Policy: **Clinical Performance System**

Date of Implementation: **December 20, 2004**

Product: **Specialty**

American Specialty Health – Specialty (ASH) utilizes a Clinical Performance System (CPS) for credentialed practitioners that defines appropriate levels of quality and medical necessity review based on peer reviewed clinical and administrative criteria. The program allows certain clinically necessary treatment/services to be rendered prior to evaluation of medical necessity by ASH. If the member requires more treatment/services than are available at the practitioner's clinical performance tier level, the practitioner will submit a Medical Necessity Review Form (MNR Form) for verification of medical necessity of those additional treatment/services by a 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 to practitioners via the Practitioner Operations Manual (POM).

The CPS may not apply to the Member 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 Practitioner Services Agreement. Practitioners are provided with Client Summaries applicable to their geographic area and clinical specialty to ensure awareness of any applicable CPS criteria for specific members.

Annual monitoring of the CPS is limited to only those specialties eligible for multiple tier levels, and only those practitioners who meet the minimum annual patient base criteria.

Each individual practitioner's performance is monitored against CPS criteria regardless of whether the practitioner is part of a group practice or professional corporation which receives reimbursement under a common tax ID number (TIN). Unless notified otherwise, practitioners are eligible for the CPS Tier 3. Credentialed practitioners are monitored at least annually and will be moved up in tier level if they continue to demonstrate compliance with all CPS criteria and will remain at their current tier or be moved down if they fail to meet criteria. 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.

Tier Determination Criteria and Progression

The CPS assesses the following criteria in the determination of the performance quality of the practitioners credentialed with ASH:

- **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 practitioner, captured through primary source verification, or obtained via National Practitioner Data Bank (NPDB)*
- **Medical Necessity Review Alerts / Clinical Service Investigations:** *Potential alerts identified by Clinical Quality Evaluators from the clinical documentation submitted by the practitioner*
- **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 practitioners 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 average based on claims data*
- **Evaluation & Management (E/M) CPT Code Use:** *Compliance with appropriate E/M CPT code use as determined by ASH clinical committees*
- **X-ray Utilization Data:** *Compliance with ASH adopted X-ray utilization Clinical Practice Guidelines (where applicable to practitioner's scope of practice)*
- **Length of Participation:** *Years of participation based on minimum of one year's claims data* available *for analysis*
- **Administrative Contract Compliance Corrective Action Plans (CAP):** *Any CAP issued for non-compliance with administrative requirements of the practitioner'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. Practitioners 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 services agreement or the ASH Practitioner Operations Manual (POM):

Tier 6

Practitioners 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

Practitioners who qualify for Tier 5 have a 12-visit MNR trigger allowing submission of claims for service rendered as defined in the POM without the requirement to submit MNR Forms for verification of medical necessity of services for up to12 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

Practitioners who qualify for Tier 4 have an 8-visit MNR trigger allowing submission of claims for service 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

Practitioners who qualify for Tier 3 have a 5-visit MNR trigger allowing submission of claims for service 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

No longer applicable.

Tier 1

Practitioners who qualify for Tier 1 do not have an MNR trigger provision. All services beyond the initial examination/evaluation in the benefit year require clinical 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.)

In addition to the practitioner's assigned tier level, ASH also evaluates practitioner x-ray use *(where applicable to practitioner's scope of practice)* for potential Specific Radiology Quality Assurance Review (SRQAR). SRQAR is the requirement to submit radiology studies for quality assurance review. If it is determined by an ASH clinical quality committee that a credentialed practitioner's radiological examination protocols are outside of typical practice patterns and evidence-based radiology guidelines, then those credentialed practitioners will be required to submit all radiology studies to ASH for quality assurance review.

Credentialed practitioners who are subject to a SRQAR requirement shall submit an MNR Form for all radiology studies. All non-radiology services will be subject to medical necessity and quality assurance review in accordance with the credentialed practitioner's tier level. Each practitioner's radiology use will be evaluated annually to determine whether it meets ASH radiology appropriateness criteria as determined by an ASH clinical quality committee.

Ongoing Clinical Services Review/Clinical Oversight

Clinical quality evaluators monitor practitioner service submissions for indications of possible under-utilization, over-utilization, and non-compliance with ASH clinical quality/medical necessity standards. The practitioner'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 practitioner 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 practitioner's Tier designation as a component of a Corrective Action Plan (CAP); and subsequently may raise a practitioner's Tier designation upon determining the practitioner 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 practitioner'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 practitioner utilization and quality data. Each practitioner is assigned a Tier based on the application of CPS criteria for raising or lowering a Tier approved by the PRC. Practitioner notification of annual review data and Tier designation occurs a minimum of fifteen (15) calendar days prior to the commencement of the Tier assigned.

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

Practitioners 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 practitioner'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.