# American Specialty Health Group, Inc.
# Instructions for Completing
# Standardized Reporting Tools
# for Physical Therapy and Occupational Therapy Services

When forms are required for verification of medical necessity, ASH Group provides standardized reporting tools to assist providers and practitioners in effectively communicating a patient's health status and medical necessity. Those forms are:

1. Initial Health Status form
2. Medical Necessity Review Form
3. Reopen/Modification form

## Why Use ASH Group Standardized Reporting Tools?

The ASH Group forms provide a standardized vehicle to communicate the details of the patient's signs and symptoms, functional limitations and progress. The ASH Group forms have been designed to provide a consistent reporting format. This consistent reporting format facilitates clear communication between you and ASH Group, helps to ensure that data submitted by all providers is evaluated equitably, and is essential in allowing ASH Group to respond to your submission accurately and rapidly.

# Overview of Forms

## Initial Health Status Form

**This form is used for first/initial submissions along with the Medical Necessity Review Form**

The **Initial Health Status Form** provides a tool to collect the patient's chief complaint(s). The record of the patient's perspective of his or her own health status, in his or her own words, is valuable to both you and the clinical quality evaluation manager. The form is also used to gather information about the patient's general health status. The demographics section of this form has been designed to collect the information you need to establish a clinical file. This should eliminate the need for additional intake forms when processing an ASH Group patient/Member.

## Medical Necessity Review Form

The following are general guidelines for completing the Medical Necessity Review Form.

**Demographic Information:** Complete all fields in this section. This allows ASH Group to confirm your identity and to verify the eligibility of the member.

**Treatment/Services Submitting for Review:** This section describes the services you are submitting for verification of medical necessity. Include all relevant information to services you are submitting for review.

**ICD-10 Codes/Diagnoses:** Document Diagnoses to the highest level of specificity. We ask that you list the ICD-10 Code on the MNR Form and that it match the narrative description. Although ICD-10 Codes are not required, their inclusion promotes the accuracy of the communication between you and ASH Group.

**Evaluation/Re-evaluation:** This section should include any pertinent historical and examination findings that contributed to the formation of your physical/occupational therapy diagnoses and treatment plan. Include location and intensity of findings and a description of progress, if submitting for continued care.

**Pt's Functional Limitations & Planned Interventions:** This section should describe any functional limitations that exist due to the condition being treated as well as the plan of care, including measurable goals.

**Outcome Assessments:** Provide results of appropriate outcome measures [e.g., Numeric Pain Scale (Required), Neck Disability Index, Oswestry Disability Index, Lower Extremity Functional Scale]. These tools allow you to quantify the patient's clinical status, identify prognostic indicators, measure changes in clinical status over time, and assess the effectiveness of your intervention, any of which will improve clinical performance.

**Signature/Date:** (Required) Your signature on this form serves as an attestation of the accuracy of the data submitted.

## Reopen/Modification Form

**This form is used either for:**

1. **Reopen (Peer to Peer Communication): Use this option when you are submitting additional/revised information for clinical review in support of treatment/services not approved in the original submission or to correct errors in the previously submitted information. Please clarify which treatment/services you are submitting for Reopen and provide rationale**

**OR**

2. **Modification: Use this option if you need to submit additional treatment/services beyond those previously submitted or change the approved dates of service. Please note that submissions for additional office visits may not be submitted with a date extension. Please clarify which treatment/services you are submitting for Modification and provide rationale**.

**ASH Group MNR Form #:** Fill in the number of the MNR Form for this submission. The MNR Form Number is on the MNRF that you receive from ASH Group and is located at the top right corner of the form.

**Note**. Reopen submissions for pre-service adverse determinations require prior patient consent in the following states: Ohio. For this reopen to be processed for patients in this state, you must check the box to indicate that in accordance with state regulatory requirements, you attest to having the member's consent prior to submitting the reopen. Note also that Medicare considers re-opens to be an appeal and the review and communication will follow the appeals requirements and processes.

**Signature/Date:** (Required)**:** Your signature on this form serves as an attestation of the accuracy of the data submitted.

## What is an MNR Response Form?

Once the determination has been rendered, you will receive the MNR Response Form (MNRF) with the information pertinent to the determination. This information will include at least the following:

**MNR Form Number:** The number assigned to this treatment form.

**Patient's Name:** The member's name, as it appears on his/her health plan identification card.

**Health Plan:** The health plan or Client who provides coverage for the member as listed on the member's health plan identification card.

**Patient's Health Plan ID Number:** The identification number the health plan or Client has assigned to this member.

**Employer Group Number:** The number assigned to the subscriber's employer.

**Contracted Provider Information:** The provider's name, address, city, state, zip code and fax number.

**Received Date by ASH Group:** Represents the date the treatment/services were faxed to ASH Group or the postmarked date the treatment/services were sent to ASH Group by mail.

**Returned Date by ASH Group:** Represents the date ASH Group returned the MNRF to you.

**Submitted (Subm):** Summarizes the total amount of treatment/services you have submitted.

**Approved (Appr)**: Summarizes the total amount of services approved for reimbursement.

**Valid From and Valid Through:** Represent the dates of service approved.

**Clinical Quality Evaluation Manager:** Provides the name, phone number and phone extension of the clinical quality evaluation manager who rendered the medical necessity determination. If you have questions regarding a Medical Necessity determination you may contact the clinical quality evaluation manager at the toll free number and phone extension provided on the MNRF.

**The following is the clinical rationale on which the decision was based and was also provided to your patient:**

If the treatment/services submitted result in an adverse determination, the rationale will be documented in this space.

**The following is for your information and was not included in the patient response:**

If the clinical quality evaluation manager has information that he/she would like to communicate to the healthcare practitioner and not to the patient, it will be documented in this space.