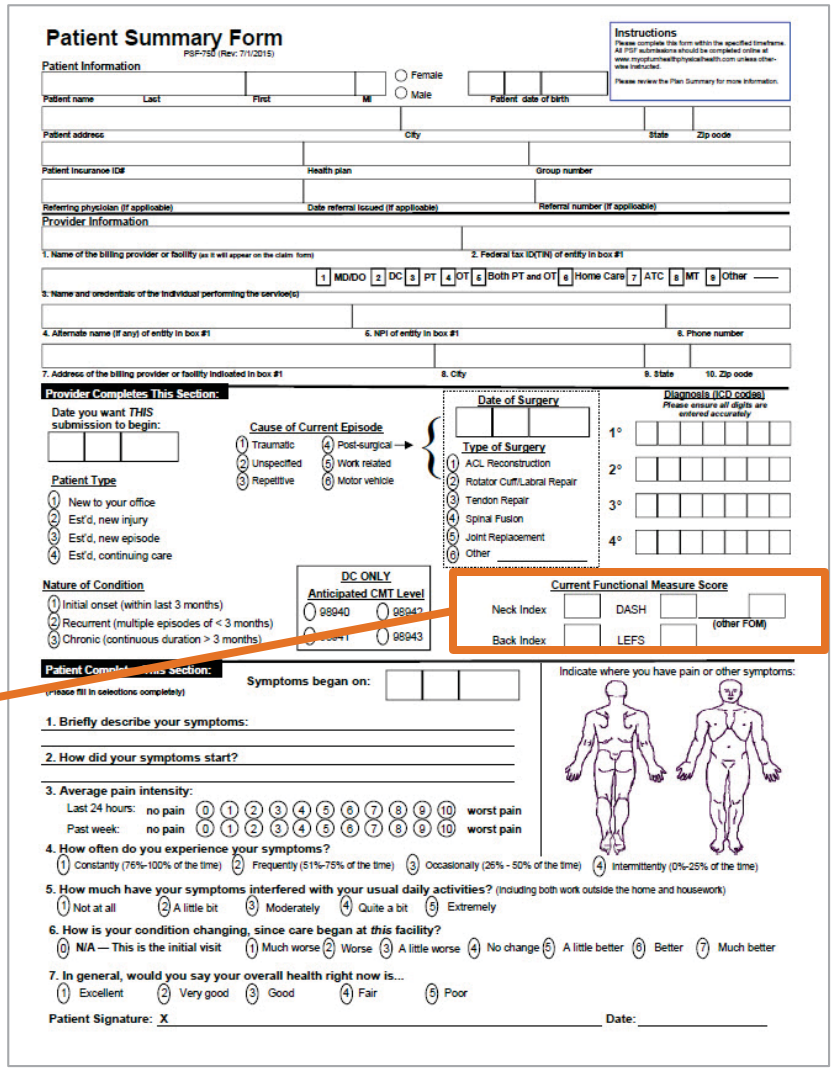
Please note

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.

Functional Outcome Measures

- Document the score in this section of the Patient Summary Form.
  - You may use other outcome measures.
  - Functional outcome measures are not required, but are highly recommended.
  - Please do not send in the actual outcome measure forms.



Patient Summary Form

PSF-75D (Rev: 7/1/2015)

Instructions

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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

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4. Alternate name (if any) of entity in box #1 — 6. 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:

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°

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: (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: _____

Current Functional Measure Score

Neck Index ☐ DASH ☐ _____ ☐ (other FOM)

Back Index ☐ LEFS ☐

Functional Outcome Measures

- OptumHealth recommends the following functional outcome measures:

  - **Neck Index** — Neck Disability Index
  - **Back Index** — Low Back Pain Disability Index
  - **DASH** — Disabilities of the Arm, Shoulder and Hand
  - **LEFS** — Lower Extremity Functional Scale

- Please select the outcome measure most applicable to the patient's condition. Enter the score on the Patient Summary Form. The discharge outcome score should be entered on the Patient Status Report (PSR). (PSR instructions can be found in the clinical resources section of the Optum provider portal).

Initial score	→	Initial submission
Interim score	→	Subsequent submission (if needed)
Discharge score	→	Patient Status Report (PSR)

Back and Neck Index Forms

- Valid and reliable questionnaires.
- Completed by the patient.
- Used to obtain data about the patient's tolerance for activities of daily living (ADLs).
- When administered prior to, during, and after an episode of care, change in the score objectively measures and documents treatment outcomes.

Back Index

Form BI100

OPTUM

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.

of washing or dressing in order to avoid pain.
y of washing or dressing even though it causes some pain.
the pain but I manage not to change my way of doing it.
the pain and I find it necessary to change my way of doing it.
to do some washing and dressing without help.
to do any washing and dressing without help.

xtra pain.
uses extra pain.
avy weights off the floor.
avy weights off the floor, but I can manage
ed (e.g., on a table).
avy weights off the floor, but I can manage
re conveniently positioned.

ut none of my usual forms of travel make it worse.
ut it does not cause me to seek alternate forms of travel.
hich causes me to seek alternate forms of travel.
xcept that done while lying down.

s me no extra pain.
ases the degree of pain.
my social life apart from limiting my more
g, etc).
and I do not go out very often.
to my home.
ause of the pain.

pain

definitely getting better.
tter but improvement is slow.
or worse.

selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

OPTUM

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 moment.
2. The pain comes and goes and is moderate.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Personal Care

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
3. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Reading

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of moderate neck pain.
4. I can hardly read at all because of severe neck pain.
5. I cannot read at all because of neck pain.

Driving

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight neck pain.
2. I can drive my car as long as I want with moderate neck pain.
3. I cannot drive my car as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe neck pain.
5. I cannot drive my car at all because of neck pain.

Concentration

0. I can concentrate fully when I want with no difficulty.
1. I can concentrate fully when I want with slight difficulty.
2. I have a fair degree of difficulty concentrating when I want.
3. I have a lot of difficulty concentrating when I want.
4. I have a great deal of difficulty concentrating when I want.
5. I cannot concentrate at all.

Recreation

0. I am able to engage in all my recreation activities without neck pain.
1. I am able to engage in all my usual recreation activities with some neck pain.
2. I am able to engage in most but not all my usual recreation activities because of neck pain.
3. I am only able to engage in a few of my usual recreation activities because of neck pain.
4. I can hardly do any recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

Work

0. I can do as much work as I want.
1. I can only do my usual work but no more.
2. I can only do most of my usual work but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Headaches

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Scoring the Back and Neck Index Forms

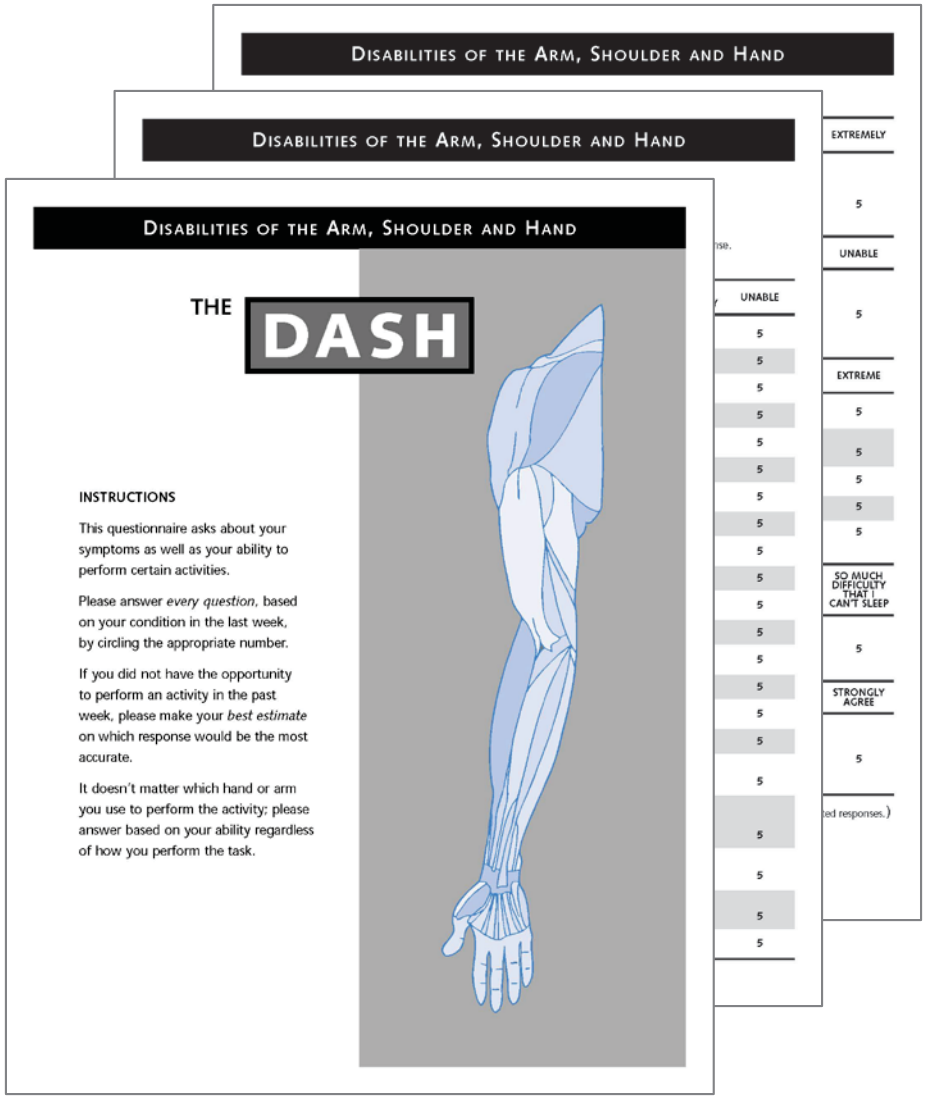
$$\text{Score} = \frac{\text{(Sum of all statements selected)}}{\text{(\# of sections with a statement selected x 5)}} \times 100$$

- Each statement corresponds to the number preceding the statement. Calculate the score by adding the selected values of statements, divide the total by the maximum possible value of the sections, and multiplying the result by 100.
- Ideally, patients should answer all 10 statements. When all statements are completed, a short cut to scoring the form is simply adding all the responses and doubling that amount. For example if the sum is 25, the disability is 50%.
- Example of scoring an incomplete index: If the patient only completes 9 statements, the maximum possible value would be 45 (9 sections x 5 points possible per statement).
- If a patient selects 2 or more answers for one statement, use the answer with the highest value when calculating the index score.

***The Back/Neck index scores are a percent (%) of the maximum possible score**

DASH – Disability of the Arm, Shoulder, and Hand

- The DASH measures the level of a upper extremity disability.
- A valid and reliable measure.
- Scored by practitioner using the designated formula.
- Score is documented on the Patient Summary Form.



Scoring of the DASH

- Patients should complete all sections based on their ability to perform activities over the past week. Only one answer should be selected per question.

- At least 27 of the 30 items must be completed for scoring.
- The assigned values are summed and then divided by the number of questions answered. This value is transformed to a score out of 100 by subtracting 1 and multiplying by 25.

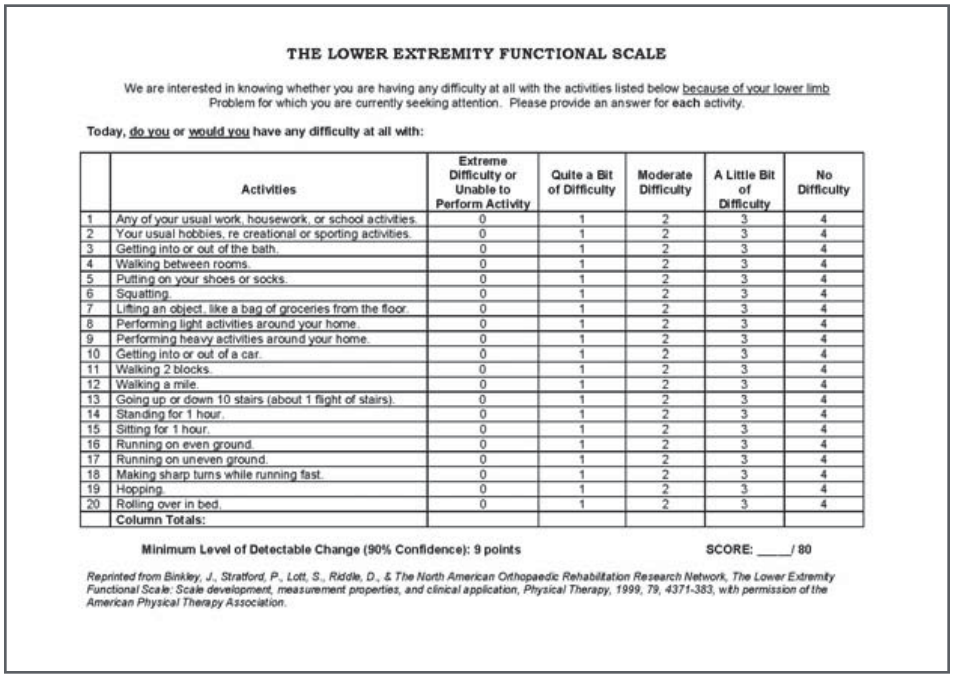
$$\text{DASH} = \left\{ \frac{(\text{sum of n responses})}{n^*} - 1 \right\} \times 25$$

*Where n is the total number of questions answered

- Since the DASH is a measure of patient disability, **a higher score indicates a higher level of upper extremity disability.**

LEFS – Lower Extremity Functional Scale

- The LEFS measures lower extremity function.
- A valid and reliable measure.
- Completed by the patient.
- Scored by practitioner and documented on the Patient Summary Form.



THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for each activity.

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	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: ____/ 80**

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

The LEFS score is simply the sum of all responses.

*Please do not calculate a percentage.

OPTUM®

Thank you for completing the
Clinical Submission Process Web Tutorial.

Please refer to the Plan Summary for additional plan specific information.