Patient Summary Form (PSF-750)

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

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

![Patient Summary Form with Provider Information highlighted]

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
   - MD/DO
   - DC
   - PT
   - OT
   - Both PT and OT
   - Home Care
   - ATC
   - MT
   - Other
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
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.

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 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.
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.
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

![Patient Summary Form](image)
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.
Functional Outcome Measures

- OptumHealth recommends the following functional outcome measures:
  - Neck Index
  - Back Index
  - DASH
  - LEFS

- 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).

<table>
<thead>
<tr>
<th>Score Type</th>
<th>Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial score</td>
<td>Initial submission</td>
</tr>
<tr>
<td>Interim score</td>
<td>Subsequent submission (if needed)</td>
</tr>
<tr>
<td>Discharge score</td>
<td>Patient Status Report (PSR)</td>
</tr>
</tbody>
</table>
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.
Scoring the Back and Neck Index Forms

Score = \frac{(\text{Sum of all statements selected})}{(\text{# of sections with a statement selected} \times 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 an 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.

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

*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 LEFS score is simply the sum of all responses.

*Please do not calculate a percentage.
Thank you for completing the Clinical Submission Process Web Tutorial.

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