

Alternative Care

Consideration for practitioners' participation with Asuris Northwest Health is based on geographic area and members' access to healthcare.

Asuris contracts with the following alternative care practitioners:

- Acupuncturists/East Asian Medicine Practitioners
- Chiropractic physicians
- Naturopathic physicians
- Nutritionists/dieticians
- Licensed Massage therapists

The following sections contain guidelines specific to each alternative care practitioner specialty. If you have any questions concerning your agreement, please call our provider network management department at **1-800-562-2156**.

For state programs the guidelines vary, please see their respective sections within this manual, or contact provider customer service at **1-888-344-5587** to verify eligibility and benefits.

Acupuncture Services

Billing Guidelines for Acupuncture

All claims must include both the diagnosis (ICD-9) and procedure codes (CPT®) in order to ensure accurate processing. The diagnosis must match the diagnosis of the referring physician.

When billing for acupuncture services, please use:

- 97810 Acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal one on one contact with patient.
- 97811 Acupuncture, one or more needles; without electrical stimulation, each additional 15 minutes of personal one on one contact with the patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)
- 97813 Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one on one contact with patient.
- 97814 Acupuncture, one or more needles; with electrical stimulation, each additional 15 minutes of personal one on one contact with patient, with reinsertion of needle(s) (List separately in addition to code for primary procedure)

Codes 97810 and 97813 will not be allowed when billed together for the same visit.

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Only one unit of service for 97810 and 97813 is allowed per date of service up to the benefit maximum. Procedures 97811 and 97814 must be explicitly denoted in the patient's medical record to be allowed.

Note: *Evaluation and management (E & M) codes cannot be used as a substitute for acupuncture treatments.*

Evaluation and Management Services

A new patient E&M service is eligible for reimbursement in addition to the acupuncture service.

Established patient evaluation and management codes may only be used if the member's condition requires separately identifiable services. These services must be above and beyond the pre-and post-services associated with acupuncture treatment. The appropriate modifier (-25) must be used to indicate a separate condition is being addressed. Medical records to support the additional E&M service may be requested and the provider shall make these records available to Asuris upon request.

Any other services apart from an E&M service provided on the same day by the same provider will be included in the allowance for the acupuncture treatment and will not be reimbursed separately.

Rehabilitation Modalities and Procedures

Rehabilitative medicine that is within the scope of license of a practitioner and provided independent of acupuncture services may be allowed in accordance with contract language and limitations specific to the member's rehabilitation benefit.

Note: *For a copy of our reimbursement policy, please contact your provider consultant at 1-800-562-2156.*

Treatment Plan

Treatment plans and progress notes may be requested for selected members. We reserve the right to review past records and claims submissions.

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Asuris requires fully documented treatment plans to include:

- I. Appropriate and legible chart note documentation
- II. Physician prescription or referral if applicable
- III. Progress reports and/or notes which document the following:
 - Diagnosis or diagnoses must support the level of care provided.
 - Medical necessity of the care provided must be demonstrated and may be subject to review.
 - Procedures performed must be within the scope of license as defined by either the Revised Code of Washington, Washington Administrative Code, or the governing Quality Assurance Commission.

If you have questions or need assistance, please call provider customer service at **1-888-344-5587**.

Acupuncture for the Treatment of Chemical Dependency

A participating acupuncturist/east asian medicine practitioner will be reimbursed for acupuncture services provided for chemical dependency treatment when the member's plan contains a benefit for both acupuncture services and chemical dependency treatment.

Acupuncture treatment for chemical dependency is covered:

- When the member's plan covers acupuncture.
- If required by the member's plan, a referral by the member's PCP or by the contracted behavioral health department organization has been filed with Asuris.
- Diagnosis supports chemical dependency benefits.
- When Smoking Cessation is covered under some plans.

Plan Exceptions

The guidelines in this section are subject to individual plan benefits and may not apply to every member.

If you have questions or need assistance, please call provider customer service at **1-888-344-5587**.

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Licensed Massage Practitioner Guidelines

For care to be covered under the member's benefit, a physician must diagnose a medical condition, which has resulted in functional loss, for which rehabilitation therapy is prescribed. The licensed massage practitioner will be reimbursed for services currently covered under the member's rehabilitation or neurodevelopmental benefits.

A managed care plan requires a referral for a covered medical condition, to the participating managed care licensed massage practitioner from the member's PCP. Preferred and Traditional plans follow the guidelines below and do not require a referral.

In addition to any prescription and/or required referral, coverage for the services of a licensed massage practitioner are also subject to applicable member contract limitations.

Most Asuris plans that reimburse for services performed by a licensed massage practitioner do so under the Outpatient Rehabilitation benefit. Therefore, these services are subject to the Outpatient Rehabilitation benefit contract requirements and limitations.

Billing Guidelines for Licensed Massage Practitioners

When billing for massage therapy services, please use the current appropriate CPT codes for services rendered.

- All licensed providers must bill for any and all services they perform under their own name. A licensed massage practitioner may not submit claims for services performed by another licensed provider.
- Osteopathic manipulation codes are only payable to MD's DO's, ARNP's, ND's. Chiropractic manipulation codes are only payable to chiropractors.
- CPT codes, such as evaluation and management codes, are not payable to physical, occupational, speech or licensed massage practitioners.
- Units of service must be included on the HCFA-1500 billing form.
- We accept a total of four units of modalities/procedures per date of service.
 - If no units are listed in the claim record, we will assume one unit of service was performed.

In rare circumstances, if the modalities performed are not described in CPT manual, use 97039 (enter description on claim form). Chart notes should specify the services that were provided.

Note: *Asuris does not reimburse Licensed Massage Practitioner's for E & M codes*

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Supplies

Supplies and materials are not separately reimbursed. Supplies provided by the licensed massage practitioner and used during the therapy session are not covered. These are considered part of the provider's operational overhead.

Services Not Covered

- Supplies
- Member transportation
- Application of hot and cold packs
- Treatment preparation
- Clean-up
- Record-keeping
- Report-writing costs
- Patient care conferences

Information Needed on a Claim

Please include the following information on the billing form when submitting claims:

- Diagnosis/ICD-9 obtained from the prescribing practitioner
- Date of condition's onset
- Name of the prescribing or the referring practitioner
- Description of body part requiring treatment (e.g., L. arm, R. knee)

Accidental Injury

Injury claims must include the following:

- Cause or source of injury
- Where the injury took place
- Whether the injury is related to an auto accident or employment
- Date of injury

For more information on billing for accidental injuries, see the *Filing Claims* section of this manual.

Maintenance Therapy

“Maintenance Therapy” means a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, any additional therapy provided is considered maintenance therapy.

Please note: Most Asuris plans exclude coverage for maintenance therapy.

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Treatment Plan

Treatment plans and progress notes may be requested for selected members. We reserve the right to review past records and claims submissions. This is to determine whether member contract criteria are met for coverage of physical therapy under the member's outpatient rehabilitation benefit.

Asuris requires fully documented treatment plans, to include:

- I. Appropriate and legible chart note documentation
- II. Physician prescription or referral if applicable
- III. Documentation of functional limitations and therapy goals.
- IV. Progress reports and/or notes which support the following:
 - Diagnosis or diagnoses must support the level of care provided.
 - Medical necessity of the care provided must be demonstrated and may be subject to review.
 - Member's progress towards meeting therapy goals.
 - Procedures performed must be within the scope of license as defined by either the Revised Code of Washington, Washington Administrative Code, or the governing Quality Assurance Commission.

If you have questions or need assistance, please call provider customer service at **1-888-344-5587**.

Prescriptions and Referrals

When a physician or other practitioner prescribes massage therapy, they must include the accident information on the prescription and, if applicable, the referral. The prescribing practitioner must also include a plan of treatment and the length of treatment. A new prescription must be on file when extending treatment beyond the dates on the original prescription.

When the treating licensed massage practitioner submits a claim, whether paper or electronic, it is not necessary to submit the member's prescription. We do require the prescription to be on file in your office.

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Electronic Claims

For electronic claims, include the following information on the claim comment line:

- Number of treatments prescribed
- Body part requiring treatment
- Duration of prescribed treatment

Plan Exceptions

The guidelines in this section are subject to individual plan benefits and may not apply to every member.

If you have questions or need assistance, please call provider customer service at **1-888-344-5587**.

Naturopathic Guidelines

Naturopaths as PCPs

PCPs have agreed to supervise, coordinate and provide initial and basic care to our managed care members, to initiate their referrals when medically necessary, and to maintain continuity of member care. Upon receipt of a referral, written acknowledgment of the referral will be issued to the member and the member's PCP.

Naturopaths as Specialists

Asuris plans may also cover naturopathic physician services as specialists.

Billing Guidelines for Naturopaths

Naturopathic PCPs and specialists should follow the billing procedures described in "Selections Guidelines" and "Practitioner Guidelines" found in their respective sections in this manual.

However, please be aware of the following additional guidelines:

- To receive coverage for medically necessary services of a naturopathic specialist, the member may need to obtain a referral from his or her PCP.
- Evaluation and management (E&M) codes are not allowed as a substitute for rehabilitation modality and procedure codes, or other medical procedure codes.
- Naturopathic physicians are included in the list of practitioners to whom female members may self-refer for covered women's health-care services.

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- All licensed providers must bill for any and all services they perform under their own name. A naturopath may not submit claims for services performed by another licensed provider.
- Osteopathic manipulation codes are only payable to MD's DO's, ARNP's, and ND's. Chiropractic manipulation codes are only payable to Chiropractors.
- Physical therapy modalities and procedures are subject to the member's outpatient rehabilitation benefit, including any limitations or exclusions. When billing for physical therapy modalities or procedures, the naturopath should follow the billing guidelines described in the "Therapy Guidelines" section of this manual.
- PCPs should contact Asuris Northwest Health for eligibility and benefits information before referring members to specialty care.
- Medications and supplies that are available over the counter (OTC) are not covered.
- Per your participating agreement, a preferred laboratory must perform all laboratory services.
 - A list of participating laboratories is available on our Web site at: www.asuris.com/provider/.

Note: *The member needs to sign a waiver acknowledging they will be responsible for any non-covered charges **prior** to services rendered at any non-participating laboratory, or for any non-covered laboratory services.*

Plan Exceptions

The guidelines in this section are subject to individual plan benefits and may not apply to every member.

If you have questions or need assistance, please call provider customer service at **1-888-344-5587**.

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Nutritionists and Dieticians

Billing Guidelines for Nutritionists and Dieticians

For care to be covered under the member's benefit, for Preferred and Traditional plans, a physician or other prescribing practitioner must diagnose a covered medical condition. The nutritionists or dietician must keep the prescription on file.

For managed care plans a participating managed care nutritionist requires a referral, with a covered medical diagnosis, from the member's PCP.

When billing for medical nutrition therapy please use the following:

- 97802 (*Medical nutrition therapy, initial assessment*)
- 97803 (*Medical nutrition therapy, re-assessment and intervention*)
- G0270 (*Medical nutrition therapy, re-assessment and subsequent interventions*)
- G0108 (*Diabetes outpatient self-management training services, individual, per 30 minutes*)

Bill using the most appropriate CPT code to describe your service(s). Evaluation and Management codes are not appropriate CPT codes and will not be allowed.

Services Not Covered

- 97804 (*Medical nutrition therapy, Group, each 30 minutes*)
- G0271 (*Medical nutrition therapy, Group reassessment*)

Services are subject to the member's contract benefit and limitations and may be subject to review. For example, if the services represent a weight loss program, depending on the member's contract, such services may be denied as non-covered obesity treatment.

With the exception of the guidelines stated above, any other services will be included in the allowance for medical nutrition therapy and will be denied as provider write off.

Plan Exceptions

The guidelines in this section are subject to individual plan benefits and may not apply to every member.

If you have questions or need assistance, please call provider customer service at **1-888-344-5587**.

Note: For a copy of our reimbursement policy, please contact your provider consultant at **1-800-562-2156**.

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Chiropractic Physician

Chiropractic care may include the following:

- Spinal manipulations (Chiropractic manipulative treatment (CMT), spinal)
- Extraplinal manipulation (CMT), extrapinal)
- Diagnostic Radiology services
- Evaluation and Management Services
- Rehabilitation modalities and procedures

The majority of our plans have no referral requirements for chiropractic care.

Not all plans cover all forms of chiropractic care:

- Some plans exclude all chiropractic care.
- Some plans only cover spinal manipulations (CMT, spinal) and do not cover evaluation and management services, diagnostic radiology services or rehabilitation modalities and procedures.

Most Asuris plans that reimburse for services performed by a chiropractor, do so under the Outpatient Rehabilitation benefit. Therefore, these services are subject to the Outpatient Rehabilitation benefit contract requirements and limitations.

Please verify eligibility and benefits with provider customer service at **1-888-344-5587**.

Billing Guidelines for Chiropractors

- All licensed providers must bill for any and all services they perform under their own name. A chiropractor may not submit claims for services performed by another licensed provider.
- Procedures performed must be within the scope of license as defined by either the Revised Code of Washington, Washington Administrative Code, or the governing Quality Assurance Commission.
- Evaluation and Management (E&M) and other CPT codes are not allowed as a substitute for spinal or extrapinal manipulation codes when spinal or extrapinal CMT is performed.
- E&M codes are not allowed as a substitute for rehabilitation modality and procedure CPT codes.
- All services performed during an encounter must be billed.

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Chiropractic Manipulative Treatment (CMT)

For spinal and extraspinal manipulations, use the following codes below:

- 98940 (*Chiropractic manipulative treatment; spinal, one to two regions*)
- 98941 (*Chiropractic manipulative treatment; spinal, three to four regions*)
- 98942 (*Chiropractic manipulative treatment; spinal, five regions*)
- 98943 (*Chiropractic extra-spinal manipulation*)

Asuris will allow one of the above spinal Chiropractic Manipulative Therapy (CMT) services and/or one extra-spinal CMT service per encounter. CMT codes include the pre-manipulation assessment and post treatment evaluation.

Note: *The level of manipulative treatment must support the diagnosis.*

Services Not Covered

- Pre-manipulation member assessments
- Associated post-service work
- Application of hot and cold packs
- Member transportation
- Treatment preparation
- Clean up
- Record keeping
- Report writing costs
- Patient care conferences

Diagnosis Code

The diagnosis must be as specific as possible and must be substantiated by the member's medical records. The diagnosis must relate to the condition and be in the primary diagnosis field. Diagnosis 839.00 (*other, multiple, and ill-defined dislocation*) does not provide sufficient information about the member's presenting condition.

Evaluation and Management Services

An initial office visit can be billed in addition to the chiropractic treatment when the member is seen for the first time. Use the appropriate E & M for an initial visit when submitting your claim.

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Established patient E&M CPT codes may only be used if the member's condition requires significant separately identifiable services. These services must be above and beyond the previously outlined pre-service and post-service work associated with the manipulation treatment. Medical records to support the additional E&M services may be requested.

- The appropriate modifier (-25) must be used if the member's condition requires a significant separately identifiable evaluation and management service.

Note: *E & M codes or any other CPT codes are not to be used as a substitute for manipulation codes.*

Information Needed on a Claim

When submitting claims, the chiropractor must include the following information on the billing form:

- Diagnosis
- Date of onset

Accidental Injury

Injury claims must include the following:

- Cause or source of injury
- Where the injury took place
- Whether the injury is related to an auto accident or employment
- Date of injury

For more information on billing for accidental injuries, see the *Filing Claims* section of this manual.

Supplies

Routine supplies and materials provided by the chiropractor and used during the therapy session are not covered. These are considered part of your operational overhead.

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Supplies sent home to be used outside the treatment session may be paid according to member plan benefits.

- Document the type of supply, quantity purchased and the cost of the supply
- Use a valid CPT/HCPCS code for supplies
- 99070 is not accepted by Asuris and will be denied.
- If there is no HCPCS code that adequately describes the supply, please use the appropriate unlisted HCPCS code(s) with a specific description of the supply included on the claim.

Diagnostic Radiology Services

Radiology films must be of sufficient diagnostic quality with a legible and permanently documented report. Radiographic findings (presence of subluxation or fracture, etc.) must be separately identified. All radiographic services must meet the WAC 246-808-565 radiographic standard.

Chiropractic Clinical Record

The chiropractic clinical record requires the specific documentation as follows:

1. **Member intake form** - includes the chief complaint or reason for the visit, including the description of the accident, injury or other cause.
2. **Exam forms** or notes for each exam performed for which an E & M code is billed. The record should support the level of the E & M code billed.
3. **Daily chart notes** must include any changes in the care or progress of the member:
 - The member's subjective response (or lack thereof) to care.
 - Objective findings (e.g., straight leg raises, functional abilities).
 - Type of care provided at each visit (e.g., Acitvator, flexion/distraction, diversified).
 - Assessment of the treatment plan and any changes in the plan.
4. **Treatment plan** includes *all* of the following:
 - Frequency and duration of care and the anticipated discharge date.
 - Short and long-term functional goals including instruction in home care exercises, strengthening and functional abilities (e.g., sitting, standing, walking).

Each identified problem must have a specific care plan. The chiropractor evaluates the effectiveness of the management care plan at each visit.

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Maintenance Therapy

“Maintenance Therapy” means a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition. Once the maximum therapeutic benefit has been achieved for a given condition, any additional therapy provided is considered maintenance therapy.

Please note: Most Asuris plans exclude coverage for maintenance therapy.

Treatment Plan for Rehabilitation Modalities and Procedures

Treatment plans and progress notes may be requested for selected members. We reserve the right to review past records and claims submissions to determine whether member contract criteria are met for coverage of outpatient rehabilitation.

Asuris requires fully documented treatment plans to include:

- I. Appropriate and legible chart note documentation
- II. Documentation of functional limitations and therapy goals.
- III. Progress reports and/or notes which support the following status of the member:
 - Diagnosis or diagnoses must support the level of care provided.
 - Medical necessity of the care provided must be demonstrated and may be subject to review.
 - Member’s progress toward meeting therapy goals.
 - Procedures performed must be within the scope of license as defined by either the Revised Code of Washington, Washington Administrative Code, or the governing Quality Assurance Commission.

Plan Exceptions

The guidelines in this section are subject to individual plan benefits and may not apply to every member.

If you have questions or need assistance, please call provider customer service at **1-888-344-5587**.

Monitoring Medical Records

Asuris has developed a tool for providers to assist them with monitoring medical records. You may find that tool on the next page in this section.

**Asuris Northwest Health
Chiropractic Practitioners
Medical Record Review Tool for Nurse Reviewers**

Practitioner Name: _____ Record # _____ of _____

Clinic Name: _____ Member's DOB: _____

Reviewer ID: _____ Date of review: _____ Age: ____ Sex: _____

Mailing
Address: _____

Physical Location Address:

Phone: _____ Fax: _____

Contact Name: _____

Review Criteria	Guideline	Yes	No	N/A	Comments
1. Legibility of record.	1. All entries are readable by a third party. Reviewer may make photocopies if necessary for review by a third party.				
2. All entries in the record are dated and have the author's name, initials or e-record identifier.	2. All initials are identified on a key located in the record or provided by the practitioner.				
3. Allergies are clearly identified within the record. There is evidence of screening when any medication or natural remedy is prescribed/recommended.	3. Allergy labels or inclusion in the medical history narrative is acceptable. When a medication or natural remedy is prescribed/recommended the record documents screening has occurred.				
4. Is the patient's previous history of medical conditions, injuries and or surgeries clearly documented prior to any treatment(s) or recommendations for treatment(s)?	4. This may be obtained by a self reported questionnaire completed by the patient or by an interview documented by the practitioner. Electronic medical records are acceptable if they can be printed or otherwise reproduced.			Never	
5. Is there a documented examination that describes the patient's presenting subjective complaints and corresponding objective findings?	5. This may be a narrative description, a list that is noted with positive and negative findings and may include electronic format.			Never	
6. Does the record include an assessment or appraisal of the patient's condition?	6. This assessment is clearly based upon the presenting subjective and objective findings.			Never	
7. Does the record include a plan of care?	7. The plan of care addresses the findings in the assessment of the patient's condition.			Never	

Review Criteria	Guideline	Yes	No	N/A	Comments
8. Does the record indicate changes, progress of the patient or the responses to care/treatment(s)?	8. This may be a narrative description, a list that is noted with positive and negative findings and may include electronic format.			Never	
9. Does the record document chiropractic diagnostic or analytical services ordered or performed?	9. This includes all x-ray, laboratory or other processes used to arrive at chiropractic treatment /services.				N/A only if not used.
10. When radiographic services are used in assessment and diagnosis are required standards at WAC 246-808-565 followed?	10. This includes: patient's name and age; doctor's name, facility name, and address; date of study; left or right marker; other markers as indicated; adequate collimation; gonad shielding, where applicable.				N/A only if not used. See full WAC for further details.
11.(a) Does the record include a section for correspondence, financial data, and billing? (b) Do the billing codes and records correspond to the documented treatment(s), care and services?	11(a) This section is clearly defined and easy to find. (b) Appropriate billing codes are used.	a) <hr/> b)	a) <hr/> b)	a) <hr/> b)	a) <hr/> b)
12. Does the record include documentation that the patient has been informed of all privacy rights under HIPAA legislation?	12. A standard signed release per HIPAA regulations is within the record.				
13. Does the record include basic demographic information	13. Includes: name, DOB, gender, marital status, employment status, employer, emergency contact.				
14. If referral(s) or other consultation is used in the care/treatment is a response in the record noted by the practitioner?	14. If referrals are used in the patient's care or management, a written response is included and the practitioner has noted by initialing or narrative comment.				
15. Are medical records and patient information kept in a confidential manner?	15. No records are left on public counters. All record storage areas are secure from public traffic flow and are locked at times the practice is closed.				
16. If the practitioner has employees, is there evidence they understand confidentiality requirements?	16. There is evidence the practitioner informs employees of confidentiality requirements at the time of hire and periodically during employment.				
17. Is written authorization obtained for the release of medical records?	17. Release of information forms are used to send out or to request additional records from another source.				
18. If records are stored off –site, a written agreement exists to ensure the security and management of the records.	18. The practitioner provides evidence of off-site security and management of records.				

Total: _____

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NOTE: Each criterion has a one (1) point value. Asuris Northwest Health minimum compliance for each contracted provider is 80%.

A “no” response requires a reviewer’s comment. This review tool was designed to be consistent with legislation at RCW 18.25, WAC 246-808 and with Asuris policies and standards for chiropractic record keeping and record documentation. Records may be referred to a Medical Director for further review, when the reviewer determines another opinion is indicated.

SCORING: TOTAL POINTS ACHIEVED: _____
OUT OF A POSSIBLE _____ POINTS = _____% COMPLIANCE.
UNMET CRITERIA: _____