CLINICAL RESOURCE GROUP, INC.

CHIROPRACTIC ADMINISTRATIVE MANUAL

UPDATED: 1-1-2012

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CHAPTER ONE

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- clinical treatment standards
- CRG participating health programs
- claims submission/payment process
- provider utilization reports
- patient satisfaction reports

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- Member Eligibility
- Member Benefit and Product Information
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- Claim Reimbursement Determinations and Adjustments
- Coordination of Benefits related to Claim Processing
- Assist with Provider Demographic Revisions and Updates

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- Member Dates of Service

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- *The CRG Web Site*

www.clinicalgroup.net contains information about CRG, Treatment Guidelines, Provider Directory, Administrative Manuals and the latest in network news and client information.

- *Provider Newsletter*

Published quarterly to make available relevant network or practice information to assist network providers to serve CRG client health plan members.

- *Provider Administrative Manual*

Assists CRG providers in understanding and implementing the administrative policies and procedures required by CRG as referenced in the Provider Participation Agreement. It is Distributed to participating providers upon request and available electronically from our web site at www.clinicalgroup.net. Updates are made periodically

- *Provider Directory*

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Network Providers will receive copies or facsimiles of CRG's client health plan's member card prior to the implementation of network services. These cards will contain the information needed to identify the patient as a member of a health plan or program working with the CRG network. If your office has any questions regarding member cards for any specific health plan you are asked to call CRG Provider Relations at the above number.

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CRG makes every attempt to resolve a health plan member's complaint at the time the complaint is received. Complaints can be made either via telephone or in writing. Providers or their staff should refer patients to CRG Member Services for further assistance if they encounter a member with a complaint. Network providers and health plan members have the right to appeal the denial of services rendered. If you have had a service denied and wish to make an appeal, you must contact CRG Provider Relations to initiate the process of appeal. You may file an appeal on behalf of patient with that patient's written authorization. We recommend that you contact CRG for the specific procedure to follow in such cases.

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Members will be directed to contact South Country Health Alliance at 866-567-7242.

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Members will be directed to contact their county financial case worker.

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The Credentialing program verifies minimal requirements for network participation. These requirements include demonstration of adequate professional academic training, experience, current licensure, and competence in their field. Recredentialing in addition includes an assessment of the patient treatment data and information collected on patients treated to further measure the competence and effectiveness of each provider to determine a provider's ability to render acceptable care to CRG client members.

The credentialing process, with credentialing criteria, is set forth in CRG's Credentialing Policy and Procedure, which is established by CRG's Quality Improvement Council and Credentialing Subcommittee, comprised of a panel of practicing network providers. All actions related to acceptance, denial, discipline and termination of an individual provider are governed by the Credentialing Plan, which is reviewed and updated at least annually.

There is a $65 non refundable credentialing fee charged to each applicant for network participation to cover the costs of primary source verification.

Primary Verification
CRG will collect and verify all credentialing criteria in accordance with National Committee for Quality Assurance (NCQA) standards for primary verification. Applicants shall cooperate fully in providing all documents requested by CRG to satisfy primary verification requirements.

Credentialing Process
CRG accepts the Minnesota Uniform Credentialing Application for individual applicants. This application and the Authorization and Release can be accessed via CRG's Web site. Log on to www.clinicalgroup.net then Select "Provider Resources". Select the "Credentialing Application". If Internet access is not available, contact Provider Services at 1-866-281-1997 to request an application.

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Applications are evaluated by CRG credentialing committee to determine eligibility compliance with the criteria outlined in the Credentialing Plan. If the committee determines that the applicant is eligible for consideration of participation, the verification process and internal review are completed and the applicant is submitted to the Quality Improvement Council for a determination.

Notification of Decision
The applicant is sent written notification of the credentialing application determination following the Quality Improvement Council meeting at which it is considered.

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Recredentialing is the process whereby CRG verifies the status of a participating individual. Recredentialing is performed every three years.

Continued participation is contingent upon the provider's continued execution of the Participation Agreement with CRG and continued compliance with all CRG administrative and credentialing requirements.

Recredentialing verifies that the provider continues to satisfy the administrative and professional criteria as outlined in the Credentialing Plan, reviews outcomes of recent malpractice cases, and considers additional information regarding the provider's performance with CRG, including but not limited to:

- Member complaints
- Results of quality reviews
- Utilization management information
- Member satisfaction surveys, where applicable
- Medical records reviews, where applicable
- Results of office site visits, where applicable
- Cooperation in following established network administrative procedures

CHAPTER FOUR

CLAIM SUBMISSION AND PAYMENT PROCESSING

CRG accepts claims electronically through the clearinghouse Office Ally. Each clinic must enroll with Office Ally directly or ensure that the clinic's billing services have secured a relationship with Office Ally on their behalf. Claims must be submitted as an EDI 837P version 5010 file. Office Ally will work directly with clinic or billing staff to ensure claim submission compatibility.

Eligibility Verification
Providers should verify recipient eligibility **every month**. Minnesota health care program (MHCP) eligibility can be verified electronically at: www.mn-its.dhs.state.mn.us or by calling CRG at 1-866-281-1997.

Documentation/Daily Notes
The following types of claims require documentation/daily notes to accompany the claim:

- CPT Code 98942
- X-Rays (Multiple Views)
- Children Ages Birth-6

Documentation should be sent separate from the electronic claims. Documentation may be faxed to 651-209-0207 or mailed to 1700 Hwy 36 W, Suite 520 Roseville, MN 55113.

Diagnostic Codes and Treatment Codes
Acceptable Diagnosis and Treatment Codes are listed in CRG's Clinical Treatment Guidelines. Refer to the Participating Provider Agreement, Fee Schedule, for covered procedure codes.

ID/PMI Number
The recipient's 8 digit PMI number must be placed in the appropriate field within the 5010 version ANSI 837P file. This is found on the recipient's South Country Health Alliance health insurance card as: **(Gxxxxxxxx01)**. Please use only the 8 numerical digits that following the "G" and preceding the "01". Example: G0643891201 can be converted to a PMI # of 06438912.

Timely Filing of Claims
The participating provider shall submit claims for services within ninety (90) days of the date of service or if there is a Coordination of Benefits, within 90 days of notification by the primary payer of the balance owing, and understand that timely submittal of claims is a condition of receiving payment.

If a claim is submitted with missing or invalid information in a required field, the claim will be returned to you for correction/addition of the required information.

Participating providers must submit claims on the recipients' behalf and work directly with CRG for reimbursement. Do not ask recipients to submit claims for services rendered.

Coordination of Benefits (C.O.B.)

When an individual receiving services from a CRG participating provider is eligible for coverage by more than one benefit plan, CRG's providers must cooperate with CRG's coordination of benefits and subrogation efforts.

When Reimbursements from multiple sources are coordinated, the combined reimbursement will be limited to 100% of the allowable charges. This is designed to eliminate over insurance or duplication of benefits.

Medicare Recipients
If the Primary payer is Medicare and the secondary payer is MinnesotaCare or Medicaid through PMAP or CBP relationships, any co-payments, co-insurance or deductibles will be paid by the secondary payer. You may receive a notice from the Medicare Intermediary informing you that the balance has been "crossed over" to the secondary MA payer. This "crossover does not apply to chiropractic. You must submit your claim for C.O.B. to CRG for payment of the balance. Providers must submit a photocopy of the Medicare EOP with their claim for C.O.B. The Medicare EOP can be sent separately from the claim to CRG via Fax or postal mail. CRG will then apply the primary payer adjustments to the submitted claim. Medicare primary claims submitted without the Medicare EOB will be denied. The clinic will have 90 days from the date of the issued Medicare EOB to submit to CRG for payment.

Modifiers to be used when submitting claims

- **AT modifier - Active Treatment** - used for covered services (spinal CMT) only. Active treatment consists of acute and chronic (active/corrective) care. The "AT" is required on CPT codes 98940, 98941 and 98942 and is designed to represent that the care is medically necessary as defined by Medicare and CRG guidelines. The AT modifier is **not** to be used for maintenance care.

- **GA modifier – Advance Beneficiary Notice (ABN) on file** – used on covered services (spinal CMT) only. Use the ABN when you expect that a covered service (spinal manipulation) will be denied because of lack of medical necessity. If the treatment of a SCHA beneficiary is maintenance care – and therefore considered not medically necessary and not reimbursable – you should discuss this with the patient and have them sign an ABN.

- **GZ modifier – Advance Beneficiary Notice (ABN) NOT on file** – used on covered services (spinal CMT) only. Use this modifier when an ABN should have been signed, but wasn't. This modified is a good-faith measure indicating that you recognize you made an error. *Note that you may **NOT** collect payment from the patient.*

- **GY modifier – Non-covered services (services that are statutorily excluded or do not meet the definition of any SCHA benefit)** – used on all non-covered services (anything NOT spinal CMT). This modifier is required on all services other than manual manipulation of the spine, including X-Rays (Medicare Advantage programs), extra spinal CMT, therapy modalities and exams.

Payment of Claim

The provider shall accept as payment in full for services the reimbursement paid by CRG in accordance with the contracted Fee Schedule. Other than the Coordination of Benefits, the provider shall not hold financially responsible, collect or attempt to collect additional reimbursement for services from a covered person or third party payer, except for; co-payments, co-insurance and deductibles as defined by the health plan members benefit plan.

CRG shall pay provider "clean" claims submitted by provider inclusive of automatic payment of interest, less any applicable co-payments, co-insurance and/or deductibles, in accordance with applicable state laws regarding prompt payment.

Send claims to Office Ally clearinghouse. Send other insurance EOB's and other claims supplements directly to CRG via fax at 651-209-0207 or by postal mail at 1700 Hwy 36 W, Suite 520 Roseville, MN 55113.

CHAPTER FIVE

Quality and Utilization Management

Quality Improvement Program

Clinical Resource Group's mission is to create provider/health plan relationships grounded in a shared commitment to excellent patient care, mutual respect and the application of practical administrative methods.

CRG was established to provide health plans and third party payers with an alternative means of arranging for and delivering ancillary health care services to its members. CRG is committed to establishing collaborative relationships with managed care plans and other payers throughout Minnesota to develop and manage ancillary provider networks that are responsive to the specific needs of the plans and members served.

CRG's Quality Improvement Plan provides the framework within which CRG strives to continually improve upon the quality, appropriateness and outcome of the health care services rendered to the population we serve.

CRG's Quality Improvement Program Structure

Clinical Resource Group's Board of Directors, President/CEO and Vice President of Clinical Services provide leadership for CRG's quality program. They have oversight responsibility for the following functional committees:

1. Quality Improvement Council
    - Six member council includes 4-6 network providers
2. Subcommittees
    - Utilization/Care Management Committee
    - Credentialing Committee

Utilization Management Program

I. Philosophy

CRG's utilization management program is designed to give each patient the opportunity to receive the proper treatment in the most appropriate setting. Treatment guidelines have been developed in collaboration with participating network providers; these guidelines serve as the basis for CRG's UM program. All CRG providers agree to practice within the standards established by CRG, participate in CRG's Quality Improvement and UM programs, and to abide by sound health care management principles to ensure all care being provided to CRG clients is appropriate for the patient's specific needs.

Our utilization management program is built on the following key healthcare management features:

- The use of sound, professional provider selection criteria;
- The use of regional Advisors that provide input into regional/community service needs, obstacles and barriers to access
- An established chiropractic peer review program; and
- The use of a chiropractic utilization management committee.

CRG views utilization management as a means of coordinating a complex array of health care services that will meet the individual patient's health care and health management needs. CRG seeks to establish, through its utilization management program and philosophy an atmosphere of Continuous Quality Improvement with patients and participating providers.

II. Utilization Management Process

CRG's Chiropractic Director is a licensed chiropractor in the state of Minnesota, and maintains an active chiropractic practice. This individual is responsible for guiding the strategic direction of CRG's UM program, providing oversight to utilization management activities and assist our providers in making appropriate clinical decisions.

The functions supporting CRG's UM model are as follows:

A. Retrospective Review

CRG believes that health care providers have a common goal to effectively address the clinical needs of patients and strive to practice within the normative standards.. Recognition as a *outlier* can be a deterrent to inappropriate medical management and utilization. CRG does not typically require either the patient or provider to obtain prior authorization for chiropractic services. An exception are those cases where a provider is participating in remedial training or as a new provider is participating in the CRG Chiropractic Authorization Program (CAP).

Instead, CRG monitors provider performance retrospectively for appropriate utilization, trends in practice patterns and compliance with treatment guidelines. This information gathered is made available to providers on an individual and aggregate basis each quarter. As the information suggests, providers are individually coached to improve upon any areas of concern by the CRG clinical Staff.

Process:

1. Clinical Resource Group will undertake peer review of the quality, medical necessity or appropriateness of care, treatment setting and duration of treatment identified from a variety of data sources.
2. Data sources include, but are not limited to
   a. Patient or client complaints,
   b. Quarterly provider statistical reports,
   c. Quality triggers established by CRG's Quality Improvement Council and/or UM Committee
   d. Claims data,
   e. Medical record reviews,
3. Retrospective review is performed by CRG's VP Clinical Services or other designated chiropractic review staff. Retrospective denials of services result only in the denial of payment to the provider, not denial of coverage to the patient.

B. Concurrent Review

Concurrent review is the ongoing process of working with the patient, the chiropractor and other health care disciplines involved in the care and treatment of patients. Individual case management begins with the identification of such cases requiring medical care coordination.

It is the goal of CRG's utilization management program to assist the patient in obtaining the highest quality of medical care in the most appropriate setting. Under CRG's Case Management Program, we:

- anticipate future needs the patient may have;
- monitor ongoing chiropractic treatment; and
- work with the patient, provider and plan administrator / health plan to facilitate the most appropriate care in the most appropriate setting;

The following criteria are used to determine medical necessity or appropriateness, treatment setting and duration of treatment:

- CRG Clinical Treatment Guidelines;
- CRG's Quality Monitoring Standards;
- CRG's Payer Clients' treatment and case management referral guidelines and certificate of coverage.
- Standard chiropractic evaluation and treatment procedures

Process

1. CRG will review the quality, medical necessity or appropriateness concerns, treatment setting and duration of treatment, identified from any data source. Reviewers will be licensed, practicing chiropractors.

2. Data sources include, but are not limited to the following:
a) Ongoing treatment authorization requests from providers,
b) Complaint investigation,
c) Quarterly provider statistical reports,
d) Quality triggers established by CRG's QIC or UM Committee or established in collaboration with the client's Quality Improvement/ UM initiatives.
e) Claims data,
f) Medical record reviews,

3. Triggers for possible case management include the following:
a) Chronic conditions
b) Frequency of care issues and concerns
c) Rehabilitation delays
d) Payer specific/employer requested

4. CRG's professional chiropractic staff performs case management reviews and all denials are determined solely by either CRG's Chiropractic Director or other chiropractic review staff responsible for Utilization Management.

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Payment of Claim

The provider shall accept as payment in full for services the reimbursement paid by CRG in accordance with the contracted Fee Schedule. Other than the Coordination of Benefits, the provider shall not hold financially responsible, collect or attempt to collect additional reimbursement for services from a covered person or third party payer, except for; co-payments, co-insurance and deductibles as defined by the health plan members benefit plan.

CRG shall pay provider "clean" claims submitted by provider inclusive of automatic payment of interest, less any applicable co-payments, co-insurance and/or deductibles, in accordance with applicable state laws regarding prompt payment.

Send claims to Office Ally clearinghouse. Send other insurance EOB's and other claims supplements directly to CRG via fax at 651-209-0207 or by postal mail at 1700 Hwy 36 W, Suite 520 Roseville, MN 55113.

CHAPTER FIVE

Quality and Utilization Management

Quality Improvement Program

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CRG was established to provide health plans and third party payers with an alternative means of arranging for and delivering ancillary health care services to its members. CRG is committed to establishing collaborative relationships with managed care plans and other payers throughout Minnesota to develop and manage ancillary provider networks that are responsive to the specific needs of the plans and members served.

CRG's Quality Improvement Plan provides the framework within which CRG strives to continually improve upon the quality, appropriateness and outcome of the health care services rendered to the population we serve.

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Clinical Resource Group's Board of Directors, President/CEO and Vice President of Clinical Services provide leadership for CRG's quality program. They have oversight responsibility for the following functional committees:

1. Quality Improvement Council
    - Six member council includes 4-6 network providers
2. Subcommittees
    - Utilization/Care Management Committee
    - Credentialing Committee

Utilization Management Program

I. Philosophy

CRG's utilization management program is designed to give each patient the opportunity to receive the proper treatment in the most appropriate setting. Treatment guidelines have been developed in collaboration with participating network providers; these guidelines serve as the basis for CRG's UM program. All CRG providers agree to practice within the standards established by CRG, participate in CRG's Quality Improvement and UM programs, and to abide by sound health care management principles to ensure all care being provided to CRG clients is appropriate for the patient's specific needs.

Our utilization management program is built on the following key healthcare management features:

- The use of sound, professional provider selection criteria;
- The use of regional Advisors that provide input into regional/community service needs, obstacles and barriers to access
- An established chiropractic peer review program; and
- The use of a chiropractic utilization management committee.

CRG views utilization management as a means of coordinating a complex array of health care services that will meet the individual patient's health care and health management needs. CRG seeks to establish, through its utilization management program and philosophy an atmosphere of Continuous Quality Improvement with patients and participating providers.

II. Utilization Management Process

CRG's Chiropractic Director is a licensed chiropractor in the state of Minnesota, and maintains an active chiropractic practice. This individual is responsible for guiding the strategic direction of CRG's UM program, providing oversight to utilization management activities and assist our providers in making appropriate clinical decisions.

The functions supporting CRG's UM model are as follows:

A. Retrospective Review

CRG believes that health care providers have a common goal to effectively address the clinical needs of patients and strive to practice within the normative standards.. Recognition as a *outlier* can be a deterrent to inappropriate medical management and utilization. CRG does not typically require either the patient or provider to obtain prior authorization for chiropractic services. An exception are those cases where a provider is participating in remedial training or as a new provider is participating in the CRG Chiropractic Authorization Program (CAP).

Instead, CRG monitors provider performance retrospectively for appropriate utilization, trends in practice patterns and compliance with treatment guidelines. This information gathered is made available to providers on an individual and aggregate basis each quarter. As the information suggests, providers are individually coached to improve upon any areas of concern by the CRG clinical Staff.

Process:

1. Clinical Resource Group will undertake peer review of the quality, medical necessity or appropriateness of care, treatment setting and duration of treatment identified from a variety of data sources.
2. Data sources include, but are not limited to
   a. Patient or client complaints,
   b. Quarterly provider statistical reports,
   c. Quality triggers established by CRG's Quality Improvement Council and/or UM Committee
   d. Claims data,
   e. Medical record reviews,
3. Retrospective review is performed by CRG's VP Clinical Services or other designated chiropractic review staff. Retrospective denials of services result only in the denial of payment to the provider, not denial of coverage to the patient.

B. Concurrent Review

Concurrent review is the ongoing process of working with the patient, the chiropractor and other health care disciplines involved in the care and treatment of patients. Individual case management begins with the identification of such cases requiring medical care coordination.

It is the goal of CRG's utilization management program to assist the patient in obtaining the highest quality of medical care in the most appropriate setting. Under CRG's Case Management Program, we:

- anticipate future needs the patient may have;
- monitor ongoing chiropractic treatment; and
- work with the patient, provider and plan administrator / health plan to facilitate the most appropriate care in the most appropriate setting;

The following criteria are used to determine medical necessity or appropriateness, treatment setting and duration of treatment:

- CRG Clinical Treatment Guidelines;
- CRG's Quality Monitoring Standards;
- CRG's Payer Clients' treatment and case management referral guidelines and certificate of coverage.
- Standard chiropractic evaluation and treatment procedures

Process

1. CRG will review the quality, medical necessity or appropriateness concerns, treatment setting and duration of treatment, identified from any data source. Reviewers will be licensed, practicing chiropractors.

2. Data sources include, but are not limited to the following:
a) Ongoing treatment authorization requests from providers,
b) Complaint investigation,
c) Quarterly provider statistical reports,
d) Quality triggers established by CRG's QIC or UM Committee or established in collaboration with the client's Quality Improvement/ UM initiatives.
e) Claims data,
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3. Triggers for possible case management include the following:
a) Chronic conditions
b) Frequency of care issues and concerns
c) Rehabilitation delays
d) Payer specific/employer requested

4. CRG's professional chiropractic staff performs case management reviews and all denials are determined solely by either CRG's Chiropractic Director or other chiropractic review staff responsible for Utilization Management.

CLINICAL RESOURCE GROUP, INC.

CHIROPRACTIC ADMINISTRATIVE MANUAL

UPDATED: 1-1-2012

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- Member Dates of Service

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www.clinicalgroup.net contains information about CRG, Treatment Guidelines, Provider Directory, Administrative Manuals and the latest in network news and client information.

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Customer Service
Representatives can answer health plan member questions related to chiropractic services and assist members in locating providers for chiropractic services. Customer Service staff are available Monday through Friday, 8:00 am – 4:30 pm to assist health plan members.

How to Contact CRG
Members can contact CRG toll free at 1-866-281-1997 or in the metro area at 651-633-6240.

Member Identification Card
Network Providers will receive copies or facsimiles of CRG's client health plan's member card prior to the implementation of network services. These cards will contain the information needed to identify the patient as a member of a health plan or program working with the CRG network. If your office has any questions regarding member cards for any specific health plan you are asked to call CRG Provider Relations at the above number.

Complaints and Appeals
CRG makes every attempt to resolve a health plan member's complaint at the time the complaint is received. Complaints can be made either via telephone or in writing. Providers or their staff should refer patients to CRG Member Services for further assistance if they encounter a member with a complaint. Network providers and health plan members have the right to appeal the denial of services rendered. If you have had a service denied and wish to make an appeal, you must contact CRG Provider Relations to initiate the process of appeal. You may file an appeal on behalf of patient with that patient's written authorization. We recommend that you contact CRG for the specific procedure to follow in such cases.

Interpreters
Members will be directed to contact South Country Health Alliance at 866-567-7242.

Transportation
Members will be directed to contact their county financial case worker.

CHAPTER THREE

Credentialing

The Credentialing program verifies minimal requirements for network participation. These requirements include demonstration of adequate professional academic training, experience, current licensure, and competence in their field. Recredentialing in addition includes an assessment of the patient treatment data and information collected on patients treated to further measure the competence and effectiveness of each provider to determine a provider's ability to render acceptable care to CRG client members.

The credentialing process, with credentialing criteria, is set forth in CRG's Credentialing Policy and Procedure, which is established by CRG's Quality Improvement Council and Credentialing Subcommittee, comprised of a panel of practicing network providers. All actions related to acceptance, denial, discipline and termination of an individual provider are governed by the Credentialing Plan, which is reviewed and updated at least annually.

There is a $65 non refundable credentialing fee charged to each applicant for network participation to cover the costs of primary source verification.

Primary Verification
CRG will collect and verify all credentialing criteria in accordance with National Committee for Quality Assurance (NCQA) standards for primary verification. Applicants shall cooperate fully in providing all documents requested by CRG to satisfy primary verification requirements.

Credentialing Process
CRG accepts the Minnesota Uniform Credentialing Application for individual applicants. This application and the Authorization and Release can be accessed via CRG's Web site. Log on to www.clinicalgroup.net then Select "Provider Resources". Select the "Credentialing Application". If Internet access is not available, contact Provider Services at 1-866-281-1997 to request an application.

Return the completed application to the CRG Provider Relations Department with all appropriate attachments. Applications should be submitted at least 60 days prior to an individual provider's anticipated start date.

Applications are evaluated by CRG credentialing committee to determine eligibility compliance with the criteria outlined in the Credentialing Plan. If the committee determines that the applicant is eligible for consideration of participation, the verification process and internal review are completed and the applicant is submitted to the Quality Improvement Council for a determination.

Notification of Decision
The applicant is sent written notification of the credentialing application determination following the Quality Improvement Council meeting at which it is considered.

This notification reports any restrictions that may have been placed on an individual provider's status. If the council determines restriction, the provider is given the facts upon which the council based its decision. If the council makes a determination to deny participation, the applicant is advised and notified of the right to review the information upon which the determination was made and to submit corrections.

Appeals
An individual provider may appeal the Quality Improvement Council's decision to accept an application with restrictions or to deny an application due to concerns related to professional competency. The provider must request a hearing, in writing, within 30 days of the date the provider was notified of the committee's determination.

Recredentialing
Recredentialing is the process whereby CRG verifies the status of a participating individual. Recredentialing is performed every three years.

Continued participation is contingent upon the provider's continued execution of the Participation Agreement with CRG and continued compliance with all CRG administrative and credentialing requirements.

Recredentialing verifies that the provider continues to satisfy the administrative and professional criteria as outlined in the Credentialing Plan, reviews outcomes of recent malpractice cases, and considers additional information regarding the provider's performance with CRG, including but not limited to:

- Member complaints
- Results of quality reviews
- Utilization management information
- Member satisfaction surveys, where applicable
- Medical records reviews, where applicable
- Results of office site visits, where applicable
- Cooperation in following established network administrative procedures

CHAPTER FOUR

CLAIM SUBMISSION AND PAYMENT PROCESSING

CRG accepts claims electronically through the clearinghouse Office Ally. Each clinic must enroll with Office Ally directly or ensure that the clinic's billing services have secured a relationship with Office Ally on their behalf. Claims must be submitted as an EDI 837P version 5010 file. Office Ally will work directly with clinic or billing staff to ensure claim submission compatibility.

Eligibility Verification
Providers should verify recipient eligibility **every month**. Minnesota health care program (MHCP) eligibility can be verified electronically at: www.mn-its.dhs.state.mn.us or by calling CRG at 1-866-281-1997.

Documentation/Daily Notes
The following types of claims require documentation/daily notes to accompany the claim:

- CPT Code 98942
- X-Rays (Multiple Views)
- Children Ages Birth-6

Documentation should be sent separate from the electronic claims. Documentation may be faxed to 651-209-0207 or mailed to 1700 Hwy 36 W, Suite 520 Roseville, MN 55113.

Diagnostic Codes and Treatment Codes
Acceptable Diagnosis and Treatment Codes are listed in CRG's Clinical Treatment Guidelines. Refer to the Participating Provider Agreement, Fee Schedule, for covered procedure codes.

ID/PMI Number
The recipient's 8 digit PMI number must be placed in the appropriate field within the 5010 version ANSI 837P file. This is found on the recipient's South Country Health Alliance health insurance card as: **(Gxxxxxxxx01)**. Please use only the 8 numerical digits that following the "G" and preceding the "01". Example: G0643891201 can be converted to a PMI # of 06438912.

Timely Filing of Claims
The participating provider shall submit claims for services within ninety (90) days of the date of service or if there is a Coordination of Benefits, within 90 days of notification by the primary payer of the balance owing, and understand that timely submittal of claims is a condition of receiving payment.

If a claim is submitted with missing or invalid information in a required field, the claim will be returned to you for correction/addition of the required information.

Participating providers must submit claims on the recipients' behalf and work directly with CRG for reimbursement. Do not ask recipients to submit claims for services rendered.

Coordination of Benefits (C.O.B.)

When an individual receiving services from a CRG participating provider is eligible for coverage by more than one benefit plan, CRG's providers must cooperate with CRG's coordination of benefits and subrogation efforts.

When Reimbursements from multiple sources are coordinated, the combined reimbursement will be limited to 100% of the allowable charges. This is designed to eliminate over insurance or duplication of benefits.

Medicare Recipients
If the Primary payer is Medicare and the secondary payer is MinnesotaCare or Medicaid through PMAP or CBP relationships, any co-payments, co-insurance or deductibles will be paid by the secondary payer. You may receive a notice from the Medicare Intermediary informing you that the balance has been "crossed over" to the secondary MA payer. This "crossover does not apply to chiropractic. You must submit your claim for C.O.B. to CRG for payment of the balance. Providers must submit a photocopy of the Medicare EOP with their claim for C.O.B. The Medicare EOP can be sent separately from the claim to CRG via Fax or postal mail. CRG will then apply the primary payer adjustments to the submitted claim. Medicare primary claims submitted without the Medicare EOB will be denied. The clinic will have 90 days from the date of the issued Medicare EOB to submit to CRG for payment.

Modifiers to be used when submitting claims

- **AT modifier - Active Treatment** - used for covered services (spinal CMT) only. Active treatment consists of acute and chronic (active/corrective) care. The "AT" is required on CPT codes 98940, 98941 and 98942 and is designed to represent that the care is medically necessary as defined by Medicare and CRG guidelines. The AT modifier is **not** to be used for maintenance care.

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CLINICAL RESOURCE GROUP, INC.

CHIROPRACTIC ADMINISTRATIVE MANUAL

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Credentialing

The Credentialing program verifies minimal requirements for network participation. These requirements include demonstration of adequate professional academic training, experience, current licensure, and competence in their field. Recredentialing in addition includes an assessment of the patient treatment data and information collected on patients treated to further measure the competence and effectiveness of each provider to determine a provider's ability to render acceptable care to CRG client members.

The credentialing process, with credentialing criteria, is set forth in CRG's Credentialing Policy and Procedure, which is established by CRG's Quality Improvement Council and Credentialing Subcommittee, comprised of a panel of practicing network providers. All actions related to acceptance, denial, discipline and termination of an individual provider are governed by the Credentialing Plan, which is reviewed and updated at least annually.

There is a $65 non refundable credentialing fee charged to each applicant for network participation to cover the costs of primary source verification.

Primary Verification
CRG will collect and verify all credentialing criteria in accordance with National Committee for Quality Assurance (NCQA) standards for primary verification. Applicants shall cooperate fully in providing all documents requested by CRG to satisfy primary verification requirements.

Credentialing Process
CRG accepts the Minnesota Uniform Credentialing Application for individual applicants. This application and the Authorization and Release can be accessed via CRG's Web site. Log on to www.clinicalgroup.net then Select "Provider Resources". Select the "Credentialing Application". If Internet access is not available, contact Provider Services at 1-866-281-1997 to request an application.

Return the completed application to the CRG Provider Relations Department with all appropriate attachments. Applications should be submitted at least 60 days prior to an individual provider's anticipated start date.

Applications are evaluated by CRG credentialing committee to determine eligibility compliance with the criteria outlined in the Credentialing Plan. If the committee determines that the applicant is eligible for consideration of participation, the verification process and internal review are completed and the applicant is submitted to the Quality Improvement Council for a determination.

Notification of Decision
The applicant is sent written notification of the credentialing application determination following the Quality Improvement Council meeting at which it is considered.

This notification reports any restrictions that may have been placed on an individual provider's status. If the council determines restriction, the provider is given the facts upon which the council based its decision. If the council makes a determination to deny participation, the applicant is advised and notified of the right to review the information upon which the determination was made and to submit corrections.

Appeals
An individual provider may appeal the Quality Improvement Council's decision to accept an application with restrictions or to deny an application due to concerns related to professional competency. The provider must request a hearing, in writing, within 30 days of the date the provider was notified of the committee's determination.

Recredentialing
Recredentialing is the process whereby CRG verifies the status of a participating individual. Recredentialing is performed every three years.

Continued participation is contingent upon the provider's continued execution of the Participation Agreement with CRG and continued compliance with all CRG administrative and credentialing requirements.

Recredentialing verifies that the provider continues to satisfy the administrative and professional criteria as outlined in the Credentialing Plan, reviews outcomes of recent malpractice cases, and considers additional information regarding the provider's performance with CRG, including but not limited to:

- Member complaints
- Results of quality reviews
- Utilization management information
- Member satisfaction surveys, where applicable
- Medical records reviews, where applicable
- Results of office site visits, where applicable
- Cooperation in following established network administrative procedures

CHAPTER FOUR

CLAIM SUBMISSION AND PAYMENT PROCESSING

CRG accepts claims electronically through the clearinghouse Office Ally. Each clinic must enroll with Office Ally directly or ensure that the clinic's billing services have secured a relationship with Office Ally on their behalf. Claims must be submitted as an EDI 837P version 5010 file. Office Ally will work directly with clinic or billing staff to ensure claim submission compatibility.

Eligibility Verification
Providers should verify recipient eligibility **every month**. Minnesota health care program (MHCP) eligibility can be verified electronically at: www.mn-its.dhs.state.mn.us or by calling CRG at 1-866-281-1997.

Documentation/Daily Notes
The following types of claims require documentation/daily notes to accompany the claim:

- CPT Code 98942
- X-Rays (Multiple Views)
- Children Ages Birth-6

Documentation should be sent separate from the electronic claims. Documentation may be faxed to 651-209-0207 or mailed to 1700 Hwy 36 W, Suite 520 Roseville, MN 55113.

Diagnostic Codes and Treatment Codes
Acceptable Diagnosis and Treatment Codes are listed in CRG's Clinical Treatment Guidelines. Refer to the Participating Provider Agreement, Fee Schedule, for covered procedure codes.

ID/PMI Number
The recipient's 8 digit PMI number must be placed in the appropriate field within the 5010 version ANSI 837P file. This is found on the recipient's South Country Health Alliance health insurance card as: **(Gxxxxxxxx01)**. Please use only the 8 numerical digits that following the "G" and preceding the "01". Example: G0643891201 can be converted to a PMI # of 06438912.

Timely Filing of Claims
The participating provider shall submit claims for services within ninety (90) days of the date of service or if there is a Coordination of Benefits, within 90 days of notification by the primary payer of the balance owing, and understand that timely submittal of claims is a condition of receiving payment.

If a claim is submitted with missing or invalid information in a required field, the claim will be returned to you for correction/addition of the required information.

Participating providers must submit claims on the recipients' behalf and work directly with CRG for reimbursement. Do not ask recipients to submit claims for services rendered.

Coordination of Benefits (C.O.B.)

When an individual receiving services from a CRG participating provider is eligible for coverage by more than one benefit plan, CRG's providers must cooperate with CRG's coordination of benefits and subrogation efforts.

When Reimbursements from multiple sources are coordinated, the combined reimbursement will be limited to 100% of the allowable charges. This is designed to eliminate over insurance or duplication of benefits.

Medicare Recipients
If the Primary payer is Medicare and the secondary payer is MinnesotaCare or Medicaid through PMAP or CBP relationships, any co-payments, co-insurance or deductibles will be paid by the secondary payer. You may receive a notice from the Medicare Intermediary informing you that the balance has been "crossed over" to the secondary MA payer. This "crossover does not apply to chiropractic. You must submit your claim for C.O.B. to CRG for payment of the balance. Providers must submit a photocopy of the Medicare EOP with their claim for C.O.B. The Medicare EOP can be sent separately from the claim to CRG via Fax or postal mail. CRG will then apply the primary payer adjustments to the submitted claim. Medicare primary claims submitted without the Medicare EOB will be denied. The clinic will have 90 days from the date of the issued Medicare EOB to submit to CRG for payment.

Modifiers to be used when submitting claims

- **AT modifier - Active Treatment** - used for covered services (spinal CMT) only. Active treatment consists of acute and chronic (active/corrective) care. The "AT" is required on CPT codes 98940, 98941 and 98942 and is designed to represent that the care is medically necessary as defined by Medicare and CRG guidelines. The AT modifier is **not** to be used for maintenance care.

- **GA modifier – Advance Beneficiary Notice (ABN) on file** – used on covered services (spinal CMT) only. Use the ABN when you expect that a covered service (spinal manipulation) will be denied because of lack of medical necessity. If the treatment of a SCHA beneficiary is maintenance care – and therefore considered not medically necessary and not reimbursable – you should discuss this with the patient and have them sign an ABN.

- **GZ modifier – Advance Beneficiary Notice (ABN) NOT on file** – used on covered services (spinal CMT) only. Use this modifier when an ABN should have been signed, but wasn't. This modified is a good-faith measure indicating that you recognize you made an error. *Note that you may **NOT** collect payment from the patient.*

- **GY modifier – Non-covered services (services that are statutorily excluded or do not meet the definition of any SCHA benefit)** – used on all non-covered services (anything NOT spinal CMT). This modifier is required on all services other than manual manipulation of the spine, including X-Rays (Medicare Advantage programs), extra spinal CMT, therapy modalities and exams.

Payment of Claim

The provider shall accept as payment in full for services the reimbursement paid by CRG in accordance with the contracted Fee Schedule. Other than the Coordination of Benefits, the provider shall not hold financially responsible, collect or attempt to collect additional reimbursement for services from a covered person or third party payer, except for; co-payments, co-insurance and deductibles as defined by the health plan members benefit plan.

CRG shall pay provider "clean" claims submitted by provider inclusive of automatic payment of interest, less any applicable co-payments, co-insurance and/or deductibles, in accordance with applicable state laws regarding prompt payment.

Send claims to Office Ally clearinghouse. Send other insurance EOB's and other claims supplements directly to CRG via fax at 651-209-0207 or by postal mail at 1700 Hwy 36 W, Suite 520 Roseville, MN 55113.

CHAPTER FIVE

Quality and Utilization Management

Quality Improvement Program

Clinical Resource Group's mission is to create provider/health plan relationships grounded in a shared commitment to excellent patient care, mutual respect and the application of practical administrative methods.

CRG was established to provide health plans and third party payers with an alternative means of arranging for and delivering ancillary health care services to its members. CRG is committed to establishing collaborative relationships with managed care plans and other payers throughout Minnesota to develop and manage ancillary provider networks that are responsive to the specific needs of the plans and members served.

CRG's Quality Improvement Plan provides the framework within which CRG strives to continually improve upon the quality, appropriateness and outcome of the health care services rendered to the population we serve.

CRG's Quality Improvement Program Structure

Clinical Resource Group's Board of Directors, President/CEO and Vice President of Clinical Services provide leadership for CRG's quality program. They have oversight responsibility for the following functional committees:

1. Quality Improvement Council
    - Six member council includes 4-6 network providers
2. Subcommittees
    - Utilization/Care Management Committee
    - Credentialing Committee

Utilization Management Program

I. Philosophy

CRG's utilization management program is designed to give each patient the opportunity to receive the proper treatment in the most appropriate setting. Treatment guidelines have been developed in collaboration with participating network providers; these guidelines serve as the basis for CRG's UM program. All CRG providers agree to practice within the standards established by CRG, participate in CRG's Quality Improvement and UM programs, and to abide by sound health care management principles to ensure all care being provided to CRG clients is appropriate for the patient's specific needs.

Our utilization management program is built on the following key healthcare management features:

- The use of sound, professional provider selection criteria;
- The use of regional Advisors that provide input into regional/community service needs, obstacles and barriers to access
- An established chiropractic peer review program; and
- The use of a chiropractic utilization management committee.

CRG views utilization management as a means of coordinating a complex array of health care services that will meet the individual patient's health care and health management needs. CRG seeks to establish, through its utilization management program and philosophy an atmosphere of Continuous Quality Improvement with patients and participating providers.

II. Utilization Management Process

CRG's Chiropractic Director is a licensed chiropractor in the state of Minnesota, and maintains an active chiropractic practice. This individual is responsible for guiding the strategic direction of CRG's UM program, providing oversight to utilization management activities and assist our providers in making appropriate clinical decisions.

The functions supporting CRG's UM model are as follows:

A. Retrospective Review

CRG believes that health care providers have a common goal to effectively address the clinical needs of patients and strive to practice within the normative standards.. Recognition as a *outlier* can be a deterrent to inappropriate medical management and utilization. CRG does not typically require either the patient or provider to obtain prior authorization for chiropractic services. An exception are those cases where a provider is participating in remedial training or as a new provider is participating in the CRG Chiropractic Authorization Program (CAP).

Instead, CRG monitors provider performance retrospectively for appropriate utilization, trends in practice patterns and compliance with treatment guidelines. This information gathered is made available to providers on an individual and aggregate basis each quarter. As the information suggests, providers are individually coached to improve upon any areas of concern by the CRG clinical Staff.

Process:

1. Clinical Resource Group will undertake peer review of the quality, medical necessity or appropriateness of care, treatment setting and duration of treatment identified from a variety of data sources.
2. Data sources include, but are not limited to
   a. Patient or client complaints,
   b. Quarterly provider statistical reports,
   c. Quality triggers established by CRG's Quality Improvement Council and/or UM Committee
   d. Claims data,
   e. Medical record reviews,
3. Retrospective review is performed by CRG's VP Clinical Services or other designated chiropractic review staff. Retrospective denials of services result only in the denial of payment to the provider, not denial of coverage to the patient.

B. Concurrent Review

Concurrent review is the ongoing process of working with the patient, the chiropractor and other health care disciplines involved in the care and treatment of patients. Individual case management begins with the identification of such cases requiring medical care coordination.

It is the goal of CRG's utilization management program to assist the patient in obtaining the highest quality of medical care in the most appropriate setting. Under CRG's Case Management Program, we:

- anticipate future needs the patient may have;
- monitor ongoing chiropractic treatment; and
- work with the patient, provider and plan administrator / health plan to facilitate the most appropriate care in the most appropriate setting;

The following criteria are used to determine medical necessity or appropriateness, treatment setting and duration of treatment:

- CRG Clinical Treatment Guidelines;
- CRG's Quality Monitoring Standards;
- CRG's Payer Clients' treatment and case management referral guidelines and certificate of coverage.
- Standard chiropractic evaluation and treatment procedures

Process

1. CRG will review the quality, medical necessity or appropriateness concerns, treatment setting and duration of treatment, identified from any data source. Reviewers will be licensed, practicing chiropractors.

2. Data sources include, but are not limited to the following:
a) Ongoing treatment authorization requests from providers,
b) Complaint investigation,
c) Quarterly provider statistical reports,
d) Quality triggers established by CRG's QIC or UM Committee or established in collaboration with the client's Quality Improvement/ UM initiatives.
e) Claims data,
f) Medical record reviews,

3. Triggers for possible case management include the following:
a) Chronic conditions
b) Frequency of care issues and concerns
c) Rehabilitation delays
d) Payer specific/employer requested

4. CRG's professional chiropractic staff performs case management reviews and all denials are determined solely by either CRG's Chiropractic Director or other chiropractic review staff responsible for Utilization Management.