American Specialty Health Group, Inc.

Out-of-Network Instruction Guide
for Podiatric Services

The following instructions are designed to assist you in interacting with the American Specialty Health Group, Inc. (ASH Group) verification of medical necessity program. It is as easy as **1, 2, 3**. This packet explains the process, your information submission options, and provides you with the several helpful tools to make the process most efficient.

The Process: How to Obtain Approval / Verification of Medical Necessity

STEP 1: Tell us about the patient's diagnosis and your treatment plan / proposed services (The OON Medical Records Cover Sheet):

In order to verify the medical necessity of the services you are providing, you will need to tell us what date or date range of the services you are submitting for review (From [date] and Through [date]) and what service(s) you want us to review by CPT and/or HCPCS code(s) and, where applicable the number of each). The OON Medical Records Cover Sheet described below should be used to communicate this information.

Some services may require Pre-Certification.
Please call ASH Customer Service for information.

STEP 2: Provide clinical documentation to support the medical necessity of the services you are rendering. (The Clinical Information Summary Sheet):

In addition to the dates and types of services you are submitting for review, we need information from your assessment of the patient (History and Exam findings), your clinical goals, and how the patient is responding to care. You may use the Clinical Information Summary Sheet (described below) or you may submit your own medical records. If you submit your own records, be sure to include patient intake or progress forms, the most recent examination forms related to the current condition/episode, and any additional information you feel supports your diagnosis and treatment plan.

STEP 3: Mail or Fax your OON Medical Records Cover Sheet and either the Clinical Information Summary Sheet or your pertinent Medical Records to:

ASH Group
P.O. Box 509077
San Diego, CA 92150-9077

Fax: 1.877.248.2746

The Tools: Maximizing Your Efficiencies

The following is an overview of the tools provided to make the verification of medical necessity process as easy as possible. This packet also includes detailed instructions in the use of these tools following this overview.

OON Medical Records Cover Sheet:

This tool should be used with each submission. It is the primary tool for communicating who you are, who the patient is, the patient's condition (diagnosis), the time period during which you treated or intend to treat the patient, and the services your have rendered or intend to render. Failure to use this tool will likely result in processing delays and requests for additional information or clarification. Please complete each field.

Clinical Information Summary Sheet:

In order to make reasonable determinations regarding medical necessity we need to understand the clinical information that you obtained in your history and examination that you relied upon to make your diagnosis and treatment recommendations. The Clinical Information Summary Sheet provides a simple format for reporting this information and the use of this Summary Sheet ensures that all of the information needed is included. The Summary Sheet includes:

a. A historical description of the Chief Complaint (what happened, when it happened and how it happened);
b. An opportunity to describe Past Medical History or Co-Morbid Factors that may affect response to care;
c. Evaluation information (summary of your clinical findings);
d. Your Therapeutic Goals; and
e. The Outcome Measures you intend to use to monitor progress toward the therapeutic goals.

Medical Records Cover Sheet **(One Per Patient)**

Treating DPM:_____

Address: _____

City/State/Zip:_____

Phone#:_____

*TIN #*_____ FAX #:_____

(Providing your FAX # will expedite the response to this request)

To: American Specialty Health	Date:
Fax: 1.877.248.2746	Pages:
Patient Name: Pt. Birth date:	Patient ID#: Gender: ☐ Male ☐ Female
Subscriber Name: Subscriber ID#:	Health Plan: Group #:

TREATMENT / SERVICES SUBMITTING FOR REVIEW

Diagnoses (ICD Code): 1._____ 3._____

2._____ 4._____

Date Range: From ____/____/_____ Through ____/____/_____

E&M Srv.: ☐99201 ☐99202 ☐99203 ☐99204 ☐99205

☐99211 x____ ☐99212 x____ ☐99213 x____ ☐99214 x____

Orthotics* / DME* / Supplies* (Codes): _____

PT (97000 series): Codes:_____ X ____; _____ X ____

Laboratory Services (codes):_____

X-rays/Imaging (CPT codes):_____

Surgery*/Debridement* Codes: _____ X ____; _____ X __

Injection Codes*: _____ X ____; _____ X ____ For Dx.#____

Casting*/Splinting*/Bracing*: Code _____X_____ For Dx.#____

Other Services (codes):_____

***These services may require Pre-Certification. Please call ASH for more information.**

By submitting this *Medical Records Cover Sheet,* I attest that the above dates and services are those I wish to have reviewed for medical necessity.

Please attach all relevant Exam Forms, Clinical Notes or Reports that support the medical necessity of the submitted services.

Clinical Information Summary Sheet

The purpose of the Clinical Information Summary Sheet is to document the significant clinical findings that contribute to the formulation of the member's diagnosis and treatment protocol. It is the standard tool you may use communicate with the peer clinical quality evaluation manager when submitting treatment/services for verification of Medical Necessity. This tool is a summary, does not constitute a complete or adequate medical record, and should not be used as your primary history and examination form. The Clinical Information Summary Sheet may be used for:

1. Documenting findings from a new patient examination or initial evaluation and re-evaluations
2. Documenting an established patient's clinical exam findings if they suffer a new injury/condition
3. Documenting an established patient's clinical exam findings if they suffer an exacerbation which requires a new treatment plan
4. Documenting established patient examination findings if continuing care is necessary or the Member is not progressing as expected

The following are general guidelines for completing the Clinical Information Summary Sheet.

Section I: Historical Information

In this section list each Chief Complaint, the date each complaint began (or if the date is unknown use a descriptor such as "gradual", "insidious", or "unknown"), the pain level for each complaint on a zero to ten scale with ten being the worst, the mechanism of injury (how each complaint began), and any pertinent past medical history or co-morbid condition that may affect recovery from the current episode (such as obesity, prior injury, diabetes, previous surgery, etc.).

Section II: Examination Information

This section allows you to report what you found in your examination. Please state the date of the examination. List any pertinent neurologic and/or vascular testing findings; biomechanical results; dermatologic conditions/findings; and the findings associated with any imaging or laboratory testing. Be sure to be specific regarding the finding.

Pre-Certification

Under this program some services will require Pre-Certification Pre-Certification is triggered by a practitioner or member contacting ASH prior to the provision of a service designated as requiring Pre-Certification. ASH has identified classes of podiatric services that are typically considered for Pre-Certification. Examples of such services for which ASH may require Pre-Certification include, but are not limited to:

- All surgical procedures (CPT 20000 series codes; 20670-29906 and 35226) including, but not limited to:
    - Wound Care, Debridement, and Excision procedures
    - Incision and Drainage procedures
    - Osteotomy, Arthrotomy, Arthrodesis, Arthroplasty, Phalangectomy, Tenotomy/Tenolysis, Amputation, and Capsulotomy procedures
    - Open Treatment of Fracture and Closed Treatment of Joint Dislocations
    - Professional component of services to be rendered at a Health Plan-contracted surgical center
    - Biopsy procedures

- Injection procedures including, but not limited to:
    - Ultrasound-guided and Fluoroscopy guided injection
    - Injection of neurolytic agents
    - Hyaluronan injections
- Durable medical equipment (DME), supports, orthotics, and/or prosthetics, including:
    - All devices with a maximum allowable fee schedule of $250 or more (podiatrists may, if they choose, request Pre-Certification for DMEs with a maximum allowable fee schedule of less than $250, in lieu of medical necessity review)
    - Foot and Ankle-Foot Orthoses (AFO)

Podiatrist may submit any podiatric service for Pre-Certification/pre-service review at any time.

If you are submitting services for Pre-Certification, please ensure that you have indicated any alternative measures you have already attempted.

Section III: Therapeutic Goals

In this section, list your goals of treatment. In addition, provide information regarding your plans for patient self-care such as exercises or home care measures. For some conditions, it may be helpful to use some type of outcome assessment tool. If this is ongoing care, please provide both the initial score and the current score.

Additional Comments

Please do not hesitate to provide any additional information you feel is important for us to know regarding the patient's condition that will aid us in making a medical necessity determination.

Clinical Information Summary Sheet

Practitioner Name_____

Patient Name_____

I. Historical Information

CHIEF COMPLAINTS:	**1**_____	**2**_____	**3**_____
DATE OF ONSET:	_____	_____	_____
0 – 10 PAIN LEVEL:	_____	_____	_____

MECH. OF INJURY/EXACERBATION_____

PERTINENT PAST HISTORY / CO-MORBIDITIES_____

II. Examination Information

Date of Exam _____ **/**_____ **/** _____

CLINICAL INDICATIONS FOR REQUESTED SERVICE(s) / PROCEDURE(s): _____

SPECIAL TESTS (e.g. Imaging; Vascular, Neurologic, etc.) ☐ **No** ☐ **Yes** Describe test and findings_____

PRIOR IMAGING? ☐ **No** ☐ **Yes** When / Findings:_____

CURRENTLY HAS or SUSPICION OF: ☐ Bone / Structural Defect ☐ Cancer/Neoplasm ☐ Neuroma / neuropathy ☐ Trauma/Fracture ☐ Plantar Fasciitis ☐ Vascular Insufficiency ☐ Infection ☐ This is Post-Operative Care

Indicated by:_____

ALTERNATIVE MANAGEMENT ATTEMPTED? ☐ **No** ☐ **Yes** How Long / Response?_____

MEDICATION	☐ No	☐ Yes, explain_____
PHYSICAL THERAPY	☐ No	☐ Yes, explain_____
SHOE MODIFICATION	☐ No	☐ Yes, explain_____
EXERCISE PROGRAM	☐ No	☐ Yes, explain_____
STRAPPING	☐ No	☐ Yes, explain_____
IMMOBILIZATION	☐ No	☐ Yes, explain_____
OTHER	☐ No	☐ Yes, explain_____

Failure/Intolerance to Pre-Fab Orthosis (OTC) ☐ No ☐ Yes, explain:_____

COMMENTS / ADDITIONAL INFORMATION RELATING TO MEDICAL NECESSITY FOR REQUESTED SERVICE(S):

III. Therapeutic Goals and Outcome Assessments:

Therapeutic Goals/Outcome Assessments:_____

Signature. (Required)_____ **Date**_____

What Is An ASH Medical Necessity Review Response Form?

Once the determination has been rendered, you will receive the ASH Medical Necessity Review 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.

Practitioner Information: The practitioner's name, address, city, state, zip code and fax number.

Received Date by ASH: 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: 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: Represents the dates of treatment/services 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

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.

Medical Necessity Review Response Form

American Specialty Health Group, Inc.

P.O. Box 509001
San Diego, CA 92150-9001
(800)972-4226
Fax (877) 248-2746

MNR Response Form Number
99999999

Confidential Health Information Notice: *The information in this fax may contain personal health information. It is being faxed to you after appropriate authorization from the patient has been obtained or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain this information in a safe, secure, and confidential manner. Re-disclosure without additional patient consent, or as permitted by law, is prohibited.*

Patient's Name: Frankie Foot	***Patient Health Plan ID Number:*** 12345678-00
Health Plan: Any Health Plan	***Employer Group Number:*** XYZ123
John Toe,DPM 123 Healthy Road Anytown, OR 11223	***Received Date:*** 11/06/2013 ***Returned Date:*** 11/06/2013 ***Fax Number:*** 1-800-000-0000

PROCEDURE	SUBM	APP	Per Date of Service	PROCEDURE	SUBM	APP	CPT Codes			
New Pt Exam	1	1	N/A	Orthotics/DME	0	0				
Est. Pt Exam	0	0	N/A	Lab	0	0				
Office Visit	10	10	N/A	Other /X-Rays	0	0				
Modalities/Procedures	10	10	1	Surgery/Debridement	0	0				
DATES OF SERVICE				Injection	0	0				
				Prolonged/ Special Services	0	0				

SUBM From	09/01/2014	***Diagnosis Code:***	Services approved on this response form are for the condition described by this diagnosis code. Please note that when billing, you must submit claims with **all** diagnosis codes documented to the highest level of specificity per HIPAA coding standards.
SUBM Thru	09/30/2014		
Approved From	09/01/2014		
Approved Thru	09/30/2014		

Clinical Quality Evaluation: Dr. Boot, DPM
Phone Ext.: 9999

This response is not a guarantee of payment; final payment is subject to group benefit limits and member eligibility.

If you would like to discuss the submitted services decision above, there are 3 options:

- For questions concerning any clinical modifications or denials, you may contact the Clinical Quality Evaluator noted on this form at 800-972-4226 or submit additional information and/or clarification on a ReOpen/Modification Form.
- Questions concerning administrative modifications or denials should be directed to a Customer Services Agent at 800-972-4226.
- You may contact the Clinical Quality Evaluator and request an appeal or submit your appeal in writing, within 180 days of the Returned Date above, to the address above, attention Appeals Coordinator.

Your patient has been notified of this decision and has been advised of the member appeal process available under the terms of his/her health benefit plan. You may view the member's appeal rights, through your ASHLink account. If you are not registered for ASHLink, please see the information below.

Note: In order for services to be Covered Services, they must be medically necessary. All medical necessity determinations are made by an appropriately licensed Clinical Quality Evaluator considering all pertinent historical, examination, course of care and outcomes data submitted for review. Clinical Quality Evaluators are not provided any type of incentive to modify or deny services. A general overview of clinical guidelines may be found within the Provider Operations manual or on www.ashlink.com.

Did you Know? You can verify member eligibility, obtain member appeal rights , submit and check the status of treatment submissions and claims on the Internet! Incentives are available to providers who use our internet services. Many other benefits exist when using electronic transactions. Just go to www.ashlink.com to find out more and how to register.

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

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