OPTUM Care®

Attestation measures guide

Use this guide as a resource to complete quality attestation forms. To complete an attestation form, please visit optumcare.com/provider-login. If you have any questions, please contact your assigned OptumCare network manager.

Measure comments

Priority measures		Comments
Colorectal screening Only one is required	**FOBT** **Flex sig – Q5 yrs** **Colonoscopy – Q10 yrs** **Cologuard**	• Documentation in the medical record must include a note indicating the year in a (YYYY) format when the colorectal cancer screening was performed and must be documented in the "medical history" section of the medical record; this ensures that the screening was performed and not merely ordered. • All progress notes must be signed by a medical provider. • A result is required for FOBT only. A result is not required for Cologuard, colonoscopy or flex sig. • FOBT tests performed in an office setting or performed on a sample collected via digital rectal exam DO NOT MEET.
	Exclusions: **Colorectal cancer** **Total colectomy**	• If the patient has had a colorectal cancer or a total colectomy any time during the patient's history through December 31, 2019, they may be excluded from the measure. The exclusion may be captured by submitting a copy of the surgical report or the medical history section of the medical record. The medical record must include a note clearly indicating colorectal cancer history or date of total colectomy. • All progress notes must be signed by a medical provider.
Breast cancer screening	**Mammogram**	• Documentation in the medical record must include a note indicating the date (MM/YYYY) when the breast cancer screening was performed and must be documented in the "medical history" section of the medical record; this ensures that the screening was performed and not merely ordered. All progress notes must be signed by a medical provider. • A copy of the radiographic report may be submitted to meet measure.
	Exclusions: **Bilateral mastectomy** **Two unilateral mastectomies (right & left)**	• If the patient has had a bilateral mastectomy any time during the patient's history through December 31, 2019, they may be excluded from the measure. • The exclusion may be captured by submitting a copy of the surgical report or the medical history section of the medical record. The medical record must include a note clearly indicating date of mastectomy. • All progress notes must be signed by a medical provider.
Diabetes care – eye exam (Performed by ophthalmologist or optometrist)		Documentation must include one of the following: • Note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating ophthalmoscopic exam was completed by optometrist or ophthalmologist, the date when the procedure was performed and the results. • Chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. • Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present.

Priority measures	Comments
Controlling high blood pressure Target systolic pressure < 140 Target diastolic pressure < 90	• If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. • The systolic and diastolic results do not need to be from the same reading; they do need to be from the same date of service.
Diabetes control A1C Target ≤ 9.0	• Documentation submitted must include the result. Medical record must include the collection date or the reported date. Undated lab results documented in the medical record will not be processed. Lab reports are acceptable documents. Screenshots of results in EMR are acceptable if the information is received in the EMR via an electronic feed.
Rheumatoid arthritis therapy	• Member must fill a DMARD at least once during the measurement year.
Diabetes care – nephropathy	• Urine test, visit with a nephrologist or ACE/ARB dispensing must be performed.
Osteoporosis management – bone density test	• A bone mineral density (BMD) test on the day of fracture or in the 180-day (6-month) period after the fracture. Documentation in the medical record must include the report indicating the date when the BMD test was performed and the result. A notation of the BMD test in the PCP progress note is not acceptable for supplemental data submissions. • If the bone density exam was paid by a source other than WellMed; the radiographic report may be submitted to meet the measure.
Statin therapy – cardiovascular disease	• Males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) received at least one high- or moderate-intensity statin medication during the measurement year.
Statin use in persons with diabetes	• Member with diabetes must have a fill for at least one statin or statin combination medication in any strength or dose using their Part D benefit during the measurement year.
Medication reconciliation post discharge	• Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following evidence meets criteria: ○ Documentation that prescribing practitioner, clinical pharmacist or registered nurse reconciled the current and discharge medications. ○ Documentation of current medications with a notation that references the discharge medications. ○ Documentation of current medications with a notation that the discharge medications were reviewed. ○ Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service. ○ Notation that no medications were prescribed or ordered upon discharge.
Adult BMI assessment	• Members 18–74 years of age, within the measurement year. Documentation in the medical record must include BMI of member.

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