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INSIDE ASH

American Specialty Health

in this issue

Clinical Practice Guidelines Updates

ASH clinical practice guidelines (CPGs) exist to provide a framework for decision making and operational processes within the organization. These important documents are consistently developed, revised, and inactivated/terminated as dictated by accreditation and certification standards, regulatory requirements, delegation requirements, peer-practitioner committee feedback, and business needs. In addition, CPGs are reviewed for current supporting literature, as well as new information, in peer-reviewed literature and technology advancement. CPGs are reviewed and updated annually, along with any other time it is necessary throughout the year.

From July 2022 through August 2022, 17 existing CPGs were presented for review and approval.

One of the CPGs had changes which were material in nature:

- Lymphedema (CPG 157)

No new CPGs were developed and approved during this timeframe.

CPGs may be found posted on our website at:
https://www.ashlink.com/ASH/public/Providers/COM/techniquy

Health care practitioners should practice only in the areas in which they are competent, based on their education, training, and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services, and whether the services are within their scope of practice.

We value your input. For comments or questions on ASH Clinical Practice Guidelines, please contact us at ClinicalQualityAdministration@ashn.com or call Practitioner Contract Services at 800.972.4226, option 4.

Update Your Information Online

Have your office hours changed? Has your address changed? Have you added or removed email addresses, fax numbers, or phone numbers? Does your office offer home-based care or telehealth services? Are you certified as a Diverse Supplier? All this important information can be quickly and easily updated directly through the ASHLink® website, ASH's secure provider portal, just by logging in and selecting *Account > Confirm / Update Your Information.*

As a contracted provider with ASH, you must provide written notice to ASH at least 30 days prior to a change. This allows ASH time to ensure our systems are updated and that health plan clients have been notified of the new information within the established timeframes. Any delay in notifying ASH of some of these types of changes could result in claims-processing issues, or even customer service issues for members.

To avoid missing important updates, changes, or health plan announcements, please be sure to review your information regularly and update it as often as needed.

If you have any questions regarding this process, or for help completing the Provider Status Change Request form, please contact Provider Contract Services at 800.972.4226, option 4. Our agents are available to assist you Monday through Friday from 8 a.m. to 5 p.m. Pacific Time.

Have You Reviewed the Language Assistance Program Annual Training?

As an ASH contracted provider, you are required to comply with ASH's Language Assistance Program. This program includes communication support services, cultural competency, and disability sensitivity. You are obligated to review the annual training which covers program expectations and education on these important topics. The training materials can be located on the ASHLink® website, ASH's secure provider portal, by logging in and clicking the Resources tab and selecting *Provider Education Library > Administrative Topics > Language Assistance and Cultural Competency Training*. Some excerpts are included below for quick reference. By communicating clearly, being aware of cultural differences, and taking positive action to remove barriers, you can help ensure that all patients have access to quality health care and support services.

Culture impacts every health care encounter. Since health care is a cultural construct based in beliefs about the nature of disease and the human body, cultural issues are central in the delivery of health services.

Cultural competency is the capability of effectively engaging with people from difference cultures. A person's culture is a main contributor to his or her concept of health and healing; how illness, disease, and their causes are perceived; behaviors around seeking health care; and attitudes toward health care practitioners.

Clear communication is the foundation of culturally competent care. Benefits of clear communication include improved safety, compliance with practitioner recommendations, practitioner and patient satisfaction, and reduced malpractice risk. The following actions can help to improve communication:

- Use a variety of instruction methods, encourage questions, and use the teach-back technique where you ask the patient to communicate back to you what it is they have understood. This ensures the patient comprehends the instructions and information.
- Try to use plain, simple language, especially when describing risks and benefits. Avoid using just numbers.
- Match the volume and speed of the patient's speech.
- Mirror body language, position, and eye contact.
- Spend a few minutes building rapport.
- Offer a qualified interpreter.

All telephonic interpretation services are free to all members, including when a member is accompanied by a family member or friend who can provide interpretation services. Contracted practitioners and their staff should not speak to members in a non-English language. ASH discourages the use of non-professional individuals for interpretation services, including, but not limited to, friends and family (particularly minors).

When working with interpreters, it is important to inform the interpreter of the specific patient needs. Make sure to allow enough time for the interpreted session and avoid interrupting. During the session, speak in first person while you face and talk to the patient directly. Use short sentences and avoid acronyms and technical terms. To arrange for interpretation services, call ASH Customer Service at 800.678.9133.

In addition to cultural considerations, some patients may also have a disability such as physical, hearing, visual, or cognitive impairment. A person with a disability is someone with a physical or mental impairment that substantially limits one or more major life activity (e.g., breathing, walking, concentrating, etc.). Some important facts about disabilities include:

- Each person's experience is different
- Some people are born with a developmental disability
- Traumatic experiences can cause disability
- Some people have adult-onset disability
- Chronic conditions can become disabling

Practitioners must ensure that physical, communication, and programmatic barriers do not inhibit participants with disabilities from obtaining all covered items and services. Some positive actions you can take include providing flexibility in scheduling as an accommodation, quiet spaces and/or help filling out forms, extra time for instructions or explanations of care, interpreters for those who are hearing impaired or whose first language is not English, and/or materials in alternate formats. Practitioners should work to remove physical, communication, and attitudinal barriers to care.

Here are some general considerations in treating persons with disabilities:

- Do not refer to the individual's disability unless it is relevant to treatment.
- Ask the person with the disability what they need to access their care. For example, "Is there anything about our conversation that you did not understand?"
- Avoid asking personal questions about their disability.
- Use person first language when addressing the person. For example, "a person who is blind" rather than "the blind person."

Tips for Working with Limited English Proficient (LEP) Members

ASH is pleased to announce another installment of information from the Industry Collaboration Effort (ICE) Provider Tools to Care for Diverse Populations. This selection focuses on tips for communication with limited English proficient (LEP) members. More details and resources can be found at:

https://www.iceforhealth.org/library/documents/Better_Communication,_Better_Care_-_Provider_Tools_to_Care_for_Diverse_Populations.pdf.

California law requires that health plans and insurers offer free interpreter services to both LEP members and health care providers. Health plans must also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

Who is a LEP member?

Individuals for whom English is not their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient.

How to identify a LEP member over the phone:

- Member is quiet or does not respond to questions
- Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions
- Member may speak and understand some English, but appears to have trouble communicating in English
- You may have a very difficult time understanding what they are trying to communicate
- Member self identifies as LEP by requesting language assistance

How to offer interpreter services:

- Let the member know you would like assistance from the interpreter service.
- Speak slowly and clearly. Do not speak very loudly or shout. Use simple words and short sentences.
  - "I think I am having trouble explaining this to you."
  - "I really want to make sure you understand. May I connect with an interpreter to help us?"
  - "Which language would you like the interpreter to speak? May I put you on hold while I connect with the interpreter?"
- Connect with contracted telephonic interpreter to identify language needed.

Best practice to capture language preference:

- For LEP members, it is a best practice to capture the members preferred language and record it in the plan's member data system.
- Example: "Please tell me what language you like to use. I will write it down for next time."

Is Your Facility Safe for Children?

Accidents can occur suddenly and without warning. Whether or not you routinely treat children,* an evaluation of your facility for potential hazards could reduce the likelihood of, or even prevent, serious injury to a child who may visit your office as a patient or accompanying a patient. When evaluating your facility, you and your staff should consider Murphy's Law: "Anything that can go wrong will go wrong." This is especially true when considering how curious young children can be. Use the following general guidelines when evaluating your facility. Please note, additional safety measures should be implemented based on the unique requirements of your facility.

- Mechanical tables (e.g., treatment tables with electrical or other moving parts) must have safety/emergency stop features such as a "kill switch" or button.
- Children must be supervised by an adult other than the patient or practitioner when mechanical tables or similar devices are being utilized.
- Children should never be left to wander unsupervised within the facility.
- All sharps disposal containers, biohazardous waste, and small objects should be removed from spaces easily reachable by a child.
- Unused electrical outlets should be covered with a safety plug.
- Be cautious of water dispensers that have both hot and cold features. Make sure they have a safety feature for hot water dispensing.
- Wires and/or cords should not be within reach of children.
- Your facility should routinely validate that all equipment is operating properly.
- Bookshelves and other large pieces of furniture should be secured and protected against toppling over if a child tries to climb or pull on them.
- Never leave a child on a table or other equipment unattended.
- Warning signs should be posted about the potential dangers to children of touching equipment. This allows parents to be aware of the potential hazards of equipment in the facility.
- Keep materials such as supplements out of children's reach.
- Make sure the waiting room is free of items that might be harmful to children. Instead, include items they can play with safely.
- Make sure you and your staff have basic emergency and life support training for children.

*Child/children within the context of this document are defined as 12 and under.

Practitioners should ensure they are compliant with all federal regulations and individual state laws.

Accessibility Compliance Survey – What You Need to Know and Do About Member Accessibility Standards

To comply with state regulations, American Specialty Health (ASH) is required to monitor that providers are complying with member accessibility standards. We do this by conducting annual telephone surveys of randomly selected contracted providers.

This is done through a **"secret shopper"** model, in which a surveyor calls the provider's office as a potential patient to see how soon he/she can schedule an appointment. Providers are surveyed both for their accessibility to treat a patient with an urgent (emergent) condition and a patient with a non-urgent (routine) condition.

Providers in this survey should demonstrate the following:

- **Urgent (emergent) condition:** Patient can obtain an appointment within 24 business hours from the time the patient called for the appointment (i.e., within the provider's next business day).
- **Non-urgent (routine) condition:** The patient can obtain an appointment within 7 business days from the time the patient called for the appointment.
- **Unable to schedule:** If the provider is unavailable to schedule an appointment within these timelines, the provider may refer the member to another contracted ASH provider. The provider may also refer the member back to ASH, who will then help the member find another available provider.

Once in the office, patients should not wait more than 30 minutes from the time of their appointment to the time they are seen by the provider.

The following points detail ASH's standard, regarding member/insured access to contracted providers:

- Contracted providers must be accessible 24 business hours a day, 7 business days a week. This means that the contracted provider must either see the patient, schedule an appointment within the applicable timelines (listed above), or direct the patient to seek another available ASH-contracted provider by referring the member to contact American Specialty Health's customer service. Providers must direct the patient to seek other immediate medical care if the condition is a medical emergency.
- If the provider is not personally available, the provider must have an answering machine, answering service, or paging system available to handle telephone calls from members.

As part of the telephone survey, you may also be evaluated on your answering machine content and language assistance services. The following points detail ASH's standard, regarding member/insured message content and must be included in your message greeting:

- A statement that, for any medical emergency, the patient should call 911
- Instructions for how the patient may leave a message for, or contact, the provider outside of business hours

A more complete list of member accessibility standards is available at: www.ashlink.com > *Resources > Providers > [Select Specialty] > Clinical Quality and Clinical Practice Guidelines > Facility Requirements Access Standards > Access Standards*

You will be notified by ASH if these standards are updated or revised.

Unproven Procedures

In many states the use of dry needling has been determined by State Licensing Boards to fall within a physical therapist's scope of practice. The evidence for the effectiveness of dry needling remains inconclusive at this time. As determined by the ASH Clinical Quality Committees, dry needling is considered unproven. However, given that many states' scope of practice regulations allow for dry needling by licensed physical therapists, prior to using dry needling ASH requires the following:

- Patients should be informed in writing that the evidence for dry needling's effectiveness is inconclusive, and that the service is unproven, rendering it not a covered service.
- All procedures, including unproven procedures, need to be documented in the patients' medical record along with documentation of the discussion about the unproven nature of the procedure.

Important note: Prior to using unproven procedures (such as dry needling), providers should confirm that their professional liability insurance covers the use of unproven procedures in the event of an adverse outcome.

Providers should practice only in the areas in which they are competent, based on their education, training, and experience. Levels of education, experience, and proficiency may vary among individual providers. It is ethically and legally incumbent on a provider to determine where they have the knowledge and skills necessary to perform such services, and whether the services are within their scope of practice and covered by their malpractice carrier.

MNR Transitions into the New Year

Many ASH Clients are eligible under the Clinical Performance System (CPS), while other clients offer a health plan specific waiver. Transitioning into a new year while in an approved course of care in either scenario can be confusing. So, what does this mean to you for your existing MNR treatment plans?

Members Eligible under the ASH CPS

The CPS allows a certain number of visits per patient to be rendered without medical necessity review (MNR) each CPS cycle. In some cases, the approved course of care may transition from one year into the next. In these cases, the CPS visits will begin after the existing, approved course of care has been exhausted. The existing, approved course of care would be considered exhausted if the number of approved visits has been rendered or it is past the ending date of the approved course of care. Remember, the CPS is per patient, per CPS cycle; it is not per patient, per condition. Additionally, CPS visits must be billed to ASH before an MNR is submitted. Otherwise, the CPS will be voided.

For example:
Services were approved from December 11, 2022 through January 11, 2023 for 4 visits.

- The contracted provider will be eligible to use their 2023 CPS visits after January 1, 2023, and after the completion of either the 4 previously approved visits or after January 11, 2023, whichever comes first.

Members Eligible Under a Health Plan Specific Waiver

Members under a health plan specific waiver follow different criteria when transitioning into a new year. When an approved course of care transitions from one CPS cycle into another, for example December 2022 to January 2023, any approved visits and/or time frame approved beyond December 31st will not carry over into the new year. The health plan specific waiver begins again on January 1st.

For example:
Services were approved for December 11, 2022 through January 11, 2023 for 4 visits. Contracted provider only used 2 visits before December 31, 2022.

- The contracted provider must use the new health plan specific waiver for visits on or after January 1, 2023. If the contracted provider chooses to use any of the 4 approved visits on or after January 1, 2023, the waiver visits will be waived and submission of an MNR form will need to be used going forward.

Please note that there are some California Providers who are on a July to June CPS cycle. This transition only affects providers on a January to December CPS cycle. If you are NOT on a January to December CPS cycle, this transition does NOT affect you.

You may verify your CPS cycle on the ASHLink® website, ASH's secure provider portal, under the Search tab. After you have searched for and selected a patient, the Eligibility Display screen will appear. Scroll down to the Client Summary Information section and select *Clinical Performance System (CPS)*. Your reset date will appear in the information that is displayed. For more information regarding the CPS, please refer to your operations manual.