American Specialty Health Plans of California, Inc.
Acupuncture Practitioner Services Agreement (California)
Attachment D: Client Summaries
Issued December 2023
Effective January 2024

Please see individual Client Summaries for details regarding the Fee Schedule Amounts, Payment Amounts, and other requirements allowed and required by each individual Client and/or ASH Plans.

In the event of an inconsistency between the Practitioner Services Agreement and/or any attachment thereto or the ASH Operations Manual, and this Attachment D (Client Summaries), the terms of the Client Summaries and Attachment I (State Specific Requirements) shall control the rights and duties of the Parties. In the event of an inconsistency between Attachment D (Client Summaries) and Attachment I (State Specific Requirements), the provisions of Attachment I shall control the rights and duties of the Parties.

The following ASH Plans Clients are currently eligible:

1) Aetna Health of California, Inc. (HMO & Medicare Advantage HMO & POS; Benefit Plan)
2) Aetna Health of California, Inc. CMS Required Chronic Low Back Pain (Medicare Advantage HMO & POS; Benefit Plan)
3) Anthem Blue Cross (HMO and Medi-Cal HMO; Benefit Plan)
4) Anthem Blue Cross (PPO; Benefit Plan)
5) Blue Shield of California (EPO, HMO & Medicare Advantage HMO & PPO; Benefit Plan)
   - Blue Shield 65 PLUS
6) Blue Shield of California (PPO; Benefit Plan)
7) Blue Shield of California CMS Required Chronic Low Back Pain (Medicare Advantage HMO & PPO; Benefit Plan)
8) Blue Shield of California Promise Health Plan (Medi-Cal; Benefit Plan)
9) Brand New Day (Medicare Advantage HMO; Benefit Plan)
10) Brand New Day CMS Required Chronic Low Back Pain (Medicare Advantage HMO; Benefit Plan)
11) CalViva Health (Medi-Cal HMO; Benefit Plan)
12) CCA Healthcare of California (Medicare Advantage HMO; Benefit Plan)
13) CCA Healthcare of California CMS Required Chronic Low Back Pain (Medicare Advantage HMO; Benefit Plan)
14) Central Health Plan (Medicare Advantage HMO; Benefit Plan)
15) Central Health Plan CMS Required Chronic Low Back Pain (Medicare Advantage HMO; Benefit Plan)
16) Health Net (EPO, HMO, & PPO; Benefit Plan)
17) Health Net (Medi-Cal HMO; Benefit Plan)
18) Humana (Medicare Advantage HMO; Benefit Plan)
19) Imperial Health Plan CMS Required Chronic Low Back Pain (Medicare Advantage HMO; Benefit Plan)
20) Inland Empire Health Plan (HMO; Benefit Plan)
21) Inland Empire Health Plan (Medi-Cal HMO; Benefit Plan)
22) Kaiser Permanente of Northern California (Medi-Cal HMO; Benefit Plan)
23) Kaiser Permanente of Northern & Southern California (HMO, POS, & Medicare Advantage HMO; Benefit Plan)
24) Kaiser Permanente of Southern California (Medi-Cal HMO; Benefit Plan)
25) LA Care Health Plan (HMO; Benefit Plan)
26) LA Care Health Plan (Medicare HMO; Benefit Plan)
27) LA Care Health Plan CMS Required Chronic Low Back Pain (Medicare HMO; Benefit Plan)
28) Providence Health Assurance (Medicare Advantage HMO; Benefit Plan)
29) Providence Health Assurance CMS Required Chronic Low Back Pain (Medicare Advantage HMO; Benefit Plan)
30) SCAN Health Plan (Medicare Advantage HMO; Benefit Plan)
31) SCAN Health Plan CMS Required Chronic Low Back Pain (Medicare HMO; Benefit Plan)
32) Scripps Health Plan (HMO; Benefit Plan)
33) Seaside Health Plan (HMO; Benefit Plan)
34) Sharp Health Plan (HMO, POS & PPO; Benefit Plan)
35) Sharp Health Plan CMS Required Chronic Low Back Pain (Medicare Advantage HMO; Benefit Plan)

The following ASH Plans Clients are currently eligible (Cont.):

36) Wellcare by Health Net (Medicare Advantage; Benefit Plan)
    - Wellcare
37) Wellcare by Health Net CMS Required Chronic Low Back Pain (Medicare Advantage HMO & PPO; Benefit Plan)
    - Wellcare

Attached to Attachment D are the Client Summaries listed above, plus applicable fee schedules.

ASH Plans may revise or modify any current or future Client Summaries, and/or add or delete any current or future Client Summaries set forth in this Attachment D pursuant to the procedures of Article 25.

Client Summaries and Fee Schedules
Table of Contents

Aetna Health of California, Inc.
(HMO & Medicare Advantage HMO & POS; Benefit Plan)

Effective 1/1/01
Revised 12/1/23

TYPE OF PLAN/EMPLOYER: Aetna Health of California, Inc. is a health plan offering and/or administering health benefits in California.

Medicare Advantage HMO & POS: Members can access care in the following California counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Marin, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, and Ventura.

TYPE OF ACCESS: The following access apply:

HMO: Direct access or medical referral. If direct access, members may self-refer to the Contracted Practitioner of their choice. If medical referral, members are required to obtain a referral from their Primary Care Physician or ASH Plans Contracted Chiropractor. A referral is valid for 12 months. If a referral is not obtained, the Contracted Practitioner must have the Member sign the "Member Plan Requirement Acknowledgment" form in order to bill the Member for services. ASH Plans will not reimburse Contracted Practitioners for services rendered without a referral. Referrals can be faxed to ASH at 877.795.2746 and can be viewed on ASHLink under the Referrals menu.

Medicare Advantage HMO & POS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Aetna identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Aetna Georgia, Louisiana, New Mexico, Oklahoma, Oregon, and Texas members: The submission of a "Medical Necessity Review Form" is not required.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Aetna Health of California, Inc
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO & POS; Benefit Plan)

Effective 1/1/21
Revised 12/1/23

TYPE OF PLAN/EMPLOYER: Aetna Health of California, Inc. (Aetna) is a health plan offering and/or administering CMS benefits in the following California counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Marin, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, and Ventura.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.

PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Aetna identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Aetna Alabama, Arkansas, Georgia, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas members: ASH Group evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **after the 12th visit or 90 days in a rolling 12-month benefit period**.

Aetna Oregon members: The submission of a "Medical Necessity Review Form" is not required.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

Aetna Oregon members: After the 12th visit or 90th day, CPT code modifier – KX **must** be billed to attest that services are medically necessary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Anthem Blue Cross
(HMO and Medi-Cal HMO; Benefit Plan)

Effective 10/1/16
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Anthem Blue Cross is a health plan offering and/or administering health benefits to California region members in the following Arizona counties: La Paz and Yuma; the state of California; and the following Oregon counties: Jackson, Klamath and Lake.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

Medi-Cal: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.

CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner may have a later effective date with Client than the effective date with ASH Plans. It is recommended that Contracted Practitioner confirm eligibility as an in-network practitioner to be eligible for reimbursement.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the following exceptions: Contracted Practitioner may elect to not participate in all Workers' Compensation Client Summaries offered by this Client and Contracted Practitioner must be enrolled with Medi-Cal through the DMHC or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule V2" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule V2" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Anthem Blue Cross identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Medi-Cal: ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services beyond the first two visits per month, except services included under the Clinical Performance System.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

OTHER: Sign up for Anthem's Network eUPDATE at https://messageinsite.com/networkeupdate to receive the most up-to-date practitioner communications. Network eUPDATE provides the latest information on products and programs, medical and reimbursement, provider manual updates, newsletters and seminar invitations.

Anthem Blue Cross
(PPO; Benefit Plan)
Effective 10/1/23

TYPE OF PLAN/EMPLOYER: Anthem Blue Cross is a health plan offering and/or administering health benefits to California region members in the following Arizona counties: La Paz and Yuma; the state of California; and the following Oregon counties: Jackson, Klamath and Lake.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
CLIENT PARTICIPATION REQUIREMENTS: Contracted Practitioner may have a later effective date with Client than the effective date with ASH Plans. It is recommended that Contracted Practitioner confirm eligibility as an in-network practitioner to be eligible for reimbursement.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that Contracted Practitioner may elect to not participate in all Workers' Compensation Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule E10" attached, up to a maximum daily reimbursement of $46.74 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule E10" attached, up to a maximum daily reimbursement of $46.74 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Anthem Blue Cross identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

OTHER: Sign up for Anthem's Network eUPDATE at https://messageinsite.com/networkeupdate to receive the most up-to-date practitioner communications. Network eUPDATE provides the latest information on products and programs, medical and reimbursement, provider manual updates, newsletters and seminar invitations.

Blue Shield of California
Blue Shield 65 PLUS
(EPO, HMO & Medicare Advantage HMO & PPO; Benefit Plan)

Effective 7/1/01
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Blue Shield of California is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.
FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule O3" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O3" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O3" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Laboratory Services.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Blue Shield of California identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Certain employer groups do not require the routine submission of "MNR Forms". Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Blue Shield of California
(PPO; Benefit Plan)

Effective 1/1/20
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Blue Shield of California is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule N3" attached, up to a maximum daily reimbursement of $48.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including examination, acupuncture or electro-acupuncture, acupressure, adjunctive therapies, special services, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule N3" attached, up to a maximum daily reimbursement of $48.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including examination, acupuncture or electro-acupuncture, acupressure, adjunctive therapies, special services, and/or counseling services.

Adjunctive Therapy: According to the "Services Fee Schedule N3" attached, up to a maximum daily reimbursement of $48.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including examination, acupuncture or electro-acupuncture, acupressure, adjunctive therapies, special services, and/or counseling services.

Special Services: According to the "Services Fee Schedule N3" attached, up to a maximum daily reimbursement of $48.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including examination, acupuncture or electro-acupuncture, acupressure, adjunctive therapies, special services, and/or counseling services.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Laboratory Services.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Blue Shield of California identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Certain employer groups do not require the routine submission of "MNR Forms". Submit "MNR Forms" to ASH Plans. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Blue Shield of California
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO & PPO; Benefit Plan)

Effective 1/1/21
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Blue Shield of California is a health plan offering and/or administering CMS benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.
PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Blue Shield of California identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **after the 12th visit or 90 days in a rolling 12-month benefit period**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Blue Shield of California Promise Health Plan
(Medi-Cal; Benefit Plan)

Effective 1/1/17
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Blue Shield of California Promise Health Plan is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: Not a Covered Service.
Acupuncture/Office Visit: Covered and reimbursed according to the "Services Fee Schedule G2" attached.
Adjunctive Therapy: Not a Covered Service.
X-Rays: Not a Covered Service.
Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.
Laboratory Services: Not a Covered Service.
Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.
Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Blue Shield of California Promise Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: The submission of a "Medical Necessity Review Form" is not required.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner may be financially responsible for Emergent/Urgent Services rendered if requested documentation is not submitted upon request by Client or ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after Emergent/Urgent Services have been rendered.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Brand New Day
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/16
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Brand New Day is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Brand New Day identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Brand New Day
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO; Benefit Plan)

Effective 9/1/20
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Brand New Day is a health plan offering and/or administering CMS benefits in California.
TYPE OF ACCESS: Direct access, Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.
PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Brand New Day identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

CalViva Health
(Medi-Cal HMO; Benefit Plan)

Effective 1/1/17
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: CalViva is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Reimbursed according to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: Reimbursed according to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: Reimbursed according to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a CalViva identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: ASH Plans allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services beyond the first two visits per month, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

CCA Healthcare of California
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/23
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Commonwealth Care Alliance Healthcare of California (CCA Health) is a health plan offering and/or administering health benefits in the following California counties: Santa Clara and San Joaquin.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Commonwealth Care Alliance Healthcare of California (CCA Health) identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

CCA Healthcare of California
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/23

Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Commonwealth Care Alliance Healthcare of California (CCA Health) is a health plan offering and/or administering CMS benefits in California.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.

PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Commonwealth Care Alliance Healthcare of California (CCA Health) identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Central Health Plan
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/23
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Central Health Plan is a health plan offering and/or administering health benefits in the following California counties: Alameda, Contra Costa, Los Angeles, Orange, Riverside, San Bernadino, San Joaquin, San Mateo, Santa Clara, and Ventura.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Central Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Central Health Plan
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/23
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Central Health Plan is a health plan offering and/or administering CMS benefits in the following California counties: Alameda, Contra Costa, Los Angeles, Orange, Riverside, San Bernadino, San Joaquin, San Mateo, Santa Clara, and Ventura.
TYPE OF ACCESS: Direct access, Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.
PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Central Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Health Net
(EPO, HMO, & PPO; Benefit Plan)

Effective 1/1/98
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Health Net is a health plan offering and/or administering health benefits in California.
PLACE OF SERVICE: Client offers in-office and telehealth services. Telehealth services must be appropriate for delivery via telehealth platform for synchronous or asynchronous care delivery.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Health Net identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Health Net
(Medi-Cal HMO; Benefit Plan)

Effective 1/1/17
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Health Net is a health plan offering and/or administering health benefits in California.
PLACE OF SERVICE: Client offers in-office and telehealth services. Telehealth services must be appropriate for delivery via telehealth platform for synchronous or asynchronous care delivery.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Reimbursed according to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: Reimbursed according to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: Reimbursed according to the "Services Fee Schedule L9" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Health Net identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: ASH Plans allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services beyond the first two visits per month, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Humana
(Medicare Advantage HMO; Benefit Plan)
Effective 1/1/15
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Humana is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: Reimbursed according to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Humana identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Imperial Health Plan
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/23
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Imperial Health Plan (Imperial) is a health plan offering and/or administering CMS benefits in the following California counties: Alameda, Amador, Butte, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Tehama, Tulare, Tuolumne, Ventura, Yolo, and Yuba.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.

PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Imperial Health Plan of California identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Inland Empire Health Plan
(HMO; Benefit Plan)
Effective 1/1/24

TYPE OF PLAN/EMPLOYER: Inland Empire Health Plan is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Inland Empire Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

* Subject to executed health plan agreement and applicable regulatory approval prior to the effective date.

Inland Empire Health Plan
(Medi-Cal HMO; Benefit Plan)

Effective 8/1/16
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Inland Empire Health Plan is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: Not a Covered Service.
Acupuncture/Office Visit: Covered and reimbursed according to the "Services Fee Schedule G2" attached.
Adjunctive Therapy: Not a Covered Service.
X-Rays: Not a Covered Service.
Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.
Laboratory Services: Not a Covered Service.
Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.
Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an Inland Empire Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: ASH Plans allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services beyond the first two visits per month, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Kaiser Permanente of Northern California
(Medi-Cal HMO; Benefit Plan)

Effective 1/1/18
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Kaiser Permanente of Northern California (Kaiser) is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: Not a Covered Service.
Acupuncture/Office Visit: Covered and reimbursed according to the "Services Fee Schedule G2" attached.
Adjunctive Therapy: Not a Covered Service.
X-Rays: Not a Covered Service.
Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.
Laboratory Services: Not a Covered Service.
Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.
Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Kaiser Permanente identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: The submission of a "Medical Necessity Review Form" is not required for the first two visits per month managed by ASH Plans. ASH Plans manages the first two visits per month. If more than two visits in any given month are needed, the member will need to contact Kaiser Permanente to be considered for additional visits through Kaiser Permanente's prior authorization process. Contracted Practitioner would then submit those extra monthly claims directly to Kaiser Permanente for processing. If ASH Plans receives any claims for visits beyond two visits in any given month, those claims will be denied as misdirected.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner may be financially responsible for Emergent/Urgent Services rendered if requested documentation is not submitted to Client for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit the first two claims per month to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. Any additional visits beyond two visits per month are managed directly by Kaiser Permanente. Extra monthly claims for prior authorized services should be sent directly to Kaiser Permanente for processing. If ASH Plans receives any claims for visits beyond two visits in any given month, those claims will be denied as misdirected.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Kaiser Permanente of Northern & Southern California
(HMO, POS & Medicare Advantage HMO; Benefit Plan)

Effective 8/1/05
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Kaiser Permanente of Southern California (Kaiser) is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Medical referral. This member's plan requires a referral from their Primary Care Physician or Medical Physician. A referral is valid for 12 months. If a referral is not obtained, the contracted practitioner must have the member sign the "Member Plan Requirement Acknowledgment" form in order to bill the member for services. ASH will not reimburse contracted practitioner for services rendered without a referral. Referrals can be faxed to ASH at 877.795.2746 and can be viewed on ASHLink under the Referrals menu.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

Pain Management Program Members: Covered Conditions are limited to the treatment of neuromusculoskeletal disorders, nausea (such as nausea related to chemotherapy, post surgery pain, or pregnancy), or pain (such as lower back pain, shoulder pain, joint pain, or headaches). Refer to ASHLink for a list of Covered Conditions (Resources > Practitioner Education Library > Clinical Topics > Payable ICD-10 Codes – In Network: American Specialty Health Pain Management Referral-Required Programs for Acupuncture).

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Reimbursed according to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: Reimbursed according to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Laboratory Services.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Kaiser Permanente identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the Member's fifth (5th) visit under the issued medical referral. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Kaiser Permanente of Southern California
(Medi-Cal HMO; Benefit Plan)

Effective 1/1/18
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Kaiser Permanente of Southern California is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: Not a Covered Service.
Acupuncture/Office Visit: Covered and reimbursed according to the "Services Fee Schedule G2" attached.
Adjunctive Therapy: Not a Covered Service.
X-Rays: Not a Covered Service.
Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.
Laboratory Services: Not a Covered Service.
Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.
Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Kaiser Permanente identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: ASH Plans allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services beyond the first two visits per month, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: ASH Plans Clinical Performance System does not apply.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

LA Care Health Plan
(HMO; Benefit Plan)

Effective 1/1/14
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: LA Care Health Plan is a health plan offering and/or administering health benefits California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a LA Care Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

LA Care Health Plan
(Medicare HMO; Benefit Plan)

Effective 1/1/17
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: LA Care Health Plan is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered conditions for Medi-Cal are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client with the exception that a Contracted Practitioner must be enrolled with Medi-Cal through the DMHO or through ASH, as the MCO, to be eligible for reimbursement for services rendered to ASH Plans Members under a Medi-Cal plan. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to the updated CPT and HCPCS codes published by the AMA. If the Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: Not a Covered Service.
Acupuncture/Office Visit: Covered and reimbursed according to the "Services Fee Schedule G2" attached.
Adjunctive Therapy: Not a Covered Service.
X-Rays: Not a Covered Service.
Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.
Laboratory Services: Not a Covered Service.
Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.
Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.
Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an LA Care Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

OTHER - MEMBER CO-PAYMENT: If a member has dual coverage, the contracted practitioner may only charge one copayment from the member's primary plan of coverage.

LA Care Health Plan
CMS Required Chronic Low Back Pain
(Medicare HMO; Benefit Plan)

Effective 1/1/21
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: LA Care Health Plan is a health plan offering and/or administering CMS benefits in the following California county: Los Angeles.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to CMS required chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.

PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client Summary, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: Not a Covered Service.

Acupuncture/Office Visit: According to the "Services Fee Schedule N5" attached.

Adjunctive Therapy: Not a Covered Service.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present an LA Care Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Providence Health Assurance
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/23
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Providence Health Assurance is a health plan offering and/or administering health benefits in the following California counties: Los Angeles and Orange**.**

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Providence Health Assurance identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Providence Health Assurance
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/23
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Providence Health Assurance is a health plan offering and/or administering CMS benefits in the following California counties: Los Angeles and Orange.

TYPE OF ACCESS: Direct access, Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.

PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Providence Health Assurance identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

SCAN Health Plan
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/19
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: SCAN Health Plan is a health plan offering and/or administering health benefits in California.

SCAN MMP Members: Members have access in the following California counties: Los Angeles, Riverside, and San Bernardino.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a SCAN Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Certain employer groups may not require the routine submission of "MNR Forms". Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

SCAN Health Plan
CMS Required Chronic Low Back Pain
(Medicare HMO; Benefit Plan)

Effective 1/1/23

Revised 10/1/23

TYPE OF PLAN/EMPLOYER: SCAN Health Plan (SCAN) is a health plan offering and/or administering CMS benefits in the following California counties: Los Angeles, Orange, and San Bernardino.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.

PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule Y4" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule Y4" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a SCAN identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Scripps Health Plan
(HMO; Benefit Plan)

Effective 1/1/17
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Scripps Health Plan is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Scripps Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Seaside Health Plan
(HMO; Benefit Plan)

Effective 1/1/15
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Seaside Health Plan is a health plan offering and/or administering health benefits in California.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule O1" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule O1" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Seaside Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Sharp Health Plan
(HMO, POS, & PPO; Benefit Plan)

Effective 1/1/00
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Sharp Health Plan is a health plan offering and/or administering health benefits to California members as follows:

HMO: Members can access care in California.

POS & PPO: Members can access care nationwide.

PLACE OF SERVICE: Client offers in-office and telehealth services. Telehealth services must be appropriate for delivery via telehealth platform for synchronous or asynchronous care delivery.

TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.

COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.

ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.

STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.

Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule L9" attached.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Sharp Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Sharp Health Plan
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO; Benefit Plan)

Effective 1/1/21
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Sharp Health Plan is a health plan offering and/or administering CMS benefits in California.
PLACE OF SERVICE: Client offers in-office and telehealth services. Telehealth services must be appropriate for delivery via telehealth platform for synchronous or asynchronous care delivery.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.
PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule M9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule M9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule M9" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Sharp Health Plan identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Wellcare by Health Net
Wellcare
(Medicare Advantage; Benefit Plan)

Effective 1/1/98
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Wellcare by Health Net and Wellcare is a health plan offering and/or administering health benefits in California.
PLACE OF SERVICE: Client offers in-office and telehealth services. Telehealth services must be appropriate for delivery via telehealth platform for synchronous or asynchronous care delivery.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to Musculoskeletal Pain Syndromes and Nausea as defined in the "Covered Conditions" section of the Practitioner Operations Manual. For the list of currently covered and payable diagnosis codes, go to ASHLink.com and access the Resources tab > Practitioner Education Library > Clinical Topics page.
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New Established Patient Evaluation & Management: According to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule L9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under the all-inclusive maximum reimbursable amount for the Acupuncture/Office Visit.

X-Rays: Not a Covered Service.

Diagnostic Imaging (MRI, CAT Scans): Not a Covered Service. Refer Member to Member's Physician for medical evaluation for determination of necessity for Diagnostic Imaging.

Laboratory Services: Contracted Practitioner may only refer Member for Laboratory Services in accordance with the "Referral to Ancillary Practitioner" provision of the Acupuncture Practitioner Services Agreement. Contact ASH Plans at 800.972.4226 to obtain referral information including the name of an approved Contracted ancillary laboratory practitioner.

Non-Covered Services: Therapeutic Massage and Tui Na are Non-Covered Services when performed as a stand-alone service. These services are only covered when covered on the fee schedule, are determined to be medically necessary, and are adjunct to an acupuncture needling session. The Contracted Practitioner may bill the Member for these Non-Covered Services by notifying the Member in advance and in writing, using the "Member Billing Acknowledgment" form of their responsibility to self-pay for Non-Covered Services.

Traditional Chinese Herbal Supplement Benefits: Not a Covered Benefit. Contracted Practitioner may bill Member directly for Herbal Consultations and/or Traditional Chinese Herbal Supplements at usual and customary charges by having the Member sign the "Member Billing Acknowledgment" form prior to the delivery of these herbal consultations and/or supplements.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Wellcare by Health Net/Wellcare identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services, except services included under the Clinical Performance System. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, Emergent/Urgent Services, quality improvement and appeals and grievances within or outside the Clinical Performance System.

EMERGENT/URGENT SERVICES: Provide Emergent/Urgent Services as defined in the Practitioner Services Agreement. The Contracted Practitioner must submit an "MNR Form" to ASH Plans for evaluation that Emergent/Urgent Services are Medically Necessary Services after the Emergent/Urgent Services have been rendered unless the services fall under the Clinical Performance System. The Contracted Practitioner will be financially responsible for Emergent/Urgent Services rendered if an "MNR Form" is not submitted in accordance with submission guidelines and timeframes.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Appeals and Grievances should be received within one (1) year of the date-of-service. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Wellcare by Health Net
Wellcare
CMS Required Chronic Low Back Pain
(Medicare Advantage HMO & PPO; Benefit Plan)

Effective 6/1/20
Revised 10/1/23

TYPE OF PLAN/EMPLOYER: Wellcare by Health Net and Wellcare is a health plan offering and/or administering CMS benefits in California.
PLACE OF SERVICE: Client offers in-office and telehealth services. Telehealth services must be appropriate for delivery via telehealth platform for synchronous or asynchronous care delivery.
TYPE OF ACCESS: Direct access. Members may self-refer to the Contracted Practitioner of their choice.
COVERED CONDITIONS: Covered Conditions are limited to chronic low back pain as defined by CMS Benefit Decision Memo (CAG-00452N) and related National Coverage Determination 30.3.3 as defined in the "Covered Conditions" section of the Practitioner Operations Manual. The definition of Covered Condition for this Medicare required coverage of acupuncture for the management of chronic low back pain has limitations. The low back pain must be chronic (lasting longer than 12 weeks) and non-specific with no systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease). It must not be associated with surgery and or pregnancy. There must be no evidence or indication of infection, such as tuberculosis or osteomyelitis; no evidence of a kidney or pelvic infection; no evidence of bone cancer or other cancer; not related to chronic kidney or other chronic genitourinary pain; and no co-morbid conditions that would contraindicate acupuncture. The eligible ICD-10 code list is located on ASHLink under Resources > Provider Education Library > Clinical Topics > Payable ICD-10 Diagnosis Codes for CMS Required Chronic Low Back Pain.
PARTICIPATION REQUIREMENT: According to CMS guidelines, Contracted Practitioners must have graduated from a professional acupuncture school during a time when the school was accredited by the Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM).
ELECTION TO NOT PARTICIPATE: Contracted Practitioner may elect to not participate with this Client. If Contracted Practitioner chooses to not participate with this Client, Contracted Practitioner may only elect to not participate in all Client Summaries offered by this Client. Refer to Practitioner Services Agreement section 5.01 for specific election provisions.
STATE SPECIFIC, REGULATORY AND ASH PLANS REQUIREMENTS: Refer to Attachment I of the Agreement for any state specific requirements that may supersede the provisions of this Client Summary, including, but not limited to, Malpractice Limit requirements.

IN-NETWORK BENEFIT COVERAGE: Members are eligible for up to 12 medically necessary visits in the first 90 days. Medicare allows up to 8 additional visits after 90 days; however, Medicare requires a patient show clinically significant improvement for services beyond the 12 visits and after 90 days. Members are eligible for up to 20 medically necessary visits in a rolling 12-month benefit period beginning the 1st of the month in which care for chronic low back pain is sought.

FEE SCHEDULE AMOUNTS: Contracted Practitioner is financially responsible to bill usual and customary rates according to the CPT codes in the attached fee schedule and agrees to accept the Fee Schedule Amounts as payment in full less applicable member responsibility. Contracted Practitioner is responsible to bill according to updated CPT and HCPCS codes as published by the AMA. If Contracted Practitioner bills a procedure code greater than what was originally approved by ASH Plans, ASH Plans will reimburse based on the level of care approved. Contracted Practitioner is responsible for billing services according to the scope of licensure in their state. ASH Plans reimbursement is subject to coding rules adopted by the National Correct Coding Initiative edits as published on the Centers for Medicare & Medicaid Services website.
Reimbursement is limited to billed charges up to the maximum of the Fee Schedule Amounts attached.

New/Established Patient Evaluation & Management: According to the "Services Fee Schedule M9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, adjunctive therapies, and/or counseling services.

Acupuncture/Office Visit: According to the "Services Fee Schedule M9" attached, up to a maximum daily reimbursement of $41.00 per date of service. Represents an all-inclusive maximum reimbursable amount for all services and/or treatments rendered during the day of the Acupuncture/Office Visit including a brief re-examination, treatment such as acupuncture or electro-acupuncture, acupressure, and/or counseling services.

Adjunctive Therapy: Covered and reimbursed under an all-inclusive, maximum reimbursable amount for Acupuncture/Office Visit.

Special Services: According to the "Services Fee Schedule M9" attached.

Annual Benefit Maximums: Each Member visit with the Contracted Practitioner will count towards the Member's Annual Visit Maximum, regardless of whether acupuncture is rendered or not.

MEMBER ELIGIBILITY AND BENEFITS: Members will present a Wellcare by Health Net/Wellcare identification card. Contact ASH Plans to verify Member's Eligibility, Benefits and Member Payments. Refer to the "Verifying Eligibility During a Member's First Visit" section of the Practitioner Operations Manual for details.

CLINICAL SERVICES PROGRAM: Client allows Medically Necessary Services for Covered Conditions to be eligible for reimbursement as a Covered Service. ASH Plans evaluation and approval of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services **in a rolling 12-month benefit period, except services included under the Clinical Performance System**. Submit "MNR Forms" to ASH Plans. Refer to the "Verification of Medical Necessity" section of the Practitioner Operations Manual for details.

Chronic Low Back Pain Medical Attestation Form: At the first visit the Member is required to complete the Chronic Low Back Pain Medical Attestation form which must be retained in the patient's medical record file. You must then review this form with the patient, sign and attest that you have determined that the patient meets the criteria for coverage eligibility. Attestation form must include the name and contact information for the patient's medical provider. This form will remain in the Member's medical record and may be requested at any time in order to audit compliance with these requirements. See Attachment D-1 for the Acupuncture for Chronic Low Back Pain Medical Attestation form, it is also available on ASHLink under Resources > Forms.

CLINICAL PERFORMANCE SYSTEM: This plan is eligible under the Clinical Performance System as described in the "Clinical Performance System" section of your Practitioner Operations Manual. Medicare requires a patient show clinically significant improvement for services beyond 12 visits and after 90 days; therefore, the submission of a "Medical Necessity Review Form" is required for reimbursement of all Covered Services after the 12th visit or 90 days, regardless of your tier level. Contracted Practitioner must confirm with the Member if they have had previous services with another ASH Plans Contracted Practitioner. Contracted Practitioner will not be reimbursed under the Clinical Performance System if the total number of dates of services billed by any Contracted Practitioner exceeds 12 visits in the first 90 days. The Clinical Performance System under this program is on a rolling 12-month period beginning on the 1st of the month in which a new episode of care is provided to a Member. The Clinical Performance System does not reset upon the annual reset date.

RETROSPECTIVE MEDICAL RECORDS EVALUATION: Medical Records may be requested, upon written notification, by ASH Plans to support the evaluation of clinical services, quality improvement and appeals and grievances within or outside the Clinical Performance System. The Chronic Low Back Pain Medical Attestation Form may be requested at any time in order to audit compliance with the requirements of this program.

CONTINUITY OF CARE: In the event of Client's termination with ASH Plans, Contracted Practitioner is required to support Member's transition of care should Member elect a practitioner other than Contracted Practitioner.

INCENTIVE PAYMENT PROGRAM REQUIREMENTS: Incentive Payment Program requirements including incentive payments and/or administrative processing fees apply to this Client Summary.

BILLING REQUIREMENTS: In order to identify that you are submitting services for reimbursement under this Medicare required coverage for chronic low back pain you must use an eligible ICD-10 code. In addition, in order to specify that the low back pain is chronic, and as an attestation that you have collected a Medical Attestation Form that verifies the member meets the criteria for Covered Conditions described above, you must bill the applicable CPT codes for E/M and/or Acupuncture Office Visit found in the Acupuncture Services Fee Schedule and add the additional non-reimbursable CPT codes 1137F and 99080 for each date of service. CPT code 1137F is a CPT Category II code, a supplemental tracking code, related to the Patient History that specifically identifies the Low Back Pain as being chronic - greater than 12 weeks. CPT code 99080 is a CPT code that identifies that you have completed or are submitting a "special report more than the information conveyed in the usual medical communications or standard reporting". Under this Medicare required coverage benefit, ASH Plans requires you to use these codes to attest that you have collected a completed Medical Attestation Form including medical provider contact information that verifies that the member meets the coverage criteria. Payment for CPT codes 1137F and 99080 are for reporting purposes only and will not be separately reimbursed. You should list the fee for these codes as $0.00 on the CMS 1500 form.

CLAIMS SUBMISSIONS, INQUIRIES AND TRACERS: Submit claims to ASH Plans. You **must** use an eligible ICD-10 code in conjunction with CPT codes 1137F and 99080 when submitting claims for each date of service for Members under this benefit plan. Refer to the "Submitting Claims" section of the Practitioner Operations Manual for details. For this Client send claims through ASHLink or by mail to: Claims Administration, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002. When billing ASH Plans, the diagnosis code will indicate the treatment being rendered is for "Low back pain", CPT code 1137F defines the "Episode of back pain lasting longer than 12 weeks," and CPT code 99080 is an attestation that you have collected a Medical Attestation Form that verifies that the member meets the criteria for Covered Conditions. Contracted Practitioner will not be reimbursed if the total number of dates of services billed by any Contracted Practitioners exceeds 12 visits in the first 90 days.

APPEALS AND GRIEVANCES: Submit "Appeals and Grievances" to ASH Plans. Refer to the "Appeals" or "Grievances" section of the Practitioner Operations Manual for details.

Attachment D-1
Acupuncture for Chronic Low Back Pain Medical Attestation Form (Sample)

Go to ASHLink > Resources > Forms to download this form.

Acupuncture for Chronic Low Back Pain: Medical Attestation

Patient Name_____ Birthdate_____ Patient ID#_____
(mm/dd/yyyy)

Health Plan_____ Subscriber Name_____ Subscriber ID#_____

We understand that you would like acupuncture treatment for your low back pain. Medicare benefits do cover the cost of acupuncture for *some types* of low back pain. Please answer the questions below to see if your Medicare benefit will cover acupuncture for your low back pain.

1. Have you had low back pain for 12 weeks (3 months) or longer? ☐ Yes ☐ No

2. Thinking about your low back pain; have any health care providers told you that any of the following are currently causing your low back pain?

No	Yes	
☐	☐	Non-specific or general low back pain or sciatica
☐	☐	An infection in the bone such as tuberculosis or osteomyelitis
☐	☐	Cancer
☐	☐	A current pregnancy
☐	☐	Body inflammation from conditions like rheumatoid arthritis, psoriatic arthri…'s disease, ankylosing spondylitis, Ulcerative colitis
☐	☐	A condition in the kidney, ovaries, intestine, prostat…

3. Have you had:

No	Yes	
☐	☐	Surgery to yo…

4. What is the … *(This is the person who knows your medi… …or got worse.)*

Medica… _____ Phone (required)_____

Address_… _____

5. **I attest th… …e answers are accurate. I understand that my answers will help determine eligibility for coverage. The Acupuncture provider will also provide information to confirm coverage.**

Attested by_____ Date_____
signature of patient

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6. **As the Acupuncture provider for this Medicare Advantage member:**

☐ **I attest that the information above has been written and submitted by the patient and I have reviewed the answers with the patient and the answers:**

☐ **Meet Medicare eligibility requirements** ☐ **Do NOT meet Medicare eligibility requirements**

Attested by (signature of Licensed provider)_____ Date_____

Provider (TIN Owner) Name_____Facility/Clinic Name_____

Facility/Clinic Address_____

Acupuncture provider must retain this form in the patient medical record. This document may be requested by ASH or its clients to audit compliance with coverage policy.

AcuCMSAttestationForm032420.docx Page 1 of 1

Services Fee Schedule O1

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	O1
99202	New patient evaluation & management service	$41.00
99203	New patient evaluation & management service	$41.00
99204	New patient evaluation & management service	$41.00
99205	New patient evaluation & management service	$41.00
99211	Established patient evaluation & management service	$41.00
99212	Established patient evaluation & management service	$41.00
99213	Established patient evaluation & management service	$41.00
99214	Established patient evaluation & management service	$41.00
99215	Established patient evaluation & management service	$41.00

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	O1
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	O1
97010	Hot/cold packs	(1)
97014	Electrical stimulation (unattended)	(1)
97026	Infrared	(1)
97110	Therapeutic procedure, one or more areas; therapeutic exercises	(1)

SPECIAL SERVICES

CODE	DESCRIPTION	O1
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Services Fee Schedule G2

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	G2
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)

Services Fee Schedule V2

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	V2
99202	New patient evaluation & management service	$41.00
99203	New patient evaluation & management service	$41.00
99204	New patient evaluation & management service	$41.00
99211	Established patient evaluation & management service	$41.00
99212	Established patient evaluation & management service	$41.00
99213	Established patient evaluation & management service	$41.00
99214	Established patient evaluation & management service	$41.00

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	V2
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	V2
97010	Hot/cold packs	(1)
97014	Electrical stimulation (unattended)	(1)
97026	Infrared	(1)
97110	Therapeutic procedure, one or more areas; therapeutic exercises	(1)

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	N3
99202	New patient evaluation & management service	$33.00
99203	New patient evaluation & management service	$36.00
99204	New patient evaluation & management service	$40.00
99205	New patient evaluation & management service	$44.00
99211	Established patient evaluation & management service	$20.00
99212	Established patient evaluation & management service	$23.00
99213	Established patient evaluation & management service	$26.00
99214	Established patient evaluation & management service	$30.00
99215	Established patient evaluation & management service	$34.00
98966(7)	Telephone assessment and management service; established patient	$10.00
98967(7)	Telephone assessment and management service; established patient	$11.50
98968(7)	Telephone assessment and management service; established patient	$13.00
98970(7)	Qualified nonphysician health care professional online digital assessment and management	$10.00
98971(7)	Qualified nonphysician health care professional online digital assessment and management	$11.50
98972(7)	Qualified nonphysician health care professional online digital assessment and management	$13.00

Additional services may be covered. Please refer to ASHLink for the complete list of covered services.

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	N3
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	$7.00
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	$7.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	N3
97010	Hot/cold packs	$10.00
97014	Electrical stimulation (unattended)	$10.00
G0283	Electrical Stimulation (unattended)	$10.00
97018	Paraffin bath	$10.00
97026	Infrared	$10.00
97032	Electrical stimulation (manual)	$10.00
97035	Ultrasound	$10.00
97039	Unlisted modality	$10.00
97110	Therapeutic procedure, one or more areas; therapeutic exercises	$10.00
97124	Massage	$10.00
97139	Unlisted therapeutic procedure (specify)	$10.00
97140	Manual therapy techniques (i.e. Tui Na)	$10.00

Additional services may be covered. Please refer to ASHLink for the complete list of covered services.

SPECIAL SERVICES

CODE	DESCRIPTION	N3
98961	Education and training for patient self-management; each 30 minutes; 2-4 patients	$8.37
98962	Education and training for patient self-management; each 30 minutes; 5-8 patients	$6.12
99078	Physician or qualified health care professional educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instrucations)	$10.00
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	$35.00
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (list separately in addition to 99358)	$10.00
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Additional services may be covered. Please refer to ASHLink for the complete list of covered services.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	O3
99202	New patient evaluation & management service	$41.00
99203	New patient evaluation & management service	$41.00
99204	New patient evaluation & management service	$41.00
99205	New patient evaluation & management service	$41.00
99211	Established patient evaluation & management service	$41.00
99212	Established patient evaluation & management service	$41.00
99213	Established patient evaluation & management service	$41.00
99214	Established patient evaluation & management service	$41.00
99215	Established patient evaluation & management service	$41.00
98966(7)	Telephone assessment and management service; established patient	$10.00
98967(7)	Telephone assessment and management service; established patient	$11.50
98968(7)	Telephone assessment and management service; established patient	$13.00
98970(7)	Qualified nonphysician health care professional online digital assessment and management	$10.00
98971(7)	Qualified nonphysician health care professional online digital assessment and management	$11.50
98972(7)	Qualified nonphysician health care professional online digital assessment and management	$13.00

Additional services may be covered. Please refer to ASHLink for the complete list of covered services.

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	O3
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	O3
97010	Hot/cold packs	(1)
97014	Electrical stimulation (unattended)	(1)
G0283	Electrical Stimulation (unattended)	(1)
97018	Paraffin bath	(1)
97026	Infrared	(1)
97032	Electrical stimulation (manual)	(1)
97035	Ultrasound	(1)
97039	Unlisted modality	(1)
97110	Therapeutic procedure, one or more areas; therapeutic exercises	(1)
97124	Massage	(1)
97139	Unlisted theraputic procedure (specify)	(1)
97140	Manual therapy techniques (i.e. Tui Na)	(1)

Additional services may be covered. Please refer to ASHLink for the complete list of covered services.

SPECIAL SERVICES

CODE	DESCRIPTION	O3
98961	Education and training for patient self-management; each 30 minutes; 2-4 patients	$8.37
98962	Education and training for patient self-management;each 30 minutes; 5-8 patient	$6.12
99078	Physician or qualified health care professional educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	$10.00
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	$35.00
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (list separately in addition to 99358)	$10.00
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Additional services may be covered. Please refer to ASHLink for the complete list of covered services.

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	Y4
99202	New patient evaluation & management service	$41.00
99203	New patient evaluation & management service	$41.00
99204	New patient evaluation & management service	$41.00
99205	New patient evaluation & management service	$41.00
99211	Established patient evaluation & management service	$41.00
99212	Established patient evaluation & management service	$41.00
99213	Established patient evaluation & management service	$41.00
99214	Established patient evaluation & management service	$41.00
99215	Established patient evaluation & management service	$41.00

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	Y4
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	$41.00
20561	Needle insertion(s) without injection(s); 3 or more muscles	$41.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	Y4
97010	Hot/cold packs	(1)
97014	Electrical stimulation (unattended)	(1)
97026	Infrared	(1)
97110	Therapeutic procedure, one or more areas; therapeutic exercise	(1)

SPECIAL SERVICES

CODE	DESCRIPTION	Y4
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Services Fee Schedule N5

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	N5
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	$41.00
20561	Needle insertion(s) without injection(s); 3 or more muscles	$41.00

Services Fee Schedule L9

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	L9
99202(7)	New patient evaluation & management service	$41.00
99203	New patient evaluation & management service	$41.00
99204	New patient evaluation & management service	$41.00
99205	New patient evaluation & management service	$41.00
99211(7)	Established patient evaluation & management service	$41.00
99212(7)	Established patient evaluation & management service	$41.00
99213	Established patient evaluation & management service	$41.00
99214	Established patient evaluation & management service	$41.00
99215	Established patient evaluation & management service	$41.00
98966(7)	Telephone assessment and management service; established patient	$10.00
98967(7)	Telephone assessment and management service; established patient	$11.50
98968(7)	Telephone assessment and management service; established patient	$13.00
98970(7)	Qualified nonphysician health care professional online digital assessment and management	$10.00
98971(7)	Qualified nonphysician health care professional online digital assessment and management	$11.50
98972(7)	Qualified nonphysician health care professional online digital assessment and management	$13.00

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	L9
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	L9
97010	Hot/cold packs	(1)
97014	Electrical stimulation (unattended)	(1)
97026	Infrared	(1)
97110(7)	Therapeutic procedure, one or more areas; therapeutic exercises	(1)

SPECIAL SERVICES

CODE	DESCRIPTION	L9
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	M9
99202(7)	New patient evaluation & management service	$41.00
99203	New patient evaluation & management service	$41.00
99204	New patient evaluation & management service	$41.00
99205	New patient evaluation & management service	$41.00
99211(7)	Established patient evaluation & management service	$41.00
99212(7)	Established patient evaluation & management service	$41.00
99213	Established patient evaluation & management service	$41.00
99214	Established patient evaluation & management service	$41.00
99215	Established patient evaluation & management service	$41.00
98966(7)	Telephone assessment and management service; established patient	$10.00
98967(7)	Telephone assessment and management service; established patient	$11.50
98968(7)	Telephone assessment and management service; established patient	$13.00
98970(7)	Qualified nonphysician health care professional online digital assessment and management	$10.00
98971(7)	Qualified nonphysician health care professional online digital assessment and management	$11.50
98972(7)	Qualified nonphysician health care professional online digital assessment and management	$13.00

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	M9
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$41.00
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	$41.00
20561	Needle insertion(s) without injection(s); 3 or more muscles	$41.00

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	M9
97010	Hot/cold packs	(1)
97014	Electrical stimulation (unattended)	(1)
97026	Infrared	(1)
97110(7)	Therapeutic procedure, one or more areas; therapeutic exercise	(1)

SPECIAL SERVICES

CODE	DESCRIPTION	M9
99417	Prolonged office or other outpatient evaluation and management service(s), each 15 minutes	$10.00

Services Fee Schedule E10

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	E10
99202	New patient evaluation & management service	$46.74
99203	New patient evaluation & management service	$46.74
99204	New patient evaluation & management service	$46.74
99211	Established patient evaluation & management service	$46.74
99212	Established patient evaluation & management service	$46.74
99213	Established patient evaluation & management service	$46.74
99214	Established patient evaluation & management service	$46.74

ACUPUNCTURE/OFFICE VISIT

CODE	DESCRIPTION	E10
97810	Acupuncture, 1 or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$46.74
97811	Acupuncture, 1 or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)
97813	Acupuncture, 1 or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient.	$46.74
97814	Acupuncture, 1 or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with patient, with re-insertion of needle(s).	(1)

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	E10
97010	Hot/cold packs	(1)
97014	Electrical stimulation (unattended)	(1)
97026	Infrared	(1)
97110	Therapeutic procedure, one or more areas; therapeutic exercises	(1)

Fee Schedule Footnotes

(1) Reimbursed under the all-inclusive maximum reimbursable amount for Acupuncture/Office Visit (97810 or 97813).

(7) CPT code is eligible as a telehealth service for eligible health plan clients.