



Optum Physical Health Clinical Submission Process Tutorial

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

Critical Case Information

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

Patient Summary Form
PSP-130 (Rev. 7/12/15)

Instructions
Please complete this form within the specified timeframe. All PSP submissions should be completed online at www.optumhealthphysicalhealth.com unless otherwise indicated. 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) MD DO DC PT OT Both PT and OT Home Care ATC MT Other

4. Alternate name (if any) of entity in box #1 6. NPI of entity in box #1 8. Phone number

7. Address of the billing provider or facility (individual in box #1) 9. Title 10. Zip code

Provider Completes This Section:

Date you want THIS submission to begin:

Cause of Current Episode

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

Patient Type

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

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°

DC ONLY

Anticipated CMT Level

1 Initial onset (within last 3 months) 98940 98942
2 Recurrent (multiple episodes of < 3 months) 98941 98943
3 Chronic (continuous duration > 3 months)

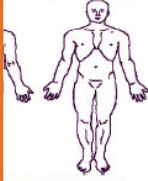
Current Functional Measure Score

Neck Index DASH
Back Index LEFS (other FOM)

Physical Measure Score

H
S (other FOM)

Do you have pain or other symptoms:



100% of the time
Often (75-99% of the time)
Sometimes (25-74% of the time)
Rarely (1-24% of the time)
Not at all

6) Better 7) Much better



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.

Cause of Current Episode

<p>① Traumatic</p> <p>② Unspecified</p> <p>③ Repetitive</p>	<p>④ Post-surgical →</p> <p>⑤ Work related</p> <p>⑥ Motor vehicle</p>
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Patient Summary Form

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 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) []

4. Alternate name (if any) of entity in box #1 [] 6. NPI of entity in box #1 [] 8. 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 ④ Post-surgical →
 ② Unspecified ⑤ Work related
 ③ Repetitive ⑥ Motor vehicle

Patient Type

New to your practice
 Est'd. new injury
 Est'd. new episode
 Est'd. continuing care

Nature of Condition

Initial onset (within last 3 months)
 Recurrent (multiple episodes of < 3 months)
 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:

Symptoms began on: []/[]/[]

(Please fill in selections completely)

1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

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

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

4. How often do you experience your symptoms?

Constantly (75%-100% of the time) Frequently (51%-75% of the time) Occasionally (26% - 50% of the time) 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)

Not at all A little bit Moderately Quite a bit Extremely

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

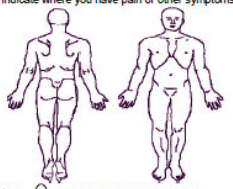
N/A — This is the initial visit Much worse Worse A little worse No change A little better Better Much better

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

Excellent Very good Good Fair Poor

Patient Signature: X _____ Date: _____

Indicate where you have pain or other symptoms:



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).

Cause of Current Episode

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

Date of Surgery

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Type of Surgery

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

Patient Summary Form
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Instructions: Please complete this form within the specified timeframe. All PSP submissions should be completed online at www.optumhealthphysicalhealth.com unless otherwise indicated. Please review the Plan Summary for more information.

Patient Information

Patient name: Last, First, MI. Sex: Female Male. Patient date of birth: _____

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): MD DO DC PT OT Both PT and OT Home Care ATC MT Other _____

Alternate name (if any) of entity in box #1: _____ 6. NPI of entity in box #1: _____ 6. Phone number: _____

7. Address of 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	④ Post-surgical →
② Unspecified	⑤ Work related
③ Repetitive	⑥ Motor vehicle

Date of Surgery

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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:

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

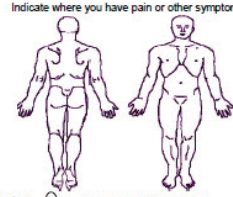
4. How often do you experience your symptoms?
① Constantly (75%-100% of the time) ② Frequently (51%-75% of the time) ③ Occasionally (26% - 50% of the time) ④ Intermittently (0%-25% of the time)

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?
① N/A - This is the initial visit ② Much worse ③ Worse ④ A little worse ⑤ No change ⑥ A little better ⑦ Better ⑧ 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: _____



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).



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 B1100


 OPTUM[®]

#v3/2/2003

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.

Neck Index
Form N1-100

 OPTUM[®]

#v3/2/2003

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.

<p>Pain Intensity</p> <p><input type="radio"/> 1 I have no pain at the moment.</p> <p><input type="radio"/> 2 The pain is very mild at the moment.</p> <p><input type="radio"/> 3 The pain comes and goes and is moderate.</p> <p><input type="radio"/> 4 The pain is fairly severe at the moment.</p> <p><input type="radio"/> 5 The pain is very severe at the moment.</p> <p><input type="radio"/> 6 The pain is the worst imaginable at the moment.</p>	<p>Personal Care</p> <p><input type="radio"/> 1 I can look after myself normally without causing extra pain.</p> <p><input type="radio"/> 2 I can look after myself normally but it causes extra pain.</p> <p><input type="radio"/> 3 It is painful to look after myself and I am slow and careful.</p> <p><input type="radio"/> 4 I need help every day in most aspects of self care.</p> <p><input type="radio"/> 5 I do not get dressed, I wash with difficulty and stay in bed.</p>
<p>Sleeping</p> <p><input type="radio"/> 1 I have no trouble sleeping.</p> <p><input type="radio"/> 2 My sleep is slightly disturbed (less than 1 hour sleepless).</p> <p><input type="radio"/> 3 My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="radio"/> 4 My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="radio"/> 5 My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="radio"/> 6 My sleep is completely disturbed (5-7 hours sleepless).</p>	<p>Lifting</p> <p><input type="radio"/> 1 I can lift heavy weights without extra pain.</p> <p><input type="radio"/> 2 I can lift heavy weights but it causes extra pain.</p> <p><input type="radio"/> 3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).</p> <p><input type="radio"/> 4 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="radio"/> 5 I can only lift very light weights.</p> <p><input type="radio"/> 6 I cannot lift or carry anything at all.</p>
<p>Reading</p> <p><input type="radio"/> 1 I can read as much as I want with no neck pain.</p> <p><input type="radio"/> 2 I can read as much as I want with slight neck pain.</p> <p><input type="radio"/> 3 I can read as much as I want with moderate neck pain.</p> <p><input type="radio"/> 4 I cannot read as much as I want because of moderate neck pain.</p> <p><input type="radio"/> 5 I can hardly read at all because of severe neck pain.</p> <p><input type="radio"/> 6 I cannot read at all because of neck pain.</p>	<p>Driving</p> <p><input type="radio"/> 1 I can drive my car without any neck pain.</p> <p><input type="radio"/> 2 I can drive my car as long as I want with slight neck pain.</p> <p><input type="radio"/> 3 I can drive my car as long as I want with moderate neck pain.</p> <p><input type="radio"/> 4 I cannot drive my car as long as I want because of moderate neck pain.</p> <p><input type="radio"/> 5 I can hardly drive at all because of severe neck pain.</p> <p><input type="radio"/> 6 I cannot drive my car at all because of neck pain.</p>
<p>Concentration</p> <p><input type="radio"/> 1 I can concentrate fully when I want with no difficulty.</p> <p><input type="radio"/> 2 I can concentrate fully when I want with slight difficulty.</p> <p><input type="radio"/> 3 I have a fair degree of difficulty concentrating when I want.</p> <p><input type="radio"/> 4 I have a lot of difficulty concentrating when I want.</p> <p><input type="radio"/> 5 I have a great deal of difficulty concentrating when I want.</p> <p><input type="radio"/> 6 I cannot concentrate at all.</p>	<p>Recreation</p> <p><input type="radio"/> 1 I am able to engage in all my recreation activities without neck pain.</p> <p><input type="radio"/> 2 I am able to engage in all my usual recreation activities with some neck pain.</p> <p><input type="radio"/> 3 I am able to engage in most but not all my usual recreation activities because of neck pain.</p> <p><input type="radio"/> 4 I am only able to engage in a few of my usual recreation activities because of neck pain.</p> <p><input type="radio"/> 5 I can hardly do any recreation activities because of neck pain.</p> <p><input type="radio"/> 6 I cannot do any recreation activities at all.</p>
<p>Work</p> <p><input type="radio"/> 1 I can do as much work as I want.</p> <p><input type="radio"/> 2 I can only do my usual work but no more.</p> <p><input type="radio"/> 3 I can only do most of my usual work but no more.</p> <p><input type="radio"/> 4 I cannot do my usual work.</p> <p><input type="radio"/> 5 I can hardly do any work at all.</p> <p><input type="radio"/> 6 I cannot do any work at all.</p>	<p>Headaches</p> <p><input type="radio"/> 1 I have no headaches at all.</p> <p><input type="radio"/> 2 I have slight headaches which come infrequently.</p> <p><input type="radio"/> 3 I have moderate headaches which come infrequently.</p> <p><input type="radio"/> 4 I have moderate headaches which come frequently.</p> <p><input type="radio"/> 5 I have severe headaches which come frequently.</p> <p><input type="radio"/> 6 I have headaches almost all the time.</p>

Back Index Score

Neck Index Score

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

of washing or dressing in order to avoid pain.
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.

extra pain.
causes extra pain.
heavy weights off the floor.
heavy weights off the floor, but I can manage
and (e.g., on a table).
heavy weights off the floor, but I can manage
are conveniently positioned.

ut nose of my usual forms of travel make it worse.
it does not cause me to seek alternate forms of travel.
which causes me to seek alternate forms of travel
except that done while lying down.

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

pain

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

selected x 5) x 100

Back Index Score



Scoring the Back and Neck Index Forms

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

- 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.

DISABILITIES OF THE ARM, SHOULDER AND HAND

THE DASH

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

1. UNABLE 5

2. UNABLE 5

3. UNABLE 5

4. UNABLE 5

5. UNABLE 5

6. UNABLE 5

7. UNABLE 5

8. UNABLE 5

9. UNABLE 5

10. UNABLE 5

11. UNABLE 5

12. UNABLE 5

13. UNABLE 5

14. UNABLE 5

15. UNABLE 5

16. UNABLE 5

17. UNABLE 5

18. UNABLE 5

19. UNABLE 5

EXTREMELY UNABLE

UNABLE

EXTREME

SO MUCH DIFFICULTY THAT I CAN'T SLEEP

STRONGLY AGREE

(red responses.)

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.

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

*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.



Thank you for completing the
Clinical Submission Process Web Tutorial.

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