Acupuncture Services

Prior Authorization Level 3

ACUP-2022-PA3
December 2022

Controlled Unclassified Information

Submission Instructions: *Please refer to the Acupuncture Services Medical Coverage Determination (MCD) when completing this form. Please apply the following naming convention for labeling the PA3 Acupuncture request PDF:* ***PA3-Acupuncture [respective CCE/NPN]"****. Send the completed form to the WTC Health Program by posting it to the CARE Portal, or the SFTP server and then send a Personally Identifiable Information (PII)-free e-mail to WTCMedCode@csra.com, indicating the secure server posting of this request. Incomplete forms will be sent back for more information****. Please do not submit any other additional information or documents unless specifically requested by NIOSH.***

Request Information

Request Date	Request Type	Date of Last Provider Visit	Date of Last Authorization

Member and Provider/Requester Information

Member Information					
Last		First		MI	
Date of Birth		Member 911#			
Member Type					
Provider Information					
CCE/NPN					
Requesting Provider Name					
Requesting Provider Credentials					
Requesting Provider Email					
Requesting Provider Phone					
Requesting Provider Fax					

WTC-Related Conditions

Relevant WTC-Related and/or Medically Associated Certified Condition(s) and ICD Code(s)
Services for non-cancer certified WTC-related or associated conditions causing chronic pain will be limited to ATI or MSD.

ICD-10 Code	Condition
WTC Health Program Approved Indication(s) identified by the Acupuncture Medical Coverage Determination (MCD):	
A referral from the WTC-affiliated provider is included with the request form.	

Acupuncture-Related Service Request

A billable medical code is required

Procedure/CPT Code	Description	Estimated Fee

Treatment Plan

The PA3 for acupuncture services will only cover a 12-calendar-month authorization period. The authorization period starts the day the member begins receiving acupuncture and ends when the 12 calendar-month period is over unless a new PA3 for acupuncture service is prepared. The Program will cover acupuncture services up to 12 visits in 90 days, and 8 additional visits will be covered for those demonstrating improvement on a subsequent PA3, for a total of 20 visits per 12-month authorization period. However, even if a new PA3 is prepared, the Program will not cover more than 20 acupuncture visits for the condition per 12 calendar-month period.

Frequency	Duration

Acupuncture Services Rationale

By initialing to the right of <u>each</u>* of the statements below, the CCE/NPN Clinical Director attests that <u>all</u> of the following statements are applicable:	
The member has chronic pain that is a result of a certified WTC-related ATI or MSD condition, or chronic pain that is a result of a condition medically associated with a certified WTC-related ATI or MSD condition, and is receiving treatment for that condition from a WTC Health Program-affiliated provider	
The acupuncture services are provided while the member is under the care of a WTC Health Program-affiliated provider.	
Acupuncture is determined to be medically necessary and all of the following criteria are established: ☐ A referral from the treating provider is provided ☐ Medical records showing that there is a medical indication for treatment, and the modality selected is effective per the evidence base, are required before pursuing acupuncture for the treatment of a member's chronic pain ☐ A treatment plan, specifying the frequency and duration of treatments is provided above	
A billable medical code is available for the acupuncture service.	

Clinical Director Concurrence

I certify that for the services requested and cited above, a Level 3 prior authorization has been granted by me based upon the corresponding requirements in the applicable MCD. This approval and all associated required documentation of policy requirements and medical necessity is being maintained in the member's medical record or other CCE/NPN tracking system.

CCE/NPN Clinical Director Signature _____ **Date**

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Decision

Decision Comments *Required for NIOSH reviewer. If denied, provide clinical rationale and specific reasons for denial, outlining which MCD criteria were not met.*

NIOSH Staff Signature **Date**