American Specialty Health Group, Inc.

Out-of-Network Instruction Guide
for Chiropractic 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):** In order to verify the medical necessity of the services you are providing, you will need to tell us what 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 / manipulation services, adjunctive therapies, x-rays, 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:**

American Specialty Health Group, Inc.
P.O. Box 509001
San Diego, CA 92150-9001

Fax: Within California ONLY fax to 1.877.427.4777. All other states fax to 1.877.304.2746.

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 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.

2. **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 as Range-of Motion, Palpation, Orthopedic and Neurologic Assessment, and Functional Limitations;
d. Your Therapeutic Goals; and
e. The Outcome Measures you intend to use to monitor progress toward the therapeutic goals.

3. **The Reopen / Modification Form:** This tool allows you to request re-review (re-open) 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 requested manipulation services and adjunctive therapies but failed to request x-rays and you find the patient is not progressing and has developed signs or symptoms supporting the need for x-rays you may use this form to add approval of x-rays to your already approved treatment plan.

   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.

Chiropractic OON Medical Records Cover Sheet

(Use One Per Patient)

PRACTITIONER NAME:	TIN #:
PRACTITIONER ADDRESS: *NPI # (Type 1-Ind):* _____	Practitioner Phone #: Practitioner FAX #: (Providing your FAX # will expedite the response to this request) *NPI # (Type 2-Org):* _____
To: American Specialty Health	Date:
Fax: Within CA ONLY: 1.877.427.4777 Outside of CA: 1.877.304.2746	Pages:
Patient Name: Patient 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 of Submitted Services for Review: From: ___/___/___ Through: ___/___/___

# of E & M Services: ☐ New Pt. Exams ☐ Est. Pt. Exams Date of Requested Exam: _____

# of Visits (Includes 98940-98943 Codes) within the above date range: ☐

Are you requesting review for Extraspinal CMT services (98943)? Yes ☐

# of Modalities/Procedures (97000-97545) within the above date range: ☐

List Modalities/Procedures by CPT: _____
(for timed therapies include units per date of service)

OTHER SERVICES WITHIN THE ABOVE DATE RANGE YOU ARE SUBMITTING FOR REVIEW:

X-Ray/Other Studies by CPT Code(s): _____ Date: _____

Durable Medical Equipment by HCPCS Code(s): _____ Date: _____

Electrodx./Prolonged/Special Services by CPT Code(s): _____ Date: _____

Other Services by CPT/HCPS Code(s): _____ Date: _____

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 Clinical Information Summary Sheet (CISS) or 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 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 range-of-motion findings as degrees or percent (%) limited. You may also comment on any pain or other findings associated with the motion in the "Comments" section. List any pertinent orthopedic, neurologic, or vascular testing findings. Be sure to be specific regarding the finding. For example, do not merely state a test was positive. A finding reported as "positive straight leg raise" is not meaningful without a description of the side on which the finding was noted and the location and character of the pain produced. List any palpation findings that contribute to the clinical picture such as the location of subluxation, trigger points, muscle tightness, and tenderness to touch. You may also report postural findings here. In the "Functional Assessment" section list any results from functional assessment testing (e.g. Repetitive Squats, Horizontal Side Bridge Test for Muscular Endurance, Sorenson Test for Muscular Endurance and Single Leg Stand Balance Test - Eyes open and closed).as well as any noted limitations in the performance of activities of daily living (ADL).

Section III: Therapeutic Goals And Outcome Assessments

In this section, list your goals of treatment (e.g. "pain relief"; "improvement in the ability to bend and lift"; "normal range of motion"; etc.). In addition, provide information regarding your plans for patient self-care such as exercises or home care measures. It is helpful to perform some type of outcome assessment tool. If this is your initial assessment, list the score obtained. If this is ongoing care, please provide both the initial score and the current score. We have specifically listed the most commonly used neck and low back tools. List any other tools in the "Other" section. It is helpful to report the patient's perceived improvement in this section as well.

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 COMPLAINT(s) with date(s) of onset: (mm/dd/yy) _____

Mech. of Injury/Exacerbation_____

Pertinent Past History / Co-Morbidities_____

II. Examination Information

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

Vital Signs: Height ____ Weight _____ Blood Pressure _____ Temp _____

Range of Motion

Cervical spine: ☐ N/A ☐ All WNL **Flexion** ___/60 or___% limited **Extension** ___/50 or___% limited

Lateral Flexion: Left ___/40 or___% limited Right ___/40 or___% limited

Rotation: Left ___/80 or___% limited Right ___/80 or___% limited

Comments_____

Lumbo-sacral: ☐ N/A ☐ All WNL **Flexion** ___/90 or___% limited **Extension** ___/30 or___% limited

Lateral Flexion: Left ___/20 or___% limited Right ___/20 or___% limited

Rotation: Left ___/30 or___% limited Right ___/30 or___% limited

Comments:_____

Extremity / Other:_____

Ortho / Neuro / Vascular / VBI: ☐ NA ☐ WNL (Please include location and intensity of any findings.)____

Chiropractic / Palpation / Postural Assessment_____

Functional Assessment / Improvement_____

III. Therapeutic Goals And Outcome Assessments

Therapeutic Goals_____

Exercise/Home Care Instructions_____

Outcome Assessments: ☐ N/A **Date score obtained:** _____

☐ Neck Disability score: Initial _____ Current _____ ☐ Roland-Morris score: Initial _____ Current _____

☐ Oswestry score: Initial _____ Current _____ ☐ Perceived Improvement _____%

☐ Other (name) score: Initial _____ Current _____

ADDITIONAL COMMENTS_____

Signature of treating D.C. (Required)_____ **Date**_____

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. For example, if you forgot to include pertinent past medical history or clinical findings from your evaluation that would affect the number or types of services approved you could provide that additional information with this form. Also, if you note that there were errors in your initial submission that may have led to services not being approved, you can correct them with this form. 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. Examples:
   a. If you did not submit for review a lumbar brace but you now feel the patient needs one, you may request medical necessity review for that brace using this form.
   b. If the approved treatment period is about to expire and you have additional approved vistis or services unused that you feel are still necessary you may request to have the end date of the treatment period extended.
   c. If you have or will soon exhaust the number of visits or services previously approved and you feel the patient only needs 1-3 additional visits you may request medical necessity for those additional dates/services with this form rather than having to submit another completed Clinical Information Summary Sheet or medical records.

Please note that you may use this form to submit a request for additional office visits and/or therapies **or** you may use it to submit a request for a date extension but you may not use this form to submit a request for both additional services and a date extension. IF you are requesting approval of additional services and an extension of the approved treatment period you will need to submit a new Medical Records Cover Sheet and either your records or a new Clinical Information Summary Sheet.

ASH MNR Form #: Fill in the number of the treatment form for this submission. The MNR Form Number is at the top right corner of the Medical Necessity Response Form (MNRF) that you receive from ASH Group.

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 these states, 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.

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

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

REOPEN / MODIFICATION

Chiropractic

For questions, please call ASH at 800.972.4226

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATION MANAGER

Patient Name_____ Patient ID #_____
Last First Initial

Patient Health Plan_____

Treating D.C._____

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 should be chosen when 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. 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.

☐ **X-Rays and/or Radiological Consultation**

Views required and Rationale for films/consult: _____

_____

☐ **Supports and Appliances**

Supports and Appliances required_____

Rationale_____

☐ **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)

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

_____

_____

☐ **Additional Therapies**

Number of submitted therapies: # _____ Please list the types of therapies (e.g., ultrasound) and rationale:

_____

☐ **Other**

Services Rationale_____

Signature of treating D.C. (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) 304-2746

MNR Response Form Number

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:	***Patient Health Plan ID Number:***
Health Plan:	***Employer Group Number:***
	Received Date:
	Returned Date:
	Fax Number:

PROCEDURE	SUBM	APP	Per Date of Service	PROCEDURE	SUBM	APP	CPT Codes			
New Pt Exam	0	0		DME	0	0				
Est. Pt Exam	0	0		Cervical X-Ray	0	0				
OV/Adjustment	0	0	0	Lumbar X-Ray	0	0				
Therapies	0	0	0	Thoracic X-Ray	0	0				
Consultation/ Preventive Services	0	0		Other	0	0				
DATES OF SERVICE				Prolonged/ Special Services	0	0				
				Lab	0	0				

SUBM From		ICD-9 Code:	Services approved on this response form are for the condition described by this ICD-9 code. Please note that when billing, you must submit claims with **all** ICD-9 codes documented to the highest level of specificity per HIPAA coding standards.
SUBM Thru			
Approved From			
Approved Thru			

Clinical Quality Evaluation:
Phone Ext.:

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 appropriately licensed Clinical Quality Evaluator. Decisions to approve only clinically necessary services are made considering all pertinent historical, examination 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 Practitioner Operations manual or on www.ashcompanies.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.ashcompanies.com and click on ASHLINK 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: