American Specialty Health Group, Inc.

Out-of-Network Instruction Guide
for Acupuncture 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 (The OON Medical Records Cover Sheet):** To verify the medical necessity of the services you are providing, you will need to tell us the date range of the services you are submitting for review (From [date] and Through [date]) and what services you want us to review (the total number of dates of services / acupuncture services, adjunctive therapies, etc.). The OON Medical Records Cover Sheet described below should be used to communicate this 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 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 509001
San Diego, CA 92150-9001

Fax: 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.

1. **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 you 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.

2. **Clinical Information Summary Sheet:** 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 as Range of Motion, Palpation, Orthopedic and Neurologic Assessment, Functional Limitations and any acupuncture specific findings such as Tongue or Pulse signs; and

    d. Your Therapeutic Goals;

3. **The Reopen / Modification Form:** This tool allows you to request re-review (reopen) of services denied when you feel there were errors or missing information in the initial submission. It also allows you to request approval services not previously submitted but which you feel are necessary within the previously approved time period.

    Examples:
    If services were denied and you failed to report a prior back surgery or that the patient has a significant co-morbid condition and you feel that information would have changed our determination, you may use this form to report that additional information.

    If you need only a short date extension or only a couple additional visits beyond what was previously approved you may request approval using this form. You do not have to submit complete medical records or a Summary Sheet but may simply provide a short description of the rationale for the date extension or additional visits.

OON Medical Records Cover Sheet (Please Use One Per Patient)

Practitioner Name:_____ TIN #_____

Practitioner Address:
Street _____
City, State, Zip:_____

Practitioner Phone#: _____

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

*NPI # (Type 1-Ind)*_____ *NPI # (Type 2-Org)*_____

To: American Specialty Health	Date:
Fax: 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: ____/____/_____

# of Exams/Evaluation Services: ☐ New Pt./Initial ☐ Est. Pt./Re-Eval.

Total # of Office Visits/Acupuncture: ☐ (New Jersey Only) Acupuncture CPT Units per Office Visit ☐

Total # of Therapies for Requested Dates ☐ (New Jersey only) Therapies per Office Visit ☐

Therapies and Modalities (Check all that apply)**:** ***Please do not use acupuncture CPT codes (97810-97814) in this section. They are automatically included in the Office Visits/Acupuncture section above.***

☐ Hot/Cold Packs (97010) ☐ Infrared (97026) ☐ Massage (97124) ☐ Therapeutic Exercise (97110)

☐ Ultrasound (97035) ☐ Other: _____

☐ Other Special Services / Lab / X-ray: List CPT code(s)_____

By submitting this *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. Include co-management information (see Section IV of the Clinical Summary Sheet) in your documentation.

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 to communicate with the peer clinical quality evaluator when submitting treatment/services for verification of Medical Necessity. This tool is a summary, does not constitute a complete or adequate 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
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: Treatment Outcome

What are the goals of the treatment plan and how are you measuring progress toward those goals? How has the patient responded to the treatments so far? It is especially important to note measurable changes in Pain Levels, Examination Findings and Functional Abilities

Section II: Current Complaints

In this section list the:

- Chief Complaint/the specific location
- The date each complaint began. If the date is unknown, please estimate or use a descriptor such as "gradual", "insidious", or "unknown".
- The cause or mechanism of injury (how the complaint began)
- The initial pain level when you started this treatment plan and the current pain level. Pain should be rated on a zero to ten scale with zero being no pain and ten being the worst pain the patient can imagine.
- How long the pain relief lasts after the treatments.
- The pain frequency as a percentage of time the pain is present
- Your observations – gait changes, energy level, mood, shen, swelling, color changes, etc.
- Tenderness to palpation rated on a 0-4 scale.
- Range of motion if it is applicable. You can describe as an estimate of % limited or give the joint, plane of motion and degrees.

Include any pertinent past medical history or co-morbid conditions that may affect recovery from the current episode (such as obesity, prior injury, diabetes, previous surgery, etc.). Any other barriers to care such as transportation constraints, schedule conflicts, etc.

Section III: Functional Assessments

List activities that are important to the patient and how they are being affected by the treatments. Examples might be working, driving, walking, household chores. Include specific measurable changes.

List any standardized functional outcome measures you have completed with the patient. Be sure to include the name of the outcome measure, body area or condition, date, and the score. If there is more than one over time, please document how the patient's score has changed.

Has there been a significant change in pain medication uses during acupuncture services?

Section IV: Co-Management

Document whether the patient is being seen with a medical physician and for what condition.

If the patient is less than three years old, include documentation of a referral on file in your records.

If the patient is 3-11 years old, document that their physician is aware they are seeking acupuncture.

If the patient is pregnant, please document medical physician care and the number of weeks of the pregnancy.

Section V: Vital Signs

Include vital signs such as height, weight, blood pressure, temperature if you have them. Please at least check a blood pressure at the initial visit and if needed thereafter.

Enter the tongue and pulse signs.

Section VI: Additional Comments

Please add relevant information that might not have been covered elsewhere on this form.

Signature

Be sure to sign and date the form.

Clinical Information Summary Sheet

Practitioner Name: _____

Patient Name: _____

SECTION I. Treatment Outcome

Treatment Goals: _____

How are you measuring progress toward goals? _____

Patient's response to most recent treatment: _____

_____

SECTION II. Current Main Complaint(s)

Date of Examination: _____

#1 Complaint/Location: _____ **Date of Onset**: _____ **Cause of Condition**:_____

Initial Pain Level: _____**Current Pain Level:** _____**How Long Pain Relief Lasts**: _____ **Pain frequency %** _____

Observation (gait, swelling, color, shen, etc.) _____

Tenderness to Palpation (0-4): _____ **Range of Motion (% limited):** _____

Other History of Complaint: _____

#2 Complaint/Location: _____ **Date of Onset**: _____**Cause of Condition**:_____

Initial Pain Level: _____**Current Pain Level:** _____**How Long Pain Relief Lasts**: _____ **Pain frequency %** _____

Observation (gait, swelling, color, shen, etc.) _____

Tenderness to Palpation (0-4): _____ **Range of Motion (% limited):** _____

Other History of Complaint: _____

Comments (e.g., Pertinent Health History or Barriers to Progress): _____

SECTION III: Functional Assessments

List the activities (sleep, work, recreation) you are monitoring for progress and any measurable results

Activity	Measurements (how much, how long, how far)	How has it changed?

List Functional Outcome Tool Name, Body Area or Condition, Date and Score.

Functional Tool Name	Body Area/Condition	Date	Score

Recent Changes in Pain Medication:_____

SECTION IV: Co-Management

Patient is Cared for by a Medical Physician: ☐ **No** ☐ **Yes: For What Condition:** _____ _____

If patient under 3 years old, do you have a written referral for acupuncture on file from their medical physician?Y☐ **N**☐

If patient is 3-11 years old, is their medical physician aware they are receiving acupuncture for this condition? Y☐**N**☐

Is this patient Pregnant? ☐ **No** ☐ **Yes; If yes, # weeks**_____ **Medical practitioner for pregnancy care?** ☐ **No** ☐ **Yes**

SECTION V: Vital Signs

Height_____**Weight** _____**BP**_____ / ____ , **Temp** _____, Tongue _____, Pulse R_____L_____

SECTION VI: Additional Comments _____

_____

Signature of Treating Practitioner _____ **Date** _____

Reopen/Modification Form

This form is used either for:

1. **Reopen**: Use this option when you are submitting additional/revised information for clinical review in support of treatment/services requested but 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 clarify which treatment/services you are submitting for modification and provide rationale. Some examples of scenarios where a modification is most appropriate include the following:
    a. To request date extensions to finish using prior approved visits,
    b. To request for additional 1-2 visits to transition to a home exercise plan that will be followed by discharge,
    c. To request a specific service such as an evaluation that occurred during the dates specified by the MNRF,
    d. If you need BOTH additional visits AND additional dates of service ('a' and 'b'), you must submit as a new MNR request, NOT a reopen or modification

This form may also be used to request a date extension (up to 30 days) to complete remaining approved visits. Another use of this form is to request additional visits (maximum of three).

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

Notes. Reopen/Modification forms must be received by ASH Group within sixty (60) days of the returned date on the MNRF or within sixty (60) days of the last approved date of service on the MNR Form for which you are submitting a Reopen/Modification form, whichever is later.

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 and some state regulations consider reopens 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

A request for a Reopen/Modification may be submitted via telephone or by faxing a Reopen/Modification form or Medical Records. Reopen/Modification forms may not be approved if you do not follow correct submission procedures or provide complete information.

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

REOPEN / MODIFICATION

Acupuncture and Oriental Medicine
For questions, please call ASH at 800.972.4226

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATOR

Patient Name_____ Patient ID#_____
Last First Initial

Patient Health Plan_____

Acupuncture Practitioner_____

Address_____

City/State/Zip_____

Phone (_____)_____

Fax (_____)_____

List the appropriate MNR Form Number for this submission.

ASH MNR FORM #

_____

☐ **REOPEN (Peer to Peer Communication)** This option must be chosen when submitting additional/revised information for clinical review to support 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. You may attach the current MNR Form and additional information may also be attached or included below.

_____

_____

Reopen submissions for pre-service adverse determinations require prior patient consent in the following states: Ohio

☐ **In accordance with state regulatory requirements, I hereby attest to having the member's consent prior to submitting this reopen. [Note: When submitting a reopen for patients in the states listed above, this box must be checked for the reopen to be processed.]**

☐ **MODIFICATION** This option should **only** be chosen if you need to submit additional treatment/services beyond those previously submitted or change the approved dates of service.

☐ **Dates of Service – Changes, Extensions,** (up to 30 days), **Reductions**

The treatment period/dates should be: Start (mm/dd/yyyy)_____ End (mm/dd/yyyy)_____

Rationale_____

☐ **Additional Office Visits** (up to 3 visits)

Additional number of visits: #_____ Please provide current subjective and objective findings and rationale. Please note that modification for additional office visits may not be submitted with a date extension.

_____

_____

☐ **Additional Examinations**

Date of Examination_____

Clinical Rationale_____

_____

☐ **Other**
Services/Clinical Rationale_____

_____

_____

_____

Signature of treating acupuncture practitioner_____ **Date**_____

What Is An MNR Response Form?

Once the medical necessity determination has been rendered, you will receive the Medical Necessity Review Response Form (MNRF) with the information pertinent to the determination.

The MNR Response Form shall be kept in the patient's file. The following sections are very important so please always review these sections carefully:

MNR Form Number: The number assigned to this MNR Form and must be used as a reference number when communicating with ASH Group regarding this determination.

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

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

Valid From and Valid Through: Represents the date range in which the approved visits can be used.

Clinical Quality Evaluator: Provides the name, phone number and phone extension of the clinical quality evaluator who rendered the Medical Necessity determination. If you have questions regarding a Medical Necessity determination you may contact the clinical quality evaluator 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 evaluator has information that they would like to communicate to the healthcare practitioner and not to the patient, it will be documented in this space.