

MEDICAL NECESSITY REVIEW FORM

For New Conditions or Continuing Care for
Acupuncture and Oriental Medicine

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATOR
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Patient Name _____ Gender: ☐ M ☐ F Birthdate _____ Patient ID# _____
Last First Initial (mm/dd/yyyy)
Subscriber Name _____ Subscriber ID# _____ Is This? ☐ Work Related
☐ Primary ☐ Auto Related
Health Plan _____ Secondary Employer _____ Group # _____
PCP Name _____ Phone # (_____) _____

Clinic Name _____
Treating Practitioner _____
Address _____
City/State/Zip _____
Phone (_____) _____ Fax (_____) _____

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address _____
City/State/Zip _____
Phone (_____) _____

CONDITION	AND	ICD CODE	Services Under The Clinical Performance System (CPS)
1. _____	_____	_____	1 st Office Visit date (mm/dd/yyyy) under CPS _____
2. _____	_____	_____	Last Office Visit date rendered under CPS _____
3. _____	_____	_____	Total number of Visits rendered under CPS _____
4. _____	_____	_____	

Eastern Diagnosis

TREATMENT PLAN/SERVICES SUBMITTING FOR REVIEW

Evaluation & Management ☐ New Pt Exam ☐ Est Pt Exam Date of Exam Findings for Chief Complaints Listed Below (required) ____/____/____
Date: From ____/____/____ Through ____/____/____ Total # Office Visits/Acupuncture ____ Total # of Therapies for Requested Dates* ____
New Jersey Only – Acu CPT units requested per date of service ____; **New Jersey Only** -Therapy units requested per date of service ____
☐ Hot/Cold Packs (97010) ☐ Infrared (97026) ☐ Massage (97124) ☐ Therapeutic Exercise (97110) ☐ Ultrasound (97035)
☐ Other [Do not enter acupuncture CPT codes (97810-97814) as they are part of OV/Acu above] _____
Other Special Services / Lab / X-ray: List CPT code(s) _____

*Therapies may not be reimbursed if those services exceed the daily maximum allowable reimbursement. Please check applicable client summary for details.

EXAM FINDINGS FOR DATE of EXAM LISTED ABOVE

CHIEF COMPLAINT(S)	1	2	3
Location	_____	_____	_____
Date of onset:	_____	_____	_____
Pain Level (0-10)	_____	_____	_____
Frequency (% of time)	_____ % of time present	_____ % of time present	_____ % of time present
Cause of Condition/Injury	_____	_____	_____
How long does relief last?	_____	_____	_____
Observation (gait, swelling, color, shen, vitality, etc.)	_____	_____	_____
Tenderness to palpation (0-4)	_____	_____	_____
Range of Motion (% limited)	_____	_____	_____

Response to most recent Treatment Plan: _____

Treatment Goals: _____

How will you measure progress toward these goals? _____

FUNCTIONAL OUTCOMES - Baseline and Changes

List the activities (sleep, work, recreation) you are monitoring for progress and any measurable results

Activity	Measurements (how much, how long, how far)	How has it changed?
_____	_____	_____
_____	_____	_____

*List Functional Outcome Tool Name, Body Area or Condition, Date and Score

Functional Tool Name	Body Area/Condition	Date	Score
_____	_____	_____	_____
_____	_____	_____	_____

Functional Outcome Tools that are either public domain or the copyright owner has made allowance for their general use are available through your ASHLink account login at www.ashlink.com on the Resources>Forms page

Changes in Pain Medication Use (e.g. name, frequency, amount, dosage) _____
Being Cared for By a Medical Physician? ☐ No ☐ Yes; For What Condition(s)? _____
If patient is under 3 years old, do you have a written referral for acupuncture on file from their medical physician for this condition? ☐ No ☐ Yes
If patient is between 3 and 11 years old, is their medical physician aware that they are receiving acupuncture for this condition? ☐ No ☐ Yes
(Required) Is this patient pregnant? ☐ No ☐ Yes; If Yes, # of weeks _____ Does patient have a medical practitioner for their pregnancy care? ☐ No ☐ Yes
Other Comments (e.g. Responses to Care, Barriers to Progress, Patient Health History) _____
Vital Signs: Height _____ Weight _____ Blood Pressure _____/_____/_____ Temp _____ BMI _____ Tobacco Use ☐ Yes ☐ No
Tongue Signs _____ **Pulse Signs** Rt _____ Lt _____
Signature of Treating Practitioner _____ **Date** _____

PLEASE SUBMIT THIS FORM WITH INITIAL HEALTH STATUS (Initial Care) OR PATIENT PROGRESS FORM (ONGOING CARE)

If billing for Medicare Required Coverage of Chronic Lower Back Pain: ☐ I hereby attest this member meets the requirements for Chronic Low Back Pain as outlined by CMS Benefit Decision Memo (CAG 00452N).