The Optum in-office assessment program can help providers identify and address chronic conditions that may otherwise go undiagnosed and/or untreated.

How do I submit assessments?
Please submit assessments and all supporting medical record documentation via:

- **Optum electronic portal/modality**
- **Optum Uploader**
  To get started, please visit: optumupload.com
- **Traceable carrier (any commercial carrier with traceable delivery):**
  Optum Prospective Programs Processing
  2222 W. Dunlap Avenue
  Phoenix, AZ 85021
- **Secure fax**
  1-972-957-2145

Who can I contact if I have questions?
For more information, please contact the Optum Provider Support Center between 8 a.m.–7 p.m. ET, Monday–Friday, at 1-877-751-9207 or call your Optum representative. You may also email providersupport@optum.com.

In-office assessment checklist

**Getting started**

- Locate the patient name toward the top of each assessment.
- Verify patient eligibility prior to rendering services, as patients can be enrolled or disenrolled throughout the year. Assessments with ineligible dates of service will not be eligible for reimbursement.
- Check to see if the patient has already been in for their comprehensive annual exam.
- If the patient has already been in, review the medical records with the assessment to determine if all gaps in care were assessed.
- If all gaps in care have been assessed, submit the medical record(s) and completed assessment per instructions noted on the assessment.
- If the patient has not yet been seen, has remaining gaps in care to address, or was last seen over 60 days ago, schedule an appointment for a comprehensive exam. Review the assessment at the time of the patient encounter to ensure all gaps in care are addressed and documented.

**Preparing medical records**

- Assess and document in the medical record all active gaps in care assessed during the encounter. Be sure to include a clear provider signature and credential(s), patient name and date of service (DOS). Document all chronic conditions and comorbid factors to the highest level of specificity as well as any completed or referred quality screenings.
- Include all medical records within the current calendar year that provide evidence that the gaps in care have been addressed. The latest DOS submitted must be within sixty (60) days to receive the full administrative reimbursement, if applicable.
- If you are unable to complete the assessment for the current calendar year, select one of the exclusion check boxes located under Patient Status Exceptions section of the assessment. A medical record is not required if you have checked one of the exclusions. Patient Status Exceptions are not eligible for reimbursement.
- Screening documentation may fall outside of the eligible date range, as outlined by Healthcare Effectiveness Data and Information Set (HEDIS®) specifications, and should be included with a current calendar year medical record.

**Submitting assessments**

Before submitting the assessment with the required medical record(s), please follow these guidelines to prevent rejected assessments:

- Attach all supporting medical record documentation and submit with completed assessment. Corresponding claims sent to the health plan for the same date of service should include all appropriate diagnosis codes as documented for the exam.
- Ensure the provider’s signature and credentials are legible and included on the medical record. Assessments are rejected for noncompliant/ illegible signatures. If using an electronic medical record (EMR), ensure the signature on file has been authenticated and is CMS compliant.
- Submit a signature log to Optum® for your provider group, even if using an EMR. This proactively assists in validating the signer’s credentials. We cannot process assessments if credentials are not present on the EMR.
- Ensure the DOS is written legibly on the first page of the medical record. If faxing, check to make sure it is not cut off in the margins.
Frequently asked questions

How does Optum populate each patient assessment?
Assessments are prepopulated for each patient based on past claims data, including primary care visits, specialists visits, hospitalizations and Rx claims.

All assessments are unique to each patient based on risk factors, emergency room visits and suspected conditions, and whether or not a patient is due for a HEDIS®-specific screening, if applicable.

Does the assessment need to be filled out at the time of the visit?
The assessment is designed to be used at the point of care and helps ensure patients receive a complete and comprehensive annual assessment. We encourage the provider to review the assessment prior to or during the patient's office visit to help assess and address all gaps in care. Proper documentation in the medical record must support all diagnoses confirmed during the encounter and screenings completed or referred.

How does Optum define a timely return?
Optum will use the latest DOS submitted and the receipt date by Optum to determine if the assessment was submitted within 60 days from the DOS. Multiple DOS may be submitted with the assessment to support the closure of all gaps in care. The latest DOS will be the one used to calculate the timely return. For example, if progress notes with the DOS of Jan. 20, 2020, and May 20, 2020, were submitted with the assessment, the May 20, 2020, will be the DOS used to calculate timely return. For this example, if the assessment is received by Optum on or before July 18, 2020, full timely reimbursement would apply to this assessment, if applicable.

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

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

Ask your Optum representative how we can support your practice.

What is the Optum in-office assessment program?
The Optum in-office assessment program promotes early detection and ongoing assessment of chronic conditions for our health plans’ Medicare Advantage, Medicaid Managed Care Plan and Affordable Care Act (ACA) members. The goal of the in-office assessment program is to help ensure that these patients receive a comprehensive annual exam and to support a variety of quality programs, including HEDIS® and the Five-Star Quality Rating System.

Additional patient assessment tools
Talk to your Optum representative for additional tools for the Optum in-office assessment program. This includes the In-Office Assessment Provider Instructions and brochure.

Who can I contact if I have questions?
For more information, please contact your Optum representative or the Optum Provider Support Center between 8 a.m.–7 p.m. ET, Monday–Friday, at 1-877-751-9207. You may also email providersupport@optum.com.