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, a physical exam 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 examination 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 will 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/, or on the Availity portal Humana "Resources" tab at https://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.
- Place the completed assessment form in the patient's medical record.
- Submit the completed assessment form to Humana by one of the two available options. (See last page for instructions.)

Should I submit a claim?

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

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

Humana practitioner assessment form

Fax completed forms to Humana at 888-838-2236

Patient name: _____ **Date of service:** ____/____/_____

Humana member ID: _____ **Date of birth:** ____/____/_____ **Gender:** ☐ Male ☐ Female

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

Medical history – If marked as "active," please also document condition in final diagnosis list.

Diagnosis	Description/remarks	Active/resolved

Providers regularly involved with care – specialists/suppliers

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

Fax completed forms to Humana at 888-838-2236

Patient name: _____ **Date of service:** ____/____/_____

Humana member ID: _____ **Date of birth:** ____/____/_____

Medication reconciliation post-discharge – Has the patient been hospitalized in the last year? If patient has had more than one discharge, include all discharges on or between Jan. 1 and Dec. 1 of the measurement year.

Yes ☐ If yes, is there documentation that the physician reconciled the current and discharge medications within 30 days after discharge?	**Date of review:** _____ **Physician:** _____ (Prescribing physician, clinical pharmacist or registered nurse)
No ☐ If no, move to next section	**Hospital discharge date:** ____/___/_____

Statin therapy – Please fill in all appropriate dates for therapy received; only ONE is needed to meet HEDIS measure.

Yes ☐ Dispensed or filled statin medication in current year ____/____/_____ **Statin therapy intensity (circle one)** High intensity ☐ / ☐ Moderate intensity	**Statin Rx name:** _____ **Rx dose:** _____
No ☐ If checked, move to next section	Excluded due to patient being dispensed at least one prescription for clomiphene ____/____/_____

Medical allergies

_____

Social history	Remarks	Social history	Remarks
Alcohol/drug use		Sexual history	
Tobacco use		High-risk lifestyle	
Diet		Physical activity	

Family history	Father	Mother	Children	Siblings	Grandparents
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐

Vitals

Height: _____ feet _____ inches **Weight:** _____pounds

Heart rate: _____ **Blood pressure:** _____/_____

Body mass index (BMI): _____ BMI not completed due to pregnancy ☐Y ☐N

Physical examination

	Within normal limits	Abnormal	Findings		Within normal limits	Abnormal	Findings
General appearance	☐	☐		Musculoskeletal	☐	☐	
Head, eyes, ears, nose and throat (HEENT)	☐	☐		Skin	☐	☐	
Cardiovascular	☐	☐		Neurological	☐	☐	
Respiratory	☐	☐		Genitourinary	☐	☐	
Gastrointestinal	☐	☐		Other	☐	☐	
Hematologic/ lymphatic/immune	☐	☐					

Additional comments: _____

Fax completed forms to Humana at 888-838-2236

Patient name: _____ **Date of service:** ____/____/_____

Humana member ID: _____ **Date of birth:** ____/____/_____

Cognitive impairment

1. Ask patient to remember the following three words, and ask the patient to repeat the words to ensure the learning was correct.

   BANANA SUNRISE CHAIR

2. Ask patient to draw a clock. After numbers are on the face, ask patient to draw hands to read 20 minutes after 8 (or 10 minutes after 11).
3. Ask the patient to repeat the three words given previously. _____ _____ _____

Scoring instructions for recalled words and clock drawing test (CDT)	Results (circle one)
3 recalled words or 1-2 recalled words + normal CDT ☐ **Negative** for cognitive impairment	Patient is **negative/positive** for cognitive impairment ☐
1-2 recalled words + abnormal CDT or 0 recalled words **Positive** for cognitive impairment ☐	Additional comments: _____
Alternate screening tool used: _____	Additional comments: _____

Immunizations

☐ Influenza virus vaccine — annually ___/___/___

Pneumococcal vaccine — two recommended in lifetime ☐ PCV13 ____/____/_____ ☐ PPSV23 ___/___/___

Cancer screening – Please fill in all appropriate dates for screening received; only ONE is needed to meet HEDIS measures under each section.

Colorectal cancer screening

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

Breast cancer screening

Screening not applicable ☐ If checked, move to next section

Mammography performed 27 months prior to Dec. 31 of the current measurement year	____/____/_____
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	____/____/_____
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	____/____/_____

Fax completed forms to Humana at 1-888-838-2236

Patient name: _____ **Date of service:** ____/____/_____

Humana member ID: _____ **Date of birth:** ____/____/_____

Disease-specific management – Please fill in all appropriate dates for screening received below; only ONE is needed to meet HEDIS® measures under each section.

Diabetic nephropathy

Screening not applicable ☐ If checked, move to next section

Nephropathy screening: micro- or macroalbumin test during calendar year ____/____/_____ Result: _____

Is patient taking angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) during calendar year? ☐ Yes ☐ No Medication _____ Dispense/fill date ____/____/_____

Nephrologist visit during calendar year: ☐ Yes ____/____/_____ ☐ No Renal transplant? ☐ Yes ____/____/_____ ☐ No

Diabetic eye care

	Name of eye care professional
Screening not applicable ☐ If checked, move to next section	
Retinal or dilated eye exam by an eye care professional during current measurement year	____/____/_____
Results: Retinopathy Yes ☐ No ☐	_____
Negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional during measurement year or prior year	____/____/_____ _____
Excluded due to diagnosis of gestational diabetes during past two calendar years	____/____/_____ _____
Excluded due to diagnosis of steroid-induced diabetes during past two calendar years	____/____/_____ _____
Excluded due to diagnosis of polycystic ovarian syndrome during past two calendar years	____/____/_____ _____

Labs for patients with diabetes

Lab not applicable ☐ If checked, move to next section		Test result
Most recent HbA1c	____/____/_____	_____
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)		
Excluded due to diagnosis of gestational diabetes in past two calendar years	____/____/_____	
Excluded due to diagnosis of steroid-induced diabetes in past two calendar years	____/____/_____	
Excluded due to diagnosis of polycystic ovarian syndrome during past two calendar years	____/____/_____	

Diabetic foot exam

Screening not applicable ☐ If checked, move to next section	Within normal limits	Abnormal	Circle abnormal finding and add comment	Comments
Skin changes	☐	☐	Atrophy, infection, ulceration(s), deformity, calluses prior amputation	
Neurologic exam	☐	☐	Ankle reflexes, pinprick, vibration, monofilament	
Vascular exam	☐	☐	Dorsalis pedis pulse, posterior tibial pulse, ankle-brachial index (ABI)	

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; only ONE is needed to meet HEDIS measures under each section.

Osteoporosis management in women who had a fracture

Screening not applicable ☐ If checked, move to next section

Osteoporosis medication was dispensed or filled within six months after the fracture ____/____/_____

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

Bone mineral density test completed within six months after the fracture ____/____/_____

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 ____/____/_____

Screening assessments

Pain screening – Please circle the level of pain patient is in on a daily basis.

☺ 0 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 - document in medication list on page 1

Functional status assessment

☐ Assessment of instrumental activities of daily living (IADLs), such as meal preparation, shopping for groceries, using public transportation, house-work, home repair, laundry, taking medications or handling finances

☐ Assessment of ADLs, such as bathing, dressing, eating, transferring, using toilet, walking

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

Other assessments

☐ Physical activity assessment ☐ Advance directive (Living will Yes/No) ☐ Aspirin use discussion ☐ Fall risk assessment

☐ Depression screening test: _____ Score: _____

☐ Medication review for potentially harmful drug-disease interactions in the elderly, such as: _____

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

	Diagnosis	ICD-10 code	Circle 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 _____

Fax completed forms to Humana at 888-838-2236

Patient name: _____ **Date of service:** ____/____/_____

Humana member ID: _____ **Date of birth:** ____/____/_____

Diagnosis (continued)

	Diagnosis	ICD-10 code	Circle treatment plan
9.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
10.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
11.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
12.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
13.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
14.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
15.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
16.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
17.	_____	_____	Medication/monitor/diet/labs/referrals/other _____
18.	_____	_____	Medication/monitor/diet/labs/referrals/other _____

Screening/prevention plan for the next five to 10 years

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, ZIP:

Humana.

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.

How to submit the practitioner assessment form claim

- A claim must be submitted with Current Procedural Terminology (CPT®) code 96160 along with the appropriate office visit, evaluation and management code (E/M) or Annual Wellness Visit code indicating a face-to-face visit occurred.
- During the coronavirus crisis, Humana is temporarily 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.

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 requiring these three components: history, examination and medical decision making
99213 – 99215	Office or other outpatient visit for the evaluation and management of an established patient requiring at least two of these three components: history, examination and medical decision making
99243 – 99245	Office consultation for a new or established patient, requiring these three key components: history, examination and medical decision-making
99253 – 99255	New or established inpatient consultation
99326 – 99328	Domiciliary or rest-home visit for the evaluation and management of a new patient
99336 and 99337	Domiciliary or rest-home visit for the evaluation and management of an established patient
99343 – 99345	Home visit for the evaluation and management of a new patient
99348 – 99350	Home visit for the evaluation and management of an established patient
99385 – 99387	Initial comprehensive preventive medicine evaluation – new patient
99395 – 99397	Periodic comprehensive preventive medicine evaluation – established patient

Humana.

Appendix 1

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/system/files/2020-01/cpt-category2-codes-long-descriptors.pdf.

*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.

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	1159F
	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

Humana.

Appendix 1, continued

Humana practitioner assessment CPT® Category II codes (continued)

Measure	Code descriptor	CPT® Category II codes
Comprehensive diabetes care	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)