American Specialty Health Group, Inc.
Instruction Guide for
Out-of-Network Massage Therapy 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 (Symptom Description) 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 assessments and dates of services). 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 Assessment findings), your clinical goals, and how the patient is responding to care. The easiest way to do this is to 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 assessment 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: 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.

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/symptom description), 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:** To make reasonable determinations regarding medical necessity we need to understand the clinical information that you obtained in your history and assessment that you relied upon to make your diagnosis/symptom description 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 such as pain during Range-of Motion, Palpation, 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 Re-open / 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.

   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:

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._____

(Symptom Description Required) 2._____ 4._____

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

#of Assessment Services: ☐ New Pt./ Initial ☐ Est. Pt./ Re-Assess.

#of Dates of Service: ☐

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 Assessment 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/symptom description and treatment protocol. It is the standard tool you may use communicate with the peer clinical 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 assessment or initial assessment and re-assessments
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: COMPLICATING CONDITIONS / FACTORS (From History)

In this section list 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.). You should also report any co-management in this section.

Section II: HEALTH STATUS

This section allows you to provide information about the Chief complaint(s) as well as the cause and stage of the current episode.

Section III: CURRENT ASSESSMENT FINDINGS TO MONITOR PROGRESS.

This section allows you to report your assessment findings including the location, character, and severity of tenderness, trigger points, spasm, or joint pain. It also includes simple outcome assessment tools.

Additional Comments

Please so 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. COMPLICATING CONDITIONS / FACTORS (From History) ☐ **None** ☐ **Cancer** ☐ **Stroke**

☐ **Osteoporosis** ☐ **High Blood Pressure** ☐ **Diabetes** ☐ **Obesity**

☐ **Pregnant, # Weeks**_____ ☐ **Smokes, Packs per day** _____

☐ **Other**_____

Is Co-management Occurring? ☐ No ☐ Yes

By whom? ☐ MD/DO ☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist ☐ Other_____

II. HEALTH STATUS **Date of Onset/Exacerbation:** (mm/dd/yyyy)____ / _____ / _____

☐ **Unknown** (Insidious / Gradual)

Chief Complaint(s): ☐ Headache ☐ Neck Pain ☐ Upper Back Pain ☐ Mid-Back Pain

☐ Low Back Pain ☐ Neck Pain with Pain into Extremity ☐ Low Back Pain with Pain into Extremity ☐ Shoulder Pain ☐ Elbow Pain ☐ Wrist/Hand Pain ☐ Hip Pain ☐ Knee Pain ☐ Ankle/Foot Pain

☐ Additional Symptoms/Complaints_____

Cause of Current Episode: ☐ Traumatic ☐ Repetitive ☐ Unknown

☐ Post-Surgical (date / type)_____

Stage of Condition: ☐ Acute (up to 6 weeks) ☐ Sub-acute (6 to12 weeks) ☐ Chronic (>12 weeks)

Nature of Condition: ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic

III. CURRENT ASSESSMENT FINDINGS TO MONITOR PROGRESS.

Date of Assessment Findings: (mm/dd/yyyy)_____ / _____ / _____

Anatomical Location ↓	**Tenderness** 1 = Mild 4 = Severe	**Trigger Points** 1 = Active 2 = Latent	**Spasm** 1 = Mild 2 = Moderate 3 = Severe	**Pain on Motion** A= Absent S = Sharp D = Dull L = Localized R = Radiating	**Comments (Provide additional information as desired for any of the information to the left)**
	1 2 3 4	1 2	1 2 3	A S D L R	
	1 2 3 4	1 2	1 2 3	A S D L R	
	1 2 3 4	1 2	1 2 3	A S D L R	
	1 2 3 4	1 2	1 2 3	A S D L R	

Outcome Assessment Tools* – Minimally a Numeric Pain Rating Scale (NPRS) is REQUIRED -List both Initial / Current date(s) and Score(s):

	Initial	**Current**		**Initial**	**Current**
List Date Obtained (mm/dd/yyyy)	___ / ___ / _____	___ / ___ / _____	**List Date Obtained** (mm/dd/yyyy)	___ / ___ / _____	___ / ___ / _____
NPRS (0-10)	_____	_____	Other_____	_____	_____

Does the patient currently have any limitations to Activities of Daily Living? ☐ **No** ☐ **Yes, Describe:**___

_____

Is there any other clinical information you would like to share?_____

_____

You are encouraged to submit additional information as necessary to support the care submitted.

By affixing my signature, I declare that the information on this form is true and accurate. In my professional judgment, my interventions are within my scope of practice, are clinically appropriate and are not contraindicated for this patient.

Signature of Massage Therapist (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. 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 and/or therapies may not be submitted with a date extension. Please clarify which treatment/services you are submitting for Modification and provide rationale.**

ASH MNR Form #: Fill in the number of the treatment form for this submission. The Medical Necessity Review 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.

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
Fax: 877.248.2746

REOPEN / MODIFICATION

Massage Therapy
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 _____

Massage Therapist Name _____ 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 **only** be chosen when submitting additional/revised information to support therapy/services **not approved** in the original submission or to correct errors in the previously submitted information.

Please clarify which therapy/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 therapy/services beyond those previously submitted or change the approved dates of service.

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

The therapy 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 may not be submitted with a date extension.

_____

_____

_____

_____

☐ **Other**

Services / Rationale _____

_____

_____

_____

_____ _____
Signature of Massage Therapist (Required) **Date**

What Is a 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 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 (Sub): 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 service approved.

Clinical Quality Evaluation Manager: Provides the name, phone number and phone extension of the Massage Therapy 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 practitioner and not to the patient, it will be documented in this space.

American Specialty Health

American Specialty Health Group, Inc.

Medical Necessity Review Response Form

P.O. Box 509001
San Diego, CA 92150-9001
(877)288-2746
Fax (877) 304-2746

MNR Response Form No.

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:

DATES OF SERVICE		***PROCEDURE***	**SUBM**	**APP**	
SUMB From		*Assessment*			***Clinical Quality Evaluator:***
SUBM Thru		*Re-Assessment*			***Phone Ext.:***
Approved From		*OV/Session*			
Approved Thru		**ICD9 Code:**			

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 877-288-2746 or submit additional information and/or clarification on a ReOpen/Modification form.
- Questions concerning administrative modifications or denials should be directed to a Customer Service Agent at 877-288-2746.
- 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 will not be included in the patient response: