American Specialty Health

Out-of-Network Instruction Guide
for Rehabilitative Services
(Physical, Occupational, and Speech Therapy and Athletic Training)

The following instructions are designed to assist you in interacting with the American Specialty Health (ASH) 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 total number of dates of services physical medicine modalities and procedures, 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 (information can be from your Evaluation and/or Re-Evaluation findings for the timeframe you are requesting), 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 evaluation 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
P.O. Box 509077
San Diego, CA 92150-9077

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/pathology codes), the time period during which you treated or intend to treat the patient, and the services you have rendered or intend to render. **OON Medical Records Cover Sheet** can be used with the below **Clinical Information Summary Sheet** or when you submit your medical records. 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:** There are three available versions of the Clinical Information Summary Sheet for physical and occupational therapy services. One is for reporting findings related to an **Orthopedic** condition, one is for **Neurologic** conditions, and one is for **Pediatric** cases. (For pediatric patients presenting with an orthopedic condition, us the CISS for Orthopedic conditions.) There are three versions available for Speech Therapy clinical findings and include one for **Speech/Language/Cognitive** disorders, one for **Dysphagia**, and one for **Continuing Care** of ST services. Athletic trainers will also use the **Orthopedic** form when treating and reporting on sports-related injury or condition. To make reasonable determinations regarding medical necessity we need to understand the clinical information that you obtained in your patient's history and clinical evaluation or assessments that you relied upon to make your 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) and patient's response to care;
    b. An opportunity to describe Past Medical History or Co-Morbid Factors that may affect response to care;
    c. Objective clinical information such as Range-of Motion, Pain levels, Palpation, Orthopedic and Neurologic Assessment, and Functional Limitations;
    d. Your Plan of care (frequency and duration) or interventions and Treatment Goals; and
    e. The Outcome Assessments 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 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 a 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 (Use One Per Patient)

PROVIDER GROUP NAME (FACILITY)_____
TREATING PRACTITIONER NAME_____
FACILITY TIN#_____

Address_____
City/State/Zip_____
Provider Phone#_____
Provider FAX #_____
(Providing your FAX # will expedite the response to this request)
*NPI # (Treating Practitioner)*_____

To: American Specialty Health	Date:
Fax: 1.877.248.2746	Pages:
Patient Name: Pt. Birth date:	Patient ID#: Gender: ☐ Male ☐ Female
Subscriber Name: Subscriber ID#:	Health Plan: Group #:

TREATMENT / SERVICES SUBMITTING FOR REVIEW

☐ PT Services ☐ OT Services ☐ ST Services ☐ AT Services (Choose only one)

Initial Start of care(mm/dd/yyyy) for this condition_____
Date of Evaluation or Reevaluation Findings: _____ # of Office Visits already rendered_____

Primary Diagnoses (ICD-10) (Highest level of specificity-Primary condition and Pathology codes)

1_____ 3_____
2_____ 4_____

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

Within above date range, please indicate:

Total #of Evaluation Services: (Circle appropriate Evaluation or Re-evaluation services submitting for review)

☐ Evaluation (97001/97003/92610/92521/92522/92523/97005
☐ Re-Evaluation (97002/97004/97006)

Total #of Dates of Service / Office Visits: ☐

Imaging / Other Studies by CPT Code(s)_____

Durable Medical Equipment by HCPCS Code(s)_____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below:

☐ I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder (ASD)

By submitting this *OON Services Cover Sheet,* I attest that the above dates and services are those I wish to have reviewed for medical necessity.

Please attach the Clinical Information Summary Sheet or all relevant Evaluation Forms, Clinical Notes or Reports that support the medical necessity of the submitted services.

Clinical Information Summary Sheet

There are six available versions of the Clinical Information Summary Sheets. There are three versions available for Physical and Occupational therapy; one is for reporting findings related to an **Orthopedic** condition, one is for **Neurologic** conditions, and one is for **Pediatric** cases. For pediatric patients presenting with an orthopedic condition, please use the CISS Orthopedic form. Athletic trainers will also use the **Orthopedic** form when treating and reporting on sports-related injury or condition. There are three versions for Speech Therapy clinical findings and include one for **Speech/Language/Cognitive** disorders, one for **Dysphagia**, and one for **Continuing Care** of ST services. The purpose of the Clinical Information Summary Sheet is to document the pertinent clinical findings that contribute to the formulation of the member's diagnosis and treatment plan. It is the standard tool you may use to communicate with the Peer Clinical Quality Evaluators (CQE) 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 evaluation form.

The Clinical Information Summary Sheet may be used for:

1. Documenting findings from an initial evaluation, re-evaluations and/or assessments
2. Documenting a patient's clinical findings if they suffer a new injury/condition
3. Documenting a patient's clinical 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 cause / mechanism of injury (how each complaint began), and the Stage and Nature of the condition.

Section II: Clinical Information

This section allows you to report what you found in your evaluation, reevaluation or assessment. The findings will vary depending on the treating practitioner's specialty and the condition the therapy is treating. PTs and OTs should choose the appropriate form as described above based on the patient diagnosis and age. SLPs should use either the **Speech/Language/Cognitive** or **Dysphagia Summary Sheets** for Evaluations and Re-evaluations or speech/language/cognitive or swallowing disorders. The Speech **Continuing Care Summary Sheet** is used for submission of updated findings for conditions that need continuing care. Athletic trainers will use the **Orthopedic** form when treating and reporting on a sports-related injury or condition. Forms are available for practitioners to submit objective findings or any pertinent clinical information to support interventions/care needed. Examples of clinical findings may include but not limited to: 1) any range-of-motion findings as degrees or percent (%) limited, 2) comment on any pain or other pertinent findings associated with the motion in the "Comments" section, 3) any pertinent orthopedic, neurologic, pediatric, speech, language or swallowing findings, 4) clinical assessment or updated goals. Be sure to be specific regarding the finding. For example, do not merely state a test was positive. A finding reported as "positive" is not meaningful without a description of the side on which the finding was noted and the location and character of the symptom produced.

Section III: Outcome Assessments

In this section, list an appropriate type of outcome assessment tool for the patient's condition. 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 tools. List any other tools by name and score in the "Other" section.

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

☐ **PT** ☐ **OT** ☐ **AT** - New or Continuing Care for **ORTHOPEDIC** conditions

Practitioner_____ Patient_____

I. Date of Onset/Exacerbation_____ Initial Start care (mm/dd/yyyy) for this condition_____

Chief Complaint(s)_____ _____

Cause of Current Episode: ☐ Traumatic ☐ Repetitive ☐ Unknown

☐ Post-Surgical (date/type)_____

Stage of Condition ☐ Acute ☐ Sub-acute ☐ Chronic

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

II. Vital Signs Height_____ Weight_____ Blood Pressure_____

Area/Joint Movement	Active ROM R/L(Degrees)	Passive ROM R/L (Degrees)	Strength R/L (0-5)	Mobility (0-6, 3=NL)	End Feel	Pain (Level/Location)
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			

Pertinent Evaluation Findings (Please include location and intensity of findings and note any significant progress)_____

Pt's Goals, Functional Limitations & Planned Interventions_____

Medical /Social Hx &/or Co-Morbidities (that may affect recovery)_____

III. OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	List Date Obtained (mm/dd/yyyy)	Current	Initial	List Date Obtained (mm/dd/yyyy)	Current
_____	ROLAND-MORRIS	_____	_____	NECK INDEX (NDI)	_____
_____	OSWESTRY	_____	_____	OPTIMAL SCORE	_____
_____	FOTO	_____	_____	LEFS (LE) score	_____
_____	Other (name and score):	_____	_____	DASH (UE) score	_____
_____	_____	_____	_____		_____

ADD'L. COMMENTS_____

Signature of treating practitioner (Required)_____ **Date**_____

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

☐ **PT** ☐ **OT** - New or Continuing Care for **NEURO** conditions

Practitioner_____ Patient_____

I. Date of Onset/Exacerbation_____ Initial Start of care(mm/dd/yyyy) for this condition_____

Chief Complaint(s)_____ _____

Cause: ☐ Traumatic ☐ Repetitive ☐ Unknown ☐ Post-Surgical (date/type)_____

Stage of Condition ☐ Acute ☐ Sub-acute ☐ Chronic

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

II. Vital Signs Height_____ Weight_____ Blood Pressure_____

Cognitive / Perceptual ☐ Intact **Impairment:** ☐ Minimal ☐ Moderate ☐ Maximum

Communication ☐ Verbal ☐ Non-Verbal ☐ Unable to Communicate
☐ Relies on primary care giver for communication needs

Mobility: Ambulation / Gait Pattern_____
Wheelchair / Assistive devices_____
Transfers_____
Bed_____

Muscle Tone:

Location	Flaccid	Hypotonic	Ataxic	Athetoid	Normal	Spastic	Rigid
Head							
Trunk							
U. E.							
L. E.							

Balance/Coordination: ☐ Normal ☐ Deficits in the following:
Static Position_____ ☐ Good ☐ Fair ☐ Poor ☐ Zero
Dynamic Position_____ ☐ Good ☐ Fair ☐ Poor ☐ Zero

Activities of Daily Living ☐ Independent ☐ Deficits in the following:
Task_____ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist
☐ Device _____
Task_____ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist
☐ Device _____

Sensation: ☐ Intact ☐ Impaired ☐ Absent ☐ Location_____

Edema ☐ None ☐ Edema in the following location_____
☐ +1 minimal (<.5cm) ☐ 2+ mild (.5cm) ☐ 3+ moderate (.5-1.5cm) ☐ +4 severe (>1.5cm)

III. OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	List Date Obtained	Current	Initial	List Date Obtained	Current
_____	(mm/dd/yyyy)	_____	_____	(mm/dd/yyyy)	_____
_____	TUG score	_____	_____	Peabody score	_____
_____	Berg Balance score	_____	_____	DASH score	_____
_____	Other (name/score)	_____	_____	LEFS (LE) score	_____

ADD'L. COMMENTS_____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below:

☐ I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder (ASD).

Signature of treating practitioner (Required)_____ **Date**_____

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

PT-OT - New or Continuing Care for **PEDIATRIC** conditions

Practitioner_____ Patient_____

Date of Onset / Medical Diagnosis_____ **Chief Complaint(s**) _____

_____

Cause of Current Episode ☐ Traumatic ☐ Congenital ☐ Unknown ☐ Post-Surgical (Date/Type)_____

Estimated frequency of treatment (per week/month)_____Estimated duration_____

Pregnancy & Birth History: Complications during pregnancy ☐ Complications during delivery ☐

Weeks of gestation at birth;_____

Behavior/Cognitive Status ☐ Alert ☐ Cooperative ☐ Responsive☐ Confused ☐ Uncooperative ☐ Impulsive ☐ Combative ☐ Unresponsive

Communication ☐ Verbal ☐ Non-Verbal ☐ Unable to Communicate ☐ Relies on primary care giver for communication needs_____

Educational Level;_____ Currently attending school? ☐Yes ☐No If yes, name of school:_____

Developmental Milestones:_____

_____

Balance ☐ Normal ☐ Deficits in the following: **Mobility** Ambulation/Gait Pattern_____

Static Position_____ ☐ Good ☐ Fair ☐ Poor ☐ Zero Wheelchair/Assistive device:_____

Dynamic Position_____ ☐ Good ☐ Fair ☐ Poor ☐ Zero Transfers:_____

Muscle Tone:_____ **Location:**_____

Gross Motor Development ☐ Independent/Age appropriate ☐ Deficits in the following:_____

Activity_____ ☐ CG/CS☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:_____

Activity_____ ☐ CG/CS☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:_____

Fine Motor Development ☐ Independent/Age appropriate ☐ Deficits in the following:_____

Activity_____ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:_____

Activity_____ ☐ CG/CS ☐ Min assist ☐ Mod assist ☐ Max assist **Goal**:_____

Self Care Activities: ☐ Normal/Age appropriate ☐ Deficits in the following:_____

Activity:_____☐ Good ☐ Fair ☐ Poor ☐ Zero **Goal**:_____

Activity:_____☐ Good ☐ Fair ☐ Poor ☐ Zero **Goal**:_____

Summary of Clinical Findings/Functional Progress_____

_____

_____

Med/Soc Hx / Co-Morbidities (that may affect recovery)_____

Functional Limitations & Planned Interventions, including Goals_____

_____

_____

_____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial		Current	Initial		Current
	List Date Obtained (mm/dd/yyyy)			**List Date Obtained** (mm/dd/yyyy)	
	BSID III			Peabody score GMQ/FMQ	
	Other (name and score)			BOT	

ADD'L. COMMENTS_____

_____

_____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below.

☐ I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder (ASD).

Signature of treating practitioner (Required)_____ **Date**_____

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

ST – Evaluation or Re-evaluation for **SPEECH/LANGUAGE/COGNITIVE** conditions

Patient Name:_____ **Diagnosis:**_____ **Practitioner Name:**_____

Date of Onset_____ **Chief Complaint(s)/Concern(s)**_____

Cause of Condition: ☐ Traumatic ☐Congenital ☐ Unknown **Stage of Condition:** ☐Mild ☐Moderate (Mod) ☐Severe

Concurrent Conditions: _____ **Prior speech/language treatment**:_____

Estimated frequency of treatment (per week/month)_____ **Estimated duration**_____

Cognitive Status: ☐Alert ☐Cooperative ☐Responsive ☐Confused ☐Follows commands ☐Impulsive ☐Capable of learning ☐Capable of retaining new information ☐Combative ☐Unresponsive. Does patient speak English? ☐Yes ☐No If no, what is primary language?_____

Hearing Status: ☐WNL ☐Impaired. Hearing aids worn ☐Yes ☐No Cochlear implant ☐Yes ☐No Type of impairment_____

Visual Status: ☐Normal ☐ Impaired: ☐Min ☐Mod ☐Severe Type of impairment_____

Oral Motor Evaluation:

LIPS: ☐WNL ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe ☐rounds lips ☐retracts ☐can purse ☐retract with teeth closed ☐other_____

Observation: Symmetry, range, speed, tone:_____ Can patient maintain labial seal at rest? ☐Yes ☐No Drooling? ☐Yes ☐No
Can do strong lip "smacks" ☐Yes ☐No Add'l Comments:_____

TONGUE: ☐WNL ☐WFL ☐ Impaired ☐Mild ☐Mod ☐Severe ☐can elevate to alveolar ridge ☐elevate outside of mouth
☐circle tongue around lips ☐lateralize to corners of mouth ☐without sliding along lips ☐using additional jaw movement ☐other_____

☐ tongue pops ☐ lateral pushes against tongue depressor **Observation:** Symmetry, range, speed, tone_____
Dyskinesia present? ☐Yes ☐No If yes, specify degree_____

JAW: ☐WNL ☐WFL ☐ Impaired ☐Mild ☐Mod ☐Severe

Observation: Symmetry, range, speed, tone:_____ Involuntary movement_____

SOFT PALATE: ☐WNL ☐WFL ☐ Mild ☐Mod ☐ Severe **Observation:**_____

Symmetry, range, speed, tone:_____Involuntary movement_____

Add'l Comments/Assessment_____

_____

☐**APRAXIA** Area affected: ☐lips ☐tongue ☐jaw ☐soft palate Severity: ☐Mild ☐Mod ☐Severe_____

☐**DYSARTHIA** Area affected: ☐lips ☐tongue Severity: ☐Mild ☐Mod ☐Severe_____

Voice: ☐WFL ☐Dysphonia ☐Aphonia Severity: ☐Mild ☐Mod ☐Severe ENT Eval: ☐Yes ☐No

(Date/Results)_____

Quality: ☐WFL ☐Impaired ☐breathy ☐hoarse ☐harsh ☐hypernasal ☐hyponasal ☐strained-strangled

Add'l Comments/Assessment _____

Max Duration of "ah" _____seconds Impaired: ☐Mild ☐Mod ☐Severe Consistent volume? ☐Yes ☐No

Volume: ☐WNL ☐WFL ☐Impaired Type/Deg of Impairment with: ☐single words_____% ☐phrases_____% ☐sentences_____%

Add'l Comments/Assessment_____

☐**DIADOCHOKINETICS:** ☐WNL ☐Labored ☐Other_____ ☐pa ☐ta ☐ka ☐pataka ☐a oo ee ☐mommy baby daddy

SPEECH: ☐WNL ☐ Impaired. If Impaired, % of Intelligibility: Syllable_____% Word_____% Phrase____% Conversation_____%

Add'l Comments/Assessment_____

Fluency: ☐Yes ☐No Type/Degree of Dysfluency: ☐Min ☐Mod ☐Severe _____% of blocks _____% of prolongations

_____% phrase repetitions _____% whole word repetitions _____% syllable repetitions _____% of sound repetitions

Add'l symptoms/findings (ie. facial/body movements)_____

LANGUAGE(Spoken):

Comprehension: ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe Pointing to objects ☐Yes ☐No 1-step command ☐Yes ☐No
Multi-step command ☐Yes ☐No Understanding conversation ☐Yes ☐No Can pt take turns in conversation independently? ☐Yes ☐No

Add'l Comments/Assessment_____

_____

Expression: ☐WNL ☐Impaired, Severity: ☐Min ☐Mod ☐Severe ☐ repetition ☐ automatic speech ☐ confrontation naming

☐Production (words, phrases, sentences) ☐Narrative (storytelling, picture description) Describe any impaired findings_____

Patient Name:_____ **Diagnosis:**_____ **Practitioner Name:**_____

LANGUAGE (Written): ☐ WNL ☐WFL ☐Impaired. If impaired, degree of impairment_____

Use of keyboard? ☐Yes ☐No AAC device used? ☐Yes ☐No If yes, list which one_____

Reading: ☐WNL ☐Impaired Describe impairments/findings_____

Understands simple written items ☐WNL ☐Impaired Describe impairments/findings_____

Understands written language ☐WNL ☐Impaired Describe impairments/findings_____

Functional Reading ☐WNL ☐Impaired Describe impairments/findings_____

COGNITIVE-COMMUNICATION: Attention ☐WNL ☐Impaired **Memory** ☐WNL ☐Impaired. If impaired, list areas of improvement needed_____

Executive function ☐WNL ☐Impaired If impaired, list areas of improvement needed_____

Can pt manage his/her own household chores? ☐Yes ☐No ☐N/A Add'l symptoms/findings_____

Pragmatics ☐WNL ☐Impaired Describe any impaired findings_____

Self-awareness ☐WNL ☐Impaired Describe any impaired findings_____

Summary of Clinical Findings_____

_____

_____

_____

Functional Limitations & Planned Interventions, including Goals_____

_____

Med/Soc Hx /Co-Morbidities (that may affect recovery)_____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable and date obtained)

Assessment	Initial Score and Date	Current Score and Date		Assessment	Initial Score and Date	Current Score and Date
Fluency Severity Scale				REEL		
PICA				SPELT		
CELF				BDAE		
CASL				PPVT		
PLS				TOLD		
NOMS Scores: Motor Pragmatics Spoken Language Written Language Problem Solving				Other (name and score) _____		

ADD'L. COMMENTS_____

_____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below.

☐ I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder (ASD).

Signature of treating practitioner (Required)_____ **Date**_____

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

ST – Evaluation or Re-evaluation for **DYSPHAGIA** conditions

Patient Name:_____ **Diagnosis:**_____ **Practitioner Name:**_____

Date of Onset/Exacerbation_____ **Chief Complaint(s)**_____

Cause of Current Condition: ☐Traumatic ☐Congenital ☐Unknown **Stage of Condition:** ☐Mild ☐Moderate (Mod) ☐Severe

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

Mental Status: ☐Alert ☐Cooperative ☐Responsive ☐Confused ☐Uncooperative ☐Impulsive ☐Lethargic ☐Combative ☐Unresponsive

Capable of learning and/or retaining new information ☐Yes ☐No if no, please explain_____

Hearing Status: ☐WNL ☐Impaired Hearing aids worn ☐Yes ☐No Cochlear implant ☐Yes ☐No Type of impairment_____

Visual Status: ☐Normal ☐Impaired ☐Min ☐Mod ☐Severe Type of impairment_____

Voice: ☐WFL ☐Dysphonia ☐Aphonia Severity: ☐Mild ☐Mod ☐Severe ENT Eval: ☐Yes ☐No

(Date/Results)_____

Quality: ☐WFL ☐Impaired ☐Breathy ☐Hoarse ☐Harsh ☐Hypernasal ☐Hyponasal ☐Strained-strangled

Add'l Comments/Assessment _____

Speech: ☐WNL ☐Impaired. If Impaired, % of Intelligibility: Syllable_____% Word_____% Phrase_____% Conversation_____%

Add'l Comments/Assessment_____

ORAL PHASE FUNCTION: ☐WNL ☐WFL ☐Impaired Severity: ☐Mild ☐Mod ☐Severe Dentition: ☐WNL ☐WFL ☐Teeth missing,
% teeth missing:_____ **Dentures present:** ☐Yes ☐ No Indicate what is present ☐Uppers ☐Lower ☐Partials

Oral Motor, Respiration and Phonation:

LIPS: ☐WNL ☐WFL ☐ Impaired ☐Mild ☐Mod ☐Severe **Observation**: Symmetry, range, speed, tone:_____

TONGUE: ☐WNL ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe **Observation:** Symmetry, range, speed, tone:_____

Dyskinesia present? ☐Yes ☐No If yes, specify degree_____

JAW: ☐WNL ☐WFL ☐Impaired ☐Mild ☐Mod ☐Severe **Observation:** Symmetry, range, speed, tone:_____

SOFT PALATE:☐WNL ☐WFL ☐ Mild ☐Mod ☐ Severe **Observation:**_____

Symmetry, range, speed, tone:_____ Involuntary movement_____

Add'l Comments/Assessment_____

Respiratory Sufficiency and Coordination ☐WNL ☐Impaired, degree of impairment_____

Check off and give date if applies: ☐Tracheostomy_____ ☐Mech. Ventilation _____ ☐Recent intubation_____

Diet texture prior to onset: Food_____ Liquid_____ Other:_____

Facial/Oral Motor asymmetry ☐Yes ☐No If yes, etiology:_____

Add'l Comments/Assessment_____

Feeding Method: ☐Independent ☐Needs assistance, level of assistance_____ ☐Dependent Endurance during feeding: ☐ WNL ☐ WFL
☐Impaired Degree of impairment_____

Management of oral secretions: ☐ WNL ☐ WFL ☐Impaired, Degree/Comments_____

Drooling? ☐Yes ☐No Ifyes, degree _____ Left, Right or Bilateral

Pocketing? ☐Yes ☐No If yes, degree _____ Left, Right or Bilateral

PHARYNGEAL PHASE FUNCTION: Aspiration (signs/symptoms present) ☐Yes ☐No If yes, describe diet and/or liquid consistencies it occurred with_____ Severity: ☐Mild ☐Mod ☐Severe

Volitional throat clear ☐Yes ☐No Volitional cough ☐Yes ☐No Spontaneous throat clear ☐Yes ☐No Spontaneous cough ☐Yes ☐No

Testing: FEES/Videoswallow Study (MBSS) ☐No ☐Yes, date_____ if yes Diet Recommendations from FEES/MBSS _____

Current Diet: ☐Solid Textures ☐Regular ☐Mechanical Soft ☐Puree ☐Liquids ☐Thin ☐Nectar ☐Honey ☐NPO ☐Other_____

Add'l Comments/Assessment:_____

Recommendation: Diet_____ Liquid_____ ☐NPO f/u MBSS indicated ☐Yes ☐No if yes date_____

☐NPO If NPO, alternative nutrition method: ☐NG tube ☐Gastrostomy ☐Jejunostomy ☐Total parenteral nutrition

Add'l Comments/Assessment;_____

Patient Name_____ **Diagnosis**_____ **Treating Practitioner**_____

ESOPHAGEAL PHASE FUNCTION: ☐WNL ☐WFL ☐Impaired Severity: ☐Mild ☐Mod ☐Severe ☐Unknown

Swallow Precautions:_____ Prognosis: ☐Good ☐Fair ☐Poor

Summary of Clinical Findings_____

Pt's Functional Limitations & Planned Interventions, including Goals _____

Med/Soc Hx / Co-Morbidities (that may affect recovery)_____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable and date obtained)

Assessment	Initial Score and Date	Current Score and Date		Assessment	Initial Score and Date	Current Score and Date
Alaryngeal Communication FCM				MASA		
D-COME-T				PAIS		
Oral Motor/Feeding Rating				SAFE		
OSMSE-3				TOSF		
NOMS Score: Swallowing				Other (list name and score) _____		

ADD'L. COMMENTS_____

Signature of treating practitioner (Required)_____ **Date**_____

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Clinical Information Summary Sheet

ST – **CONTINUING CARE** for **SPEECH** conditions

(Check one) ☐ Dysphagia ☐ Speech/Language/Cognitive

Patient Name_____ **Diagnosis**_____ **Practitioner Name**_____

Date of Onset/Exacerbation_____ **Chief Complaint(s)**_____

Initial Start of care (mm/dd/yyyy) for this condition:_____

Cause of Current Condition: ☐Traumatic ☐Congenital ☐Unknown

Stage of Condition: ☐ Mild ☐ Moderate ☐ Severe

DATE OF MOST RECENT VISIT (mm/dd/yyyy)_____Response to care:_____

ASSESSMENT:

Chief Complaints_____

Current Findings_____

_____

_____

_____

HAS THERE BEEN PROGESS OR IMPROVEMENT NOTED TOWARDS INITIAL GOALS?

☐ Yes ☐No, Explain_____

_____

FUNCTIONAL OUTCOME MEASURE (include name and score - initial and current)_____

_____

HAVE THERE BEEN ATTEMPTS TO WITHDRAW OR DECREASE FREQUENCY OF CARE? ☐ No ☐ Yes, Explain_____

_____

HAS A HOME EXERCISE PROGRAM AND/OR DIET RECCOMENDATIONS BEEN PROVIDED? ☐ No ☐ Yes, Explain_____

_____

OBJECTIVES FOR CONTINUED CARE AND CURRENT GOALS_____

_____

_____

PATIENT/CAREGIVER EDUCATION OR TRAININNG? ☐ Initiated ☐ Completed ☐ Other Explain_____

_____

ESTIMATED DATE OF DISCHARGE (mm/dd/yyyy)_____

Signature of treating SLP (Required)_____ **Date**_____

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

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 <u>not approved</u> 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. If you need to add a new diagnosis or body region during the same timeframe of previously approved, please include the clinical findings for the new diagnosis or body region.**

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/treatments <u>may not</u> 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 MNR Form for this submission. The MNR Form Number is on the Medical Necessity Response Form (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 509077, San Diego, CA 92150-9077
Fax: 877.248.2746

REOPEN / MODIFICATION

Rehabilitative 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

Patient Health Plan_____

Provider (TIN Owner) Name_____
Treating Therapist_____
Facility/Clinic Name_____
Facility/Clinic 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.

☐ **Durable Medical Equipment**
HCPCS Code and Description_____
Rationale_____

_____

☐ **Add Additional Services Not Previously Submitted (e.g. EMG, NCV, FEES, MBS, other tests and measures)**

☐ **EMG** ☐ **NCV** ☐ **FEES** ☐ **MBS** ☐ **Other**
Provide rationale and additional clinical findings to support additional services.

CPT Code and Description_____
Rationale_____

_____

☐ **Dates of Service OR Visit Modification** Alteration to both DOS and visits cannot occur, if this is necessary then please submit an updated MNR Form in place of this modification.

☐ **Date Change**
The treatment period/dates should be: Start (mm/dd/yyyy)_____ **End (mm/dd/yyyy)**_____
Rationale_____

☐ **Date Extension** (up to 30 days)
I am submitting for a date extension for this patient to _____ (mm/dd/yyyy).
Rationale_____

☐ **Additional Office Visits**
I am submitting for Additional Number of Visits: # _____ **(maximum allowable is 2 in the already approved time frame, if > 2 visits needed please submit a new MNR)**. Discharge from care is expected at the completion of this time frame.
Rationale_____

_____

If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below:

☐ **I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder**

Signature of treating practitioner (Required)_____ **Date**_____

What is an MNR Response Form?

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

Provider Information: The provider's name, address, city, state, zip code and fax number.

Received Date by ASH: Represents the date the treatment/services were faxed to ASH or the postmarked date the treatment/services were sent to ASH by mail.

Returned Date by ASH: Represents the date ASH 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: Represent the dates of service 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. 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 provider and not to the patient, it will be documented in this space.