Policy:	**Clinical Performance System – Physical Therapy/Occupational Therapy**
Date of Implementation:	**October 18, 2012**
Product:	**Specialty**

American Specialty Health – Specialty (ASH) utilizes a Clinical Performance System (CPS) for contracted providers. Each contracted provider will be placed in a clinical performance tier that defines the appropriate trigger for medical necessity/quality assurance review based on peer reviewed clinical and administrative criteria. The program allows certain clinically necessary treatment/services to be rendered prior to verification of medical necessity by ASH. If the member requires more treatment/services than are available prior to reaching the applicable medical necessary review trigger, a Medical Necessity Review Form (MNR Form) must be submitted for verification of medical necessity of those additional treatment/services by a peer clinical quality evaluator for those services to be eligible for reimbursement. As there is no requirement for prior authorization, services may be rendered, and post-service review may be performed within 180 days of the service being rendered or as applicable state law may describe.

Treatment/services available under the CPS are communicated via the ASH Provider Operations Manual (POM).

The CPS may not apply to the Client Benefit Plans of certain clients. Client-specific exceptions to the CPS will be set forth in the applicable Client Summaries, which are components of the Provider Services Agreement. Providers are given Client Summaries applicable to their geographic area and clinical specialty to ensure awareness of any applicable CPS criteria for specific members.

Each provider's participating facility's performance is monitored against CPS criteria. Unless notified otherwise, each contracted provider is eligible for the CPS Tier 3. Providers are monitored at the Tax ID number (TIN) level annually. The provider's compliance with the criteria will be based on an aggregate compilation of data from all credentialed practitioners performing healthcare services in the contracted provider's participating facility(ies). Providers can be moved up in tier level if they continue to demonstrate compliance with all CPS criteria and can remain at their current tier or be moved down if they fail to meet criteria from an aggregate facility(ies) perspective.

Tier Determination Criteria and Progression

The CPS assesses criteria in the determination of the performance quality of the providers participating with ASH, including but not limited to the following:

- **Annual Patient Base:** *Patient base greater than or equal to 20 ASH members/patients within the one (1) to three (3) year period are considered to provide a statistically meaningful sample*
- **Malpractice Claims:** *Number and amount of malpractice settlements reported by provider/practitioner, captured through primary source verification, or obtained via National Practitioner Databank (NPDB)*
- **Medical Necessity Review Alerts / Clinical Service Investigations:** *Potential alerts identified by Clinical Quality Evaluators from the clinical documentation submitted*
- **Quality of Care Grievances:** *A member complaint or grievance that, upon completion of the investigation, reveals improper standard(s) of practice*
- **Member Administrative Complaints:** *Validated member administrative complaints identified through Customer Service, patient satisfaction surveys, other member communications, etc.*
- **Clinical Corrective Action Plans (CAP):** *Any steps which providers must take to bring their practices into compliance with ASH standards*
- **State Board Action/Attestation Issues:** *Documented state board action or attestation issues (e.g., conviction of misdemeanor, felony, moral or ethical crime)*
- **Patient Office Visit Average:** *Used office visits per patient per year based on claims data*
- **Units of Service per Date of Service (DOS) per Patient:** *Average units of service per DOS per patient per year used based on claims data*
- **Evaluations and Re-evaluations Average:** *Evaluations (initial plus re-evaluations) used on average per patient per year based on claims*
- **Length of Participation:** *Years of participation based on minimum of one year's claims data* available *for analysis.*
- **Administrative Contract Compliance CAP:** *Any CAP issued for non-compliance with administrative requirements of the provider's contract.*

No criterion or tier level threshold is intended to imply an absolute level of appropriate treatment/therapy but rather, is used to determine the appropriate point at which ASH will apply its quality assurance and medical necessity review processes including the requirement to submit MNR Forms for verification of medical necessity of services. Providers who have consistently demonstrated patterns of utilization and quality that suggest a low level of compliance with the ASH clinical services process should have a higher level of oversight. Those with high levels of performance should have less oversight.

Clinical performance tiers are summarized below; a more detailed description of the CPS can be found in the ASH Provider Operations Manual (POM):

Tier 6

Providers who qualify for Tier 6 have no Medical Necessity Review (MNR) trigger, allowing submission of claims for service(s) rendered as defined in the POM without the requirement to submit MNR Forms for verification of medical necessity for reimbursement of services. (Client-specific exceptions may exist in which case details are set forth in applicable Client Summaries.)

Tier 5

Providers who qualify for Tier 5 have a 12-visit MNR trigger allowing submission of claims for service(s) rendered as defined in the POM without the requirement to submit MNR Forms for verification of medical necessity of services for up to 12 visits per patient per year. (Client-specific exceptions may exist in which case details are set forth in applicable Client Summaries.) After 12 visits, an MNR Form submission is required for verification of medical necessity for reimbursement of any additional services.

Tier 4

Providers who qualify for Tier 4 have an 8-visit MNR trigger allowing submission of claims for service(s) rendered as defined in the POM without the requirement to submit MNR Forms for verification of medical necessity of services for up to 8 visits per patient per year. (Client-specific exceptions may exist in which case details are set forth in applicable Client Summaries.) After 8 visits, an MNR Form submission is required for verification of medical necessity for reimbursement of any additional services.

Tier 3

Providers who qualify for Tier 3 have a 5-visit MNR trigger allowing submission of claims for service(s) rendered as defined in the POM without the requirement to submit MNR Forms for verification of medical necessity of services for up to 5 visits per patient per year. (Client-specific exceptions may exist in which case details are set forth in applicable Client Summaries.) After 5 visits, an MNR Form submission is required for verification of medical necessity for reimbursement of any additional services.

Tier 2

Reserved. Not applicable for this specialty.

Tier 1

Providers who qualify for Tier 1 do not have an MNR trigger provision. All services beyond the initial evaluation require medical necessity review and verification of medical necessity to be considered for reimbursement. (Client-specific exceptions may exist in which case details are set forth in applicable Client Summaries.)

Ongoing Clinical Services Review/Clinical Oversight

Clinical quality evaluators monitor provider service submissions for indications of possible under-utilization, over-utilization, and non-compliance with ASH clinical quality/medical necessity standards. The provider's clinical performance patterns are also evaluated on an ongoing basis through an analysis of claims data, continued compliance with quality criteria, and appeals and grievances in order to identify quality of care and/or health and safety issues.

If a contracted provider or credentialed practitioner performing services in a contracted provider's participating facility or virtual environment exhibits a pattern of practicing outside professionally recognized standards of care or health and safety issues are identified, a peer review clinical quality evaluator will submit a Clinical Performance Management Alert or a Clinical Services Alert. The alert is forwarded to the Clinical Services Investigation Team (CSIT) and, if appropriate, to the Practice Review Committee (PRC). The PRC may lower a provider's Tier designation as a component of a Corrective Action Plan (CAP); and subsequently may raise a provider's Tier designation upon determining the provider is compliant with the provisions of the CAP. (See the *Clinical Performance Alerts, Clinical Services Alerts, and Corrective Action Plans Practitioner/Provider Clinical Issues (QM 2 – S) policy* for additional information regarding CAPs.) (Note: Urgent health and safety issues are evaluated and remedied immediately by senior clinical management. See the *Management of Urgent Clinical Concerns (QM 10 – S) policy.)*

Alerts documenting quality, medical necessity and/or Clinical Services program issues are maintained in the provider's quality assurance file and evaluated during the annual CPS review.

Review and Assignment of Tiers

On at least an annual basis, Clinical Quality Administration (CQA) staff review provider utilization and quality data. This data is an aggregate of data from all credentialed practitioners providing services within each of the provider's participating facility(ies) under the Provider's TIN. Each provider is assigned a Tier level at the TIN level based on the application of CPS criteria for raising or lowering a Tier approved by the PRC. Provider notification of annual review data and Tier designation occurs a minimum of fifteen (15) calendar days prior to the commencement of the Tier assigned. ASH may conduct reviews more frequently than annually, in its sole discretion. Given this, the annual tier assignment can be changed by ASH at any time if it believes the criteria/data supports the change.

CPS Changes

ASH Group will monitor the data and results of the Clinical Performance System on a regular basis and may, at its sole discretion, make updates and changes to the program, including, but not limited to, discontinuing Tier changes for providers individually or

network-wide for any period of time; increasing the frequency of review and reporting; changing Tier assignment by ASH at any time if criteria/data supports the change. In the event that a Tier change is implemented, the new tier is applied to any claims submissions after the new tier takes effect, regardless of the date of service (within that 180-day claims submission timeline allowance). ASH will update and distribute by ASHLink communications updates to CPS guidelines, measurement, and/or policies. ASH will perform, at a minimum, annual review of providers for reporting of provider practices.

Appeals of Tier Designation

Providers have the option to appeal their annual review Tier designation. Tier appeals are considered, and a final determination adjudicated by the Quality Improvement Committee (QIC), a peer review committee. The QIC, when considering Tier designation appeals, makes decisions consistent with the established ASH Tier Determination Criteria. The QIC may grant a provider's appeal if they determine that the ASH Tier Determination Criteria was inappropriately applied, was based on inaccurate or incomplete data, or the practitioner submits additional information which the QIC determines is sufficient to overturn how the criteria was applied.