Humana Practitioner Assessment Form (PAF)

What is the Humana PAF?

The Humana Practitioner Assessment Form (PAF) is intended to guide a comprehensive health assessment. The form consists of elements from the Annual Wellness Visit and Healthcare Effectiveness Data and Information Set (HEDIS®) measures. The form can be used by physicians and other healthcare providers to help document vital information for Humana Medicare Advantage-covered patients during an annual face-to-face or telehealth visit. The Humana PAF is a stand-alone medical record, which should include supporting documentation for all services billed in order to capture the true health status of the patient.

Why should I complete the PAF?

The PAF serves as a concise template that helps to ensure all the elements of a comprehensive health and quality assessment are documented, while assisting in HEDIS measurement closure.

Completion of the form enhances complete and accurate medical record documentation, which allows diagnosis coding to the highest level of specificity and identifies opportunities to positively impact patient care with HEDIS and Star Ratings measures. It can help improve coordination of care and help patients access applicable Humana care management programs.

How do I complete the PAF?

- Ensure you are using the most updated PAF. The current version of the PAF can be found at Humana's website, humana.com/provider/support/clinical/quality-resources/ and select the "Preventive Care" tab, or on the Availity Essentials portal, select the Humana "Resources" tab at apps.availity.com/availity/web/public.elegant.login.
- Contact your assigned Humana-covered patient to schedule him or her for an appointment.
- Complete the Humana PAF during a face-to-face encounter or telehealth visit between a patient and a licensed medical doctor (M.D.), doctor of osteopathy (D.O.), physician assistant (PA) or nurse practitioner (NP).
- Examine, evaluate and treat the patient as you normally would, being sure to assess all of his or her chronic health conditions, if any, as well as any acute conditions that may be present.
- Ensure that the assessment form is completed in its entirety and signed by the rendering healthcare provider.
- Attach additional documentation as needed (see User Guide for instructions).
- Submit the completed assessment form to Humana by one of the two available options. (See page 11 for instructions.)
- Place the completed assessment form in the patient's medical record.

Should I submit a claim?

Yes, a claim must be submitted with Current Procedural Terminology (CPT®) code 96160 in conjunction and on the same claim with the appropriate office visit, evaluation and management code (E/M) or Annual Wellness Visit code indicating a face-to-face visit occurred. (See page 11 for instructions.).

If you have additional questions, please contact your Humana market representative.

Fax completed forms to Humana at 888-838-2236

Patient name: _____ Date of service: ___ / ___ /___

Humana member ID: _____ Date of birth: ___ / ___ /___

Humana Practitioner Assessment Form

Reason for visit (mark all that apply):

☐ Initial AWV ☐ Subsequent AWV ☐ Preventive Physical Exam ☐ Other _____

Patient demographics and vital signs

Gender: ☐ Male ☐ Female **Age:** _____

Race/ethnicity: ☐ Hispanic/Latino ☐ American Indian ☐ Alaska Native ☐ Black/African American ☐ African ☐ Asian ☐ Asian Indian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ Other _____

How would you rate your overall health over the past month ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height: _____ ft. _____ in. **Weight:** _____ pounds **Body Mass Index (BMI):** _____

Heart rate: _____ bpm **Blood pressure:** ____/____ **BMI not completed due to pregnancy:** Y ☐ N ☐

O2 Sat: _____% **Supplemental oxygen use?** Y ☐ N ☐

Current medical team involved with care (Please specify as primary care, specialist, supplier, emergency contact, etc.).

_____ _____

_____ _____

_____ _____

Personal medical history – If marked as "active," please also document condition in final

Diagnosis	Description/remarks	Active/resolved

Patient name: _____ Date of service: ___ / ___ /___

Humana member ID: _____ Date of birth: ___ / ___ /___

Surgical history

Procedure	Reason for procedure	Date	Surgeon or facility

Current medications – Please include over-the-counter medications.

Name of medication	Dose/frequency	Conditions being treated

Medication review:

- ☐ Reviewed for allergies
- ☐ Reviewed for potentially harmful drug-disease interactions
- ☐ Reviewed the medical necessity for any medications that fall into the AGS Beers Criteria

Does the patient have a current opioid prescription? If yes, review the following:

- ☐ Utilized opioid use disorder (OUD) risk tool
- ☐ Evaluated pain severity & current treatment plan
- ☐ Reviewed non-opioid treatment options
- ☐ Referred to specialist

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Humana member ID: _____ Date of birth: ___ / ___ /___

Pain screening – Please circle the level of pain that patient experiences on a daily basis.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain **Moderate pain** **Extreme pain**

☐ **If pain, check box if evidence of pain management.**

If currently prescribed pain medication, please document in medication list.

Family history ☐ Reviewed and discussed

Pertinent diagnoses in parents, siblings, children, others:

_____

_____

_____

Mental health screening

Mental health screening tool used? Y ☐ N ☐

If yes, which one: ☐ PHQ-2 ☐ PHQ-9 ☐ Other: _____ **Score:** _____

Diagnoses (if present, please specify severity and include in diagnosis summary):

_____

_____

Safety assessed and addressed as applicable? Y ☐ N ☐

Functional status assessment

☐ Results using a standardized functional status assessment tool Name of tool: _____

☐ Assessment of instrumental activities of daily living (IADLs) ☐ Assessment of ADLs

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Patient name: _____ Date of service: ___ / ___ /___

Humana member ID: _____ Date of birth: ___ / ___ /___

Additional medical counseling/screening assessments (check any that are completed)

☐ **Alcohol/drug use**

Screen for potential substance use disorders (SUDs)

Review the patient's risk factors and refer for treatment, as appropriate

☐ **Tobacco use/cessation**

Do you currently use tobacco? Y ☐ N ☐

Discuss smoking cessation treatments

☐ **Diet/nutrition**

Review daily intake and goals

☐ **Physical activity/exercise**

In the past week, how many days did you exercise? _____ days

Does pain interfere with ADLs? Y ☐ N ☐

Discuss goals: ☐ start ☐ increase ☐ maintain exercise

☐ **Fall prevention**

Have you fallen, or nearly fallen, in the past 12 months? Y ☐ N ☐

Have you had any problems with balance or walking in the past 12 months? Y ☐ N ☐

Review medications for side effects that could contribute to falls
Assess for visual and hearing impairment
Discuss additional prevention/treatment options, including using a cane or walker, or doing an exercise or physical therapy program

☐ **Urinary incontinence**

Have you leaked any urine, even a small amount, in the past 6 months? Y ☐ N ☐

Discuss bladder training exercises, medications, or surgery, as appropriate

☐ **Immunizations**

Influenza virus vaccine — annually Y ☐ N ☐ ____/____/____

Pneumococcal vaccine — two recommended in lifetime

☐ PCV13 ____/____/____ ☐ PPSV23 ____/____/____

☐ **Home safety**

Do you have a smoke alarm that works, appropriate assistive devices, and a clear escape route in case of emergencies? Y ☐ N ☐

☐ **Seatbelt use**

Do you use a seatbelt 100% of the time when you are in a car? Y ☐ N ☐

☐ **Advance care planning**

Discuss living wills, advance directives, power of attorney (at patient's discretion) Y ☐ N ☐

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Humana member ID: _____ Date of birth: ___ / ___ /___

Physical examination (at provider discretion) *While a physical exam is not a mandatory component of an Annual Wellness Visit or Humana's Practitioner Assessment Form, providers are encouraged to document pertinent physical findings, to the extent the visit type allows, to help aid in supporting diagnoses and provide a complete medical record.*

General: ☐ Well-nourished ☐ Alert ☐ No acute distress ☐ Review of Systems Performed

Abnormal exam findings: _____

Cognitive impairment

Cognitive impairment assessment completed (e.g., Mini-Cog, three-word recall, clock drawing, etc.) Y ☐ N ☐

Findings: ☐ Negative for cognitive impairment ☐ Positive for cognitive impairment

Additional comments: _____

HEDIS® measures — Please fill in all appropriate dates for screening received

Colorectal Cancer Screening

☐ Screening not applicable If checked, please provide reason: _____

Excluded due to total colectomy	___/___/___
Excluded due to diagnosis of colorectal cancer	___/___/___
Colonoscopy performed in current year or nine previous years	___/___/___
CT colonography performed in current year or four previous years	___/___/___
Flexible sigmoidoscopy performed in current year or four previous years	___/___/___
Stool DNA with fecal immunochemical test (FIT) DNA test (Cologuard®) performed in current year or two previous years	___/___/___
Fecal occult blood test (FOBT) performed in current year	___/___/___

Breast Cancer Screening

☐ Screening not applicable If checked, please provide reason: _____

Excluded due to bilateral mastectomy	___/___/___
Excluded due to two unilateral mastectomies with service dates 14 days or more apart	___/___/___ AND ___/___/___
Excluded due to unilateral mastectomy with bilateral modifier	___/___/___
Mammography performed 27 months prior to Dec. 31 of the current year	___/___/___

Patient name: _____ Date of service: ___ / ___ /___

Humana member ID: _____ Date of birth: ___ / ___ /___

Osteoporosis Management in Women who Had a Fracture

☐ Screening not applicable If checked, please provide reason: _____

Excluded due to bone mineral density testing within 24 months prior to fracture ____ / ____ / ____

Excluded due to patient receiving osteoporosis prescription within 12 months prior to fracture ____ / ____ / ____

Excluded because fracture was a finger, toe, face or skull ____ / ____ / ____

Excluded due to unilateral mastectomy code with right side modifier and a unilateral mastectomy with a left side modifier on the same or different date of service ____ / ____ / ____

Date in which osteoporosis medication was dispensed or filled (must be within six months after the fracture occurred to be compliant for this measure) ____ / ____ / ____

Medication name: _____ **Administration route:** _____ **Dosage:** _____

Bone mineral density test completed within 6 months of the fracture ____ / ____ / ____

Transitions of Care

☐ Screening not applicable If checked, please provide reason: _____

Inpatient Admission Notification – is there documented evidence that the patient's PCP or ongoing care provider was notified of the patient's inpatient admission, on the day of or up to 2 days after the admission (3 days total)? Y ☐ N ☐

Medication Reconciliation Post-Discharge – is there documented evidence in the outpatient record that the patient's discharge medications and outpatient medications were reconciled, with notation of such, on the day of discharge through 30 days after discharge (31 days total)? Y ☐ N ☐

Patient Engagement After Inpatient Discharge – is there documented evidence that the patient had engagement with their PCP or ongoing care provider within 30 days of discharge (excluding the day of discharge)? Y ☐ N ☐

Receipt of Discharge Information – is there documented evidence that the patient's PCP or ongoing care provider was notified of the patient's discharge status, on the day of or up to 2 days after the discharge (3 days total)? Y ☐ N ☐

Statin Therapy – Please fill in all appropriate dates for therapy received

☐ **No** If no, move to next section

Excluded due to patient being dispensed at least one prescription for clomiphene ____ / ____ / ____

☐ **Yes** Dispensed or filled statin medication in current year ____ / ____ / ____

Statin therapy intensity (check one)

☐ High intensity ☐ Moderate intensity

Statin Rx name: _____

Rx dose: _____

Fax completed forms to Humana at 888-838-2236

Patient name: _____ Date of service: ___ / ___ /___

Humana member ID: _____ Date of birth: ___ / ___ /___

Disease-specific management – Please fill in all appropriate dates for screening received below.

Does the patient have diabetes? Y ☐ N ☐

If yes, consider performing a diabetic foot exam and check all that apply:

☐ Skin changes reviewed ☐ Neurological exam performed ☐ Vascular exam performed

Diabetic eye care

☐ Screening not applicable (If checked, please provide reason:_____)

Patient excluded from measure due to not having a diabetes diagnosis AND having a diagnosis of one of the following during the past two calendar years:

☐ Gestational diabetes ☐ Steroid-induced diabetes ☐ Polycystic ovary syndrome

Dx date: ____ / ____ / ____ Dx date: ____ / ____ / ____ Dx date: ____ / ____ / ____

Name of eye care professional _____

Retinal or dilated eye exam by an eye care professional during current measurement year ____ / ____ / ____

Results: Retinopathy Y ☐ N ☐

Negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional during measurement year or prior year ____ / ____ / ____

Labs for patients with diabetes

☐ Screening not applicable (If checked, please provide reason: _____)

Patient excluded from measure due to not having a diabetes diagnosis AND having a diagnosis of one of the following during the past two calendar years:

☐ Gestational diabetes ☐ Steroid-induced diabetes ☐ Polycystic ovary syndrome

Dx date: ____ / ____ / ____ Dx date: ____ / ____ / ____ Dx date: ____ / ____ / ____

Kidney Health Evaluation

eGFR Estimated Glomerular Filtration Rate Lab Test **AND** uACR Urine Albumin-Creatinine Ratio Lab Test

____ / ____ / ____ ____ / ____ / ____

OR

Quantitative Urine Albumin Test ____ / ____ / ____ **AND** Urine Creatinine Test ____ / ____ / ____

(The service dates for the Urine Albumin Test and Urine Creatinine Test need to be 4 days or less apart.)

Hemoglobin A1C Control

Most recent HbA1C Result: _____ Result date: ____ / ____ / ____

Fax completed forms to Humana at 888-838-2236

Patient name: _____ Date of service: ___ / ___ /___

Humana member ID: _____ Date of birth: ___ / ___ /___

Diagnosis – Please provide the appropriate active diagnoses and corresponding codes.

	Diagnosis	ICD 10 code	Treatment plan		
1.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
2.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
3.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
4.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
5.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
6.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
7.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
8.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
9.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		
10.	_____	_____	☐ Medication ☐ Monitor ☐ Diet ☐ Labs ☐ Referrals ☐ Other _____		

Screening/prevention plan for the next 5 to 10 years

_____

_____

Fax completed forms to Humana at 888-838-2236

Patient name: _____ Date of service: ___ / ___ /___

Humana member ID: _____ Date of birth: ___ / ___ /___

Follow-up/referral/test ordered

_____

_____

_____

Assessment statement:

Healthcare provider acknowledges and agrees that Humana will update and adjust this form as necessary. Updated forms will be available for use in the secure section of Humana's website: **humana.com/provider/support/clinical/quality-resources/.**

Medicare payment to Medicare Advantage organizations is based, in part, on each patient's diagnoses, as attested to by the patient's attending healthcare provider by virtue of his or her signature on this medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to a fine, imprisonment or civil penalty under applicable federal laws.

By signing this document, you attest to having assessed the patient in a face-to-face visit and reviewed the medical documents to complete the form using the best of your medical knowledge, having placed the completed original of this form in the patient's medical record and having ensured fully documented proof of service of all completed fields is contained in the patient's medical record. (Note: If the practice has an electronic medical record system, scan the assessment and attach the image to the electronic record.)

To the best of my knowledge, information and belief, the information provided regarding diagnoses is truthful and accurate.

_____	_____	_____
Healthcare provider name and credentials (printed)	Healthcare provider signature and credentials (signed)	Date

Provider office number: _____

Billing healthcare provider ID: _____ Provider type: ☐ Taxpayer identification number (TIN) ☐ National provider identifier (NPI)

Healthcare provider address: _____

City, State, and Zip: _____

How to submit the Practitioner Assessment Form (PAF)

Method 1: Upload

Upload completed PAF records directly to Humana using the fast and secure provider portal with the following steps:

1. Go to www.submitrecords.com/humana and enter the secure password **hfpaf83**.
2. Click the "Add files" button and choose the medical records from your internet browser.
3. Upload single records in either PDF or TIF format. You can batch upload multiple records in a zip file in the same file formats.
4. Add any information regarding the record(s) into the notes section. You can add records to a maximum of 100MB of space per upload.
5. Click "Upload" and the selected medical records will be electronically routed to the Humana repository system.
6. Log confirmation numbers upon upload and use for internal tracking and reconciliation.

For technical assistance with the provider upload portal, please call 801-984-4540. Records will be stored in the secure Humana repository system. The website www.submitrecords.com/humana has been verified by Entrust®, an identity-based security software provider. All transactions are protected by 128-bit secure sockets layer (SSL).

Method 2: Fax

If you do not have online capabilities, you may fax medical records and/or completed forms to Humana medical record retrieval at **888- 838-2236.** Please use a cover page and ensure that page does not contain any personal health information. Log confirmation receipt upon fax submission and use for internal tracking and reconciliation.

- **The PAF record should be submitted to Humana within sixty (60) days from the rendering date of service.**
- **If you are enrolled in EHR subscriptions with automated medical record submission, you may no longer need to manually fax or up- load completed PAFs to Humana. For more information on this capability, contact your Humana market representative.**

How to submit the practitioner assessment form claim

- A claim must be submitted with Current Procedural Terminology (CPT®) code 96160 in conjunction and on the same claim with the appropriate office visit, evaluation and management code (E/M) or Annual Wellness Visit code indicating a face-to-face visit occurred.
- Humana is permitting PAF visits to be conducted via telehealth. PAFs performed via telehealth must be conducted using a real-time interactive audio and video telecommunications system. To indicate that a PAF telehealth visit was performed using both real-time interactive audio and video telecommunications system, CPT® code 96160 should be billed in conjunction with one of the PAF program approved E/M codes with the modifier 95 appended and the place of service (POS) code that would have been reported had the service been furnished in person.
- CPT® category ll or supplemental tracking codes used for performance measurement can be included on the 96160 claim (See Appendix 1)
- Include supporting documentation within the PAF for all services billed.
- Please adhere to all correct coding guidelines when applying a modifier.

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The table below identifies E/M codes that correlate with elements of a Humana PAF visit.

CPT® code	Description
G0402	Welcome to Medicare visit – Initial preventive physical examination (IPPE)
G0438 and G0439	Annual Wellness Visit – Initial and subsequent
99203 – 99205	Office or other outpatient visit for the evaluation and management of a new patient which requires a medically appropriate history and/or examination and low/moderate/high level of decision making
99213 – 99215	Office or other outpatient visit for the evaluation and management of an established patient which requires a medically appropriate history and/or examination and low/moderate/high level of decision making
99243 – 99245	Office consultation for a new or established patient which requires a medically appropriate history and/or examination and low/moderate/high level of decision making
99253 – 99255	Inpatient consultation for a new or established patient which requires a medically appropriate history and/or examination and low/moderate/high level of decision making
99342, 99344, and 99345	Home or residence visit for the evaluation and management of a new patient which requires a medically appropriate history and/or examination and low/moderate/high level of decision making
99348 – 99350	Home or residence visit for the evaluation and management of an established patient which requires a medically appropriate history and/or examination and low/moderate/high level of decision making
99385 – 99387	Initial comprehensive preventive medicine evaluation – new patient
99395 – 99397	Periodic comprehensive preventive medicine evaluation – established patient
99495 – 99496	Transitional care management services of moderate/high medical complexity requiring a face-to-face visit within 14/7 days of discharge

Humana Practitioner Assessment Form CPT® Category II codes

The following chart shows which measures are tracked and which codes may be used for each measure. For a complete list of CPT Category II codes, American Medical Association (AMA) members can go to the AMA website at www.ama-assn.org/practice-management/cpt/need-coding-resources.

* CPT Category II codes with an asterisk will not close the care opportunity because they're not included in the National Committee for Quality Assurance (NCQA) HEDIS® technical specifications. However, please use CPT Category II codes because they provide valuable quality information when submitted. It is anticipated that the use of Category II codes for performance measurement will decrease the need for record abstraction and chart review.

The use of these codes is optional. The codes are not required for correct coding and may not be used as a substitute for Category I codes.

Appendix 1

Humana Practitioner Assessment Form CPT® Category II codes

Measure	Code descriptor	CPT® Category II codes
Adult BMI assessment	Body mass index (BMI) documented	3008F*
Annual flu vaccine	Influenza immunization ordered or administered	4037F*
	Influenza immunization administered or previously received	4274F*
Breast cancer screening	Screening mammography results documented and reviewed	3014F*
Blood pressure control	Most recent systolic blood pressure < 130 mmHg	3074F
	Most recent systolic blood pressure 130-139 mmHg	3075F
	Most recent systolic blood pressure > or equal to 140 mmHg	3077F
	Most recent diastolic blood pressure < 80 mmHg	3078F
	Most recent diastolic blood pressure 80-89 mmHg	3079F
	Most recent diastolic blood pressure > or equal to 90 mmHg	3080F
Care for older adults	Advanced care planning discussed and documented – Advance care plan or surrogate decision-maker documented in medical record	1123F
	Advanced care planning discussed and documented in medical record – Patient didn't wish to or was unable to provide an advance care plan or name a surrogate decision-maker	1124F
	Pain assessment – Pain present and severity quantified	1125F
	Pain assessment - No pain documented	1126F
	Medication list documented[1]	1159F
	Review of all medications (prescriptions, OTC, supplements) conducted and documented by a prescribing practitioner[1]	1160F
	Functional status assessed	1170F
Colorectal cancer screening	Colorectal cancer screening results documented and reviewed	3017F
Comprehensive diabetes care	Dilated retinal exam with eye care professional, with evidence of retinopathy	2022F
	Dilated retinal exam with eye care professional, without evidence of retinopathy	2023F
	7 standard field stereoscopic retinal photos with interpretation documented and reviewed, with evidence of retinopathy	2024F
	7 standard field stereoscopic retinal photos with interpretation documented and reviewed, without evidence of retinopathy	2025F

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[1]Both codes (1159F and 1160F) are required if the record does not contain other evidence of a medication list and medication review.

Humana Practitioner Assessment Form CPT® Category II codes		
Measure	**Code descriptor**	**CPT® Category II codes**
Comprehensive diabetes care [cont.]	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos, results documented and reviewed, without evidence of retinopathy	2033F
	Most recent HbA1c level < 7.0%	3044F
	Most recent HbA1c level ≥ 7.0% and < 8.0%	3051F
	Most recent HbA1c level ≥ 8.0% and ≤ 9.0%	3052F
	Positive microalbuminuria test result reviewed and documented	3060F
	Negative microalbuminuria test result reviewed and documented	3061F
	Positive macroalbuminuria test result reviewed and documented	3062F
	Documentation of treatment for nephropathy	3066F
	Low risk for retinopathy (No evidence of retinopathy in the prior year)	3072F
	ACE inhibitor or ARB therapy prescribed or currently being taken	4010F
Medication reconciliation post-discharge	Discharge medications reconciled with current medications in outpatient record	1111F
Osteoporosis management in women who had a fracture	Central dual-energy X-ray absorptiometry (DXA) results documented	3095F*
	Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	4005F*
Pneumonia vaccine	Pneumococcal vaccine administered or previously received	4040F*

These codes describe clinical components that may be typically included in evaluation and management services or clinical services and, therefore, do not have a relative value associated with them. Category II codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

Category II codes described in this section make use of alphabetical characters as the fifth character in the string (i.e., four digits followed by the letter F). These digits are not intended to reflect the placement of the code in the regular (Category I) part of the CPT code set. (Source: AMA website at **https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/cpt/cpt-cat2-codes_0.pdf**)