American Specialty Health Group, Inc.

Out-of-Network Instruction Guide
for Naturopathic 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 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 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.

   Please note the following regarding the use of the Prolonged Services Codes listed on the Cover Sheet:

   99417: Prolonged physician service in the office or other outpatient setting may be used with 99205 or 99215.

   99354 and 99355 may be used for prolonged services for outpatient consultations.

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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 description of the Current and Past Health History;
    - **b.** Evaluation information
    - **c.** Your Therapeutic Goals; and the Outcome Measures you intend to use to monitor progress toward the therapeutic goals.
    - **d.** Additional Comments
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 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.

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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

Primary Diagnoses (ICD Codes): 1.____________ 3.__________________

2.__________________ 4.__________________

Date Range: From: ____/____/_______ Through: ____/____/_______

Evaluation and Management Services:

New Patient Code ☐ 99202 ☐ 99203 ☐ 99204 ☐ 99205

Est. Patient Code, Total #: _____ 99211 X _____ 99212 X ___ 99213 X ___ 99214 X ___ 99215 X ____

Prolonged Services (Use only with 99205 or 99215): 99417 X _____

Durable Medical Equipment: Total # ______, HCPCS Code(s)__________________

Modalities/Procedures (CPT -97000-97545) during date range: Total #_____

Please note the type of modalities/procedures and number per type:

☐ **Diathermy (97024) x____** ☐ **E- Stim. (97032) x__ __** ☐ **Hot/Cold Packs (97010 x____**

☐ **Hydrotherapy (97039) x____** ☐ **Manual Therapy (97140) x____** ☐**US Therapy (97035) x____**

☐ **Other Modalities/Procedures by CPT Code:**

Consultation: CPT Code(s): ____

Prolonged Consultation: Total # ________ 99354 X _______ 99355 X _______

Lab/Diagnostic Studies / Other Services by 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.

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 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 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:

Document the total time spent on E/M services provided on the day of the visit or anticipated per visit. This time would not include non-E/M services such as time spent providing therapies or services of health care staff other than the Naturopath. Alternatively, document the level of medical decision-making to support the E/M service code chosen.

Section II:

In this section describe the patient's current health condition(s), complaints and all pertinent past medical history or co-morbid condition (s) that may affect recovery from the current episode (such as obesity, prior injury, diabetes, previous surgery, etc.).

Section III:

This section allows you to report what you found in your examination. If treatment is for a neuro-musculo-skeletal (NMS) condition, list any pertinent, ROM, orthopedic, neurologic, or vascular testing findings. Be sure to be specific regarding the findings. For example, do not merely state a test was positive. A finding is not meaningful without a description of the side on which the finding was noted and the location and character of the symptom re-produced. List any palpation findings that contribute to the clinical picture such as the location of trigger points, muscle tightness, and tenderness to touch. You may also report postural findings here. You should use this section to include any other tests or findings you have noted in your evaluation of non-NMS conditions. You may include pertinent lab or other diagnostic test results. Please include vital signs for all patients.

Section IV:

In this section, list your specific objectives/goals of treatment. In addition, provide information regarding your plans for patient self-care management such as dietary, exercise and/or lifestyle changes.

Additional Comments

Please do not hesitate to provide any additional information you feel is important for us to know regarding the patient's condition(s) that will aid us in making a medical necessity determination. You may also submit your chart notes, exam forms or other pertinent clinical records.

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Clinical Information Summary Sheet

Practitioner Name:________________________

Patient Name:____________________________

I. Is E/M code choice based on Time or Level of Medical Decision-Making (MDM)?

☐ **TIME (#minutes ______). Total E/M time spent by physician/other qualified health care provider on date of the encounter**

OR ☐ **Medical Decision-Making _______** ☐ **straightforward** ☐ **low** ☐ **moderate** ☐**high________**

II. CURRENT/PAST HEALTH HISTORY____

____

____

____

III. OBJECTIVE FINDINGS____

____

____

____

____

VITAL SIGNS: Ht________ Wt____________ B/P___________ Pulse___________ Temperature_______

LAB and/or other Diagnostic Testing Results____________________________________

____

IV. TREATMENT OBJECTIVES/GOALS____

____

____

____

PATIENT EDUCATION/RISK MANAGEMENT____

____

____

____

ADDITIONAL COMMENTS OR ATTACH YOUR DAILY NOTES OR OTHER CLINICAL RECORDS

____

____

____

Signature of Treating Practitioner________________________________ **Date**____________________

(Required)

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**.

A request for a Reopen/Modification may be submitted via telephone, fax, or through the secure electronic submission of 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.

ASH MNR Form #: Fill in the number of the treatment 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.

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

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P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

REOPEN / MODIFICATION

Naturopathy

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______________________________

Treating N.D.______________________ 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 **only** 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)

☐ **Lab / Imaging / Dx. Studies**
Services by CPT code & Clinical Rationale______________________________

____

☐ **Dates of Service – Changes, Extensions** (Maximum treatment plan 6 months), **Reductions**
The treatment/services dates should be: Start (mm/dd/yyyy) ____________ End (mm/dd/yyyy) ____________
Clinical Rationale______________________________

____

☐ **Additional/New Diagnosis**______________________________

☐ **Additional E/M Services, Total #:** ____
99211 x ______ 99212 x ______ 99213 x______ 99214 x______ 99215 x______
Clinical Rationale______________________________

____

☐ **Additional Prolonged Services, Therapies or Other Services:**

Prolonged Services: (Use only with 99205 or 99215) 99417 X _____

Therapies: Total # _____, Diathermy 97024 x ____ Hydrotherapy 97039 x ____ Hot/Cold Packs 97010 x____

Therapeutic US 97035 x ____ Electrical Stimulation 97032 x ____ Manual Therapy 97140 x ____

Consultation: CPT Code(s) ______________________________

Prolonged Consultations: Total # _______**99354 X** _______ **99355 X** _______

Other Therapies or Services by CPT code ______________________________

Clinical Rationale______________________________

Please note that you may submit for additional office visits and/or therapies or you may submit for a date extension, however, you may not submit for both.

ADDITIONAL INFORMATION

____

____

Signature of treating Practitioner of Naturopathic Services (Required)______________________ **Date**__________

Patient Progress Form

The Patient Progress form provides a tool to collect the patient's subjective assessment of their progress since treatment began. The value of this form is that it records the patient's progress in a subjective manner. The record of the patient's perspective of his or her current health status and treatment progress, in his or her own words, is valuable to both you and the clinical quality evaluator.

Typically you will have your patient complete the Initial Health Status form at the time of their initial visit in your office. The Patient Progress form will not typically be completed until the time of your first re-examination. If, however, the patient's clinical condition has significantly changed over the course of those visits provided under the Clinical Performance System waiver, you may choose to include the Patient Progress form along with the Initial Health Status form at the time of your initial submission. You may submit the Patient Progress form at any time you feel this information may be helpful in documenting the patient's current clinical condition. The clinical quality evaluator may request the Patient Progress form at any time to assist in the evaluation of submitted treatment/services.

When care is necessary beyond your initial approved treatment/services, the Patient Progress form should be faxed with the MNR Form. The absence of the Patient Progress form will not be the sole reason for care denial. However, a continuing care plan may appear to be less Medically Necessary if the patient's progress is neither evaluated on the MNR Form nor made available on the Patient Progress form. In these cases, the clinical quality evaluator might adversely determine the care proposed by you, the treating practitioner based only on the information on the MNR Form.

The patient should complete the Patient Progress form in its entirety and fully address their current problem and the progress they have made thus far. Though it is essential to understand the patient's perspective of his or her condition and progress, the Medical Necessity will not be solely determined with the patient's forms either. If any discrepancies are identified between the MNR Form and the Patient Progress form, the clinical quality evaluation manager may call you to verify the conditions before rendering a clinical determination.

When the form has been completed, the patient must sign and date the bottom line to account for the accuracy of the information recorded. If the patient is unable to fill out the form on his or her own, you or your staff can assist the patient by completing this part of the patient history. Whenever possible, the visual analog pain scale and pain drawings should be completed by the patient to get their first-hand perception of their condition. You or your staff must then co-sign this form along with the patient's signature. If the patient has multiple areas of complaint, a Patient Progress form may be completed for each area of complaint if more space is needed to accurately describe the patient's condition. Please make sure the patient understands the Accuracy of Information statement that precedes his/her signature. When submitting clinical forms electronically, your copy of this form should be retained as it may be requested as part of routine audits.

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FAX: 877.248.2746

PATIENT PROGRESS

Patient completes this form. Naturopathy
For questions, please call ASH at 800.972.4226

PLEASE PRINT LEGIBLY

Patient Name____

Please complete the following questions. This form serves as a tool to assist your practitioner and ASH in evaluating your response to care.

Current Conditions/Complaints	Rate your overall progress since starting care				
1	Excellent	Good	Fair	Poor	No progress
2	Excellent	Good	Fair	Poor	No progress
3	Excellent	Good	Fair	Poor	No progress
4	Excellent	Good	Fair	Poor	No progress

How long does your improvement last? ________________

Describe your current overall health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What types of treatments are you currently using?

☐ Acupuncture treatment ☐ Home care/self care ☐ Spinal Adjustment/Manipulation
☐ Allergy treatment ☐ Therapeutic Massage Services ☐ Supplements/herbs
☐ Dietary change ☐ Medications ☐ Other ____________________
☐ Exercise ☐ Physical therapy

Which treatment(s) have been most helpful? Please describe____________________________

Are you satisfied with your overall progress? ☐ Yes ☐ No. Please explain________________________

Have your abilities to perform and enjoy your activities of daily living or work activities improved?

☐ Yes ☐ No Explain____

Are you following the recommendations (e.g., diet, exercise, taking supplements) from your naturopathic doctor? ☐ Yes ☐ No Please explain the barriers to being able to follow the plan:___________

If you have developed any new health concerns, please describe. ☐ N/A________________________

Is this being treated? ☐Yes ☐ No ☐ N/A. Please describe________________________________

If you have a new complaint, injury or other event in your life that has prolonged your care, please describe. ☐N/A ____

Do you have any new health goals or a specific area you wish to focus on with your naturopathic doctor?

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature______________________________________ **Date**__________________________

NDPtProgress062818.docx

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.

Keep this form in your patient's file and be sure to review the following important areas:

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.

Submitted (Subm): 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 dates of treatment/services approved.

Clinical Quality Evaluator: This form 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 evaluator 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.

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