American Specialty Health Group, Inc.

Out-of-Network Instruction Guide
for Nutrition 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 / nutrition 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 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 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 had not reported pertinent information you feel 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 of 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: _____

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 10 Code): 1._____ 3._____

2._____ 4._____

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

# of Assessment Services: ☐ New Pt./Initial

☐ Est. Pt./Re-Assessment.

Total # 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 and treatment protocol. It is the standard tool you may use to communicate with the peer clinical evaluation manager when submitting a nutrition care plan 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
2. Documenting an established patient's clinical assessment if they suffer a new injury/condition
3. Documenting an established patient's clinical assessment if they suffer an exacerbation which requires a new nutrition care plan
4. Documenting established patient assessment 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: Services provided prior to today and the therapy outcome

In this section you should list any treatments you have already rendered and how the patient responded to those visits.

Section II: Historical Information

In this section list each Chief Complaint along with related historical findings, any pertinent past medical history or co-morbid condition that may affect recovery.

Section III: Physical Assessment Information

This section allows you to report vital signs, anthropometric measurements and a summary of what you found in your physical assessment. For example, list important findings regarding hydration status, wasting, cognition, alertness, abdominal palpation, swellings, etc.

Section IV: Laboratory and other Diagnostic Testing Results

Please include the main laboratory, home testing or other diagnostic results used to complete your evaluation and care plan and to track outcomes. Examples might be home blood glucose monitoring, electrolyte levels, or lipid levels. Other diagnostic results such as bone densitometry can also be recorded in this section.

Section V: Nutrition Assessments/Conclusions

In this section, please explain your assessments of the current nutritional status, any progress made toward goals and any changes you plan to make to your care plan.

Section VI: Nutrition Care Plan Objectives/Goals

It is helpful to list your goals of nutrition care. (e.g.; etc.). Record the desired outcomes of interventions such as dietary recommendations, nutrient supplementation, home care instructions, and patient education. The goal of the nutrition care plan should be appropriate for the diagnosed medical condition for which the care is provided.

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. Services provided prior to today and the responses to the nutrition care

Total # of Visits _____. Patient's response to care _____

II. Historical Information

Current main complaint(s) _____

Pertinent health/social/family history _____

Other ongoing treatments (e.g., medications, supplements)_____

Diet recall, record, food frequency conclusions_____

Medication/Nutrient/Supplement Interactions_____

III. Physical Assessment Information

Date of physical assessment ____**/** ____ **/** _____

Vital Signs and anthropometric measurements: Height_____ **Weight**_____, BMI _____ WC ____

IBW _____ **BP**_____ / _____ mmHg, **Pulse** _____ Other_____

Summary of your physical assessment findings_____

IV. Laboratory and other Diagnostic Testing Results

V. Nutrition Assessments/Conclusions

VI. Nutrition Care Plan Objectives/Goals

Additional Comments_____

Signature of treating nutrition services practitioner (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.

Please note that you may use this form to submit a request for additional office visits and/or services **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 MNR 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
Fax: 877.248.2746

REOPEN / MODIFICATION

Nutrition Services
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

Clinic Name_____
Practitioner Name_____
Address_____
City/State/Zip_____
Phone (_____) _____ Fax (_____) _____

Patient Health Plan _____

List the MNR Form Number this submission pertains to.
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.

☐ **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.

_____

_____

☐ **Other**
Services/Clinical Rationale_____

_____

_____

_____ _____
Signature of Practitioner of Nutrition Services (Required) **Date**

What Is An MNR Response Form?

Once the medical necessity determination has been rendered, you will receive the MNR 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.

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: 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: Represent the dates of service approved.

Clinical Quality Evaluation Manager: Provides the name, phone number and phone extension of the clinical evaluation manager who rendered the Medical Necessity determination. **If you have questions regarding a Medical Necessity determination you may contact the clinical quality evaluation manager 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 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.