PROVIDER CREDENTIALING POLICIES & PROCEDURES

FOR

CHIROPRACTIC MANAGEMENT SERVICES, LLC

(CMS)

CHIROPRACTIC MANAGEMENT SERVICES, LLC
PROVIDER CREDENTIALING POLICY & PROCEDURES

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CHIROPRACTIC MANAGEMENT SERVICES, LLC
PROVIDER CREDENTIALING POLICY & PROCEDURES

CREDENTIALING / RECREDENTIALING PROCEDURE

DEFINITIONS

1.1: The terms contained herein shall have the same definitions as those set forth in the Chiropractor Agreement between CMS and all of its CMS Chiropractors.

GENERAL

2.1: The credentialing/recredentialing process is a review of each Chiropractor's credentials, education, training, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history, professional competency, physical and mental health, and adherence to professional ethics for the purpose of granting participation in the Chiropractic Management Services, Inc. (CMS) network. Credentialing is not delegated to outside agents. The credentialing process includes verification that the information obtained is accurate and complete. The provider must respond to any reasonable CMS request for additional information including, but not limited to, a chiropractic record review, as well as applicable site visits. Chiropractic providers of CMS have been and will continue to be selected on the basis of detailed membership criteria developed to better assure three major objectives:

- Chiropractic care will be convenient and readily accessible for CMS members.
- Chiropractic care of a high quality will be provided to CMS members.
- Chiropractic care will be delivered in a cost-effective manner.

2.2: CMS does not make credentialing and recredentialing decisions based solely on the applicant's race, ethnic/national identity, gender, age, sexual orientation or the type of procedures or the type of patients in which the practitioner specializes. CMS also requires that all credentialing committee

members sign a release form stating that they do not discriminate when making decisions about credentialing and recredentialing. Every 6 months the Executive Director will audit the credentialing committee decisions to ensure the committee's decisions are non-discriminatory.

2.3: CMS recognizes the provider's right to review information submitted in support of the credentialing application to the extent permitted by law. This review is limited to information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards); with the exception of references, recommendations or other peer review protected information. The requested information is then disclosed to the provider via written correspondence within 30 days of the provider's request. Providers may obtain information regarding the status of their credentialing or recredentialing process by calling the Provider Relations Department. The provider's rights are disclosed to them in the membership application.

2.4: We are committed to maintaining the complete confidentiality of our provider's personal and professional information to the extent permitted by law. As part of our commitment to confidentiality:

- We will not discuss the names of providers with anyone that is not a part of our business.
- All information about providers and their personal/professional information will be used within our business in a professional manner.
- Provider information will never be provided to a third party unless we have the appropriate consent and/or authorization signed by the provider.
- Provider information is stored in locked file cabinets within the CMS offices. Provider information on the computer is user name and password protected.

Should we ever inadvertently make a mistake regarding the confidentiality of a provider's information, we will immediately do everything possible to correct the error.

2.4.1: Naturally we want to do everything possible to avoid a complaint from a provider

regarding our privacy policy. If a provider asks you how to make a complaint please tell them the following:

- The complaint must name the staff person and describe what the patient believes the person did improperly.
- The law requires that all complaints be in writing.
- The complaint must be filed within 180 days of when the provider knew the problem occurred. Please tell the provider filing a complaint that we will do everything possible to resolve the problem. Let them know that the office manager will be in touch with them as soon as possible. If a provider files a complaint, it should be given to the office manager immediately.

2.4.2: Whenever we change our notice we will immediately replace that notice that is on public display and make the notice available to our provider's on request. We will also make sure that each employee had received a copy of the notice and has read and understands that notice. We will retain a copy of each of our notices for the six years required by the law.

2.4.3: It is unfortunate, but it may be necessary to discipline an employee that violates the provider's right to privacy or does not follow our policies and procedures. We will do our best to understand any extenuating circumstances before we take disciplinary action.

Our disciplinary Actions can include:

- Warnings (oral)
- Reprimands (written)
- Probation

- Demotion
- Temporary suspension
- Discharge of employment
- Restitution of damages
- Referral for criminal prosecution

Any disciplinary action will be documented in the employment file of the staff person. The file will contain specific information including:

- The date of incident
- The name of reporting party
- The name of the person responsible for taking action
- Follow-up action taken

APPLICATION PROCESS

3.1: In order to be eligible for membership in CMS, the applying Chiropractor must furnish documentary proof that he/she meets the following requirements and any others as determined by the CMS Articles of Incorporation, By-laws, and Board of Directors.

3.2: Provider candidate completes and signs the CMS Membership Application, and sends it to the CMS office, along with copies of his/her State Chiropractic License, DEA Certificate (if applicable), Chiropractic College Diploma, and Malpractice Insurance Declaration Page for review.

3.3: Random patient records and x-rays are requested with the application and are then reviewed to check quality (i.e., patient notes are complete, legible and in SOAP format).

CREDENTIALING PROCESS

4.1: Upon receipt of a completed membership application, the CMS Director of Provider

Relations handles the primary credentialing as follows (CMS credentialing is not delegated to outside agents):

4.1.1: The application form is reviewed for missing or incomplete information. Random patient records and x-rays must accompany any application for membership. Work history verification must be initialed and dated by the CMS Director of Provider Relations. All on-line (electronic) verifications must have the initials of the reviewer and the date of the review on either the actual verification document or on the checklist/profile. All application supporting documentation (i.e. DEA, CDS, and insurance certificate) must be date-stamped.

4.1.2: The candidate's State chiropractic license is verified with the state(s) Department of Regulation and Licensing of the Chiropractic Examining Board where the applicant is practicing (primary source verified through the applicable State Licensing Board and confirmed annually by CMS). The candidate must hold a valid, unrestricted license to practice as a chiropractor in the states(s) where the applicant is practicing and not have been subject to any disciplinary actions by the state(s) Department of Regulation and Licensing of the Chiropractic Examining Board. Disciplinary actions include, without limitation, license revocation or suspension, probation, or limitations of practice, if they have had disciplinary actions it is the provider's responsibility to provide all details and documentation of said discipline. Candidate must provide full details of any malpractice claims. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. The candidate's education is verified with the applicable state(s) Department of Regulation and Licensing, where the applicant is practicing (primary source verified through the applicable State Licensing Board and confirmed annually by CMS). If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provider written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the

documentation form the provider, the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

4.1.3: The candidate's name/business entity is searched in the Health and Human Services OIG Exclusion database for provider specific information. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provider written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

4.1.4: The candidate's name/business entity is searched in the Excluded Parties Listing System (EPLS) database for provider specific information. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provider written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given

ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

4.1.5: Letters are sent to current (and past, if applicable) malpractice carriers to inquire about any malpractice history for the past five (5) years or from the initial date as a practicing provider if chiropractor is a recent graduate. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provider written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

4.1.6: Letters are sent to the candidate's current malpractice carrier to confirm that malpractice insurance coverage is current, and coverage levels meet our minimum requirements. The candidate must maintain policies of professional liability insurance of not less than $1,000,000 per claim and $3,000,000 in the aggregate. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provider written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update

all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

4.1.7: CMS is a subscriber to CIN-BAD (Chiropractic Information Network - Board Actions Databank), an on-line service of the Federation of Chiropractic Licensing Boards. CIN-BAD maintains a national database of board actions reported by each U.S. state chiropractic regulatory licensing board, and/or exclusions from Medicare/Medicaid reimbursement by Health & Human Services. CIN-BAD is recognized by NCQA as an acceptable source for agencies to check for chiropractic board actions as part of the credentials verification processes. Via the Internet, CMS queries CIN-BAD for any history of board actions. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provider written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update any and all forms which will be presented to the Credentialing Committee. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

5.1: The CMS Executive Director reviews the monthly Report of Decisions obtained from the State of Wisconsin Department of Regulation and Licensing and also verifies that primary credentialing has been completed for each membership application received. The candidate's application, random patient records and x-rays (if submitted for review) and corresponding credentialing information is then

presented by the CMS Executive Director at the next monthly Credentialing Committee meeting for review by the Credentialing Committee (a heterogeneous committee comprised of 3 practicing chiropractors who are members in CMS and the CMS Chiropractic Services Director). Evidence of injurious and/or poor quality care is a basis for exclusion from membership in CMS and reported to the State. The Executive Director signs log sheet to confirm the reports have been reviewed.

5.2: The CMS Executive Director reviews the Monthly Report from the State of Wisconsin OCI to make sure that any CMS network providers or applicants have not had any action against them. Also reviewed by the Executive Director on a monthly basis is the OIG Sanction report from CMS. The Executive Director signs log sheet to confirm the reports have been reviewed. The response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting.

6.1: At the monthly Credentialing meetings, the membership applications, medical records, and x-rays are reviewed based on a numeric scale as decided by the credentialing committee. All information provided is no more than 180 calendar days old at the time of the credentialing review. To be approved for a full CMS membership with no restrictions/conditions the provider must score a minimum of 12 for medical records and a minimum score of 30 on their x-rays. To receive a conditional approval (which requires a 6 month re-review of patient records and x-rays) the provider must score a minimum of 10 for medical records and a minimum score of 25 for their x-rays. If a provider has not submitted their random x-rays and patient notes, they will receive a conditional approval which will include suggestions on how provider can become compliant with the CMS credentialing standards and will be subject to review of those items in the next six months. Once a provider has been approved, on-site credentialing interviews are assigned to the CMS Executive Director, or his designee. The CMS Director of Provider Relations, or his/her designee, takes the minutes of the Credentialing Committee meetings. The following is reviewed at the on-site interviews:

6.1.1: Candidates must have a minimum of one year of actual experience as a practicing

Chiropractor if applying to the CMS network as a sole Chiropractor. Chiropractor associates with less than one year actual experience that are under the guidance of an existing experienced CMS Chiropractor are eligible for consideration.

6.1.2: If candidate is requesting to be added as an associate at an existing CMS provider office, and it has been more than 24 months since the initial visit to that office, an on-site interview is conducted by the CMS Director of Provider Relations, or his/her designee. The associate will be conditionally approved and will be re-credentialed six months after their initial date. This re-credential will include a review of random patient records and x-rays.

6.1.3: The candidate must maintain patient care records that document and substantiate chiropractic care rendered.

6.1.4: Although it is preferred, it is not required that the candidate have on-site x-ray equipment. If acceptable arrangements have been made for patient x-rays, the CMS Board of Directors reserves the right to approve or decline membership in CMS.

6.1.5: The quality of the staff and overall office operations is assessed. The candidate must maintain sufficient and appropriate facilities and staff to provide quality, cost-effective chiropractic care; schedule regular office hours each week for direct patient care with 32 hours being the minimum requirement; be available for telephone consultations for patients during and after normal office hours; and maintain 24 hour emergency service.

6.1.6: The compliance of HIPAA is assessed in the on-site interviews. Providers must be HIPAA compliant for membership in CMS.

6.1.7: If the total number of years that a Chiropractor applicant has been in practice and the number of years at his/her current location differs, it is reviewed at the on-site interview. Clarification of any gaps is reported back to the CMS Board of Directors for their consideration and final decision.

6.1.8 During the onsite interview the following additional items are discussed: Space

available, number of patients seen per day, monthly new patient volume & HIPAA compliance. The HIPAA compliance is rated on a 0-5 scale. The minimum passing score is 13. If a provider falls below the minimum required score they will be reviewed every 60 days until they are passing.

7.1: Reports of on-site credentialing interviews are reviewed at the next monthly Board of Directors meeting for a decision of acceptance/denial of candidates' applications to the CMS provider network.

7.1.1: For those candidates who are approved, an approval notice and two CMS provider agreements are mailed to them for their signature within sixty (60) days of said approval. They are also sent a copy of the CMS Administrative Manual which includes additional contractual language regarding claim submission procedures, Grievance and Appeal processes, and notification of the provider's rights. The signed agreements are returned to CMS for our execution and then one original copy is forwarded to the provider for their records. If a provider requests status on their credentialing, the office staff refers to the CMS log sheet to see if any information is still outstanding and if their file is complete, then provider is notified of the next credentialing committee meeting date. Upon approval by the committee, network notifications are sent via email and an effective date is given. At this time a welcome letter is sent to the provider stating their effective date.

7.1.2: If a candidate is denied membership to the CMS provider network, written notice is sent to the chiropractor stating the reason for denial, along with suggestions from the Credentialing Committee on what the provider needs to do to become compliant with the credentialing standards and guidelines. The chiropractor is advised that he/she has the opportunity to correct any information, which may be incorrect. The chiropractor's written response must be mailed to CMS within 10 days from receipt of the notice he/she received. Upon receipt of response from provider, this information is then re-presented to the credentialing committee as the next scheduled meeting.

NOTE: If a candidate is denied membership based on quality of patient care, it is reported to the State.

7.1.3 All candidates, regardless of the decision, are notified in writing within 60 days of the date of decision by the CMS Board of Directors. The provider is notified via mail and/or email the status of their application as a Welcome letter or if denied, a letter of denial with reasons stated. Upon termination with the network, provider is notified via certified mail of their termination effective date per their contract and the reasons for termination. This letter is signed by the Executive Director. Any change in status is received by CMS either by fax or mail from the provider and scanned to our Provider Relations to be entered on CMS Log sheet and Network Notifications are sent to all networks the provider is contracted with through CMS and the appropriate effective date assigned.

7.1.4 The credentialing and recredentialing processes are performed under the oversight of the Chiropractic Services Director (CSD).

RECREDENTIALING PROCESS

1.1: A Provider Recredentialing Form is sent to all CMS providers every 36 months. They are requested to complete the form, sign it, and return the form to CMS along with current copies of their State license (every other year), DEA certificate (if applicable), and declaration page of the malpractice insurance coverage.

2.1: Upon receipt of a completed provider recredentialing form and supporting documentation, the CMS Director of Provider Relations handles the primary recredentialing as follows:

2.1.1: The recredentialing form is reviewed for missing or incomplete information. If missing information, CMS staff will call provider to inform them of needed information and provider will be given a date to comply which is one week. If still no response after one week, CMS will send a certified letter indicating non-compliance. If no response within 2 weeks, then termination procedures will follow. All application supporting documentation (i.e. DEA, CDS, and insurance certificate) must be date-stamped. All on-line (electronic) verifications completed must have the initials of the reviewer and

the date of the review on either the actual verification document or on the checklist/profile.

2.1.2: The chiropractor's State license is verified with the state(s) Department of Regulation and Licensing of the Chiropractic Examining Board (primary source verified through the applicable State Licensing Board and confirmed annually by CMS). The CMS provider must hold a valid, unrestricted license to practice as a chiropractor in their State and not have been subject to any disciplinary actions by the state(s) Department of Regulation and Licensing of the Chiropractic Examining Board. Disciplinary actions include, without limitation, license revocation or suspension, probation, or limitations of practice, if they have had disciplinary actions it is the provider's responsibility to provide all details and documentation of said discipline. The CMS provider must provide full details of any previous, current, or future malpractice claims. The candidate's education is verified with the applicable state(s) Department of Regulation and Licensing, where the applicant is practicing (primary source verified through the applicable State Licensing Board and confirmed annually by CMS). The Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provide written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

2.1.3: Letters are sent to current (and past, if applicable) malpractice carriers to inquire about any malpractice history for the past five (5) years or from the initial date as a practicing provider if

chiropractor is a recent graduate. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provide written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

2.1.4: Letters are sent to the provider's current (and past, if applicable) malpractice carriers to inquire about any malpractice history and malpractice insurance coverage levels are confirmed with current malpractice carrier. The CMS provider must maintain policies of professional liability insurance of not less than $1,000,000 per claim and $3,000,000 in the aggregate. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provide written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

2.1.5: The Chiropractic Information Network - Board Action Databank (CIN-BAD), a service of the Federation of Chiropractic Licensing Boards, is queried for any malpractice history. CIN-BAD reports include any chiropractic board actions (for each U.S. state) and federal Department of Health and Human Services exclusions. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting if necessary. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provide written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

2.1.6: The candidate's name/business entity is searched in the Health and Human Services OIG Exclusion database for provider specific information. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provide written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

2.1.7: The candidate's name/business entity is searched in the Excluded Parties Listing System (EPLS) database for provider specific information. Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. If in searching and verifying the provider's submitted information CMS becomes aware of any discrepancy CMS will provider written notice to the provider within five (5) business days of discovering the discrepancy. The notice will direct the provider to submit all information to the Director of Provider Relations. Upon receipt of the documentation form the provider the Director of Provider Relations will review and make sure to update all forms which will be presented to the Credentialing Committee. The provider is given ten (10) business days from the date of the letter to respond to the discrepancies. If the provider fails to respond within the designated time frame, then the application does not proceed in the credentialing process and the provider is notified in writing that his or her application is no longer in process.

3.1: The CMS Executive Director reviews the monthly Report of Decisions obtained from the State of Wisconsin Department of Regulation and Licensing and also verifies that primary recredentialing has been completed for each CMS provider. The recredentialing information is then presented by the CMS Executive Director at the next monthly Credentialing Committee meeting for review by the Credentialing Committee (a heterogeneous committee comprised of 3 practicing chiropractors who are members in CMS and the CMS Chiropractic Services Director.) All information provided is no more than 180 calendar days old at the time of the recredentialing review. Evidence of injurious and/or poor quality care by a CMS provider is a basis for termination from membership in CMS and reported to the State. The Executive Director signs log sheet to confirm the reports have been reviewed.

3.2: The CMS Executive Director reviews the Monthly Report from the State of Wisconsin OCI to make sure that any CMS Network providers or applicants have not had any action against them. Also reviewed by the Executive Director on a monthly basis is the OIG Sanction report from CMS.

Response/report is added to credentialing packet which will be given to the Credentialing Committee at the next meeting. The Executive Director signs log sheet to confirm the reports have been reviewed.

3.3: The credentialing and recredentialing processes are performed under the oversight of the Chiropractic Services Director (CSD). Upon approval, notification is sent via email.

AMENDMENT

5.1: This Credentialing/Recredentialing Procedure may be amended, in whole or in part, by the Credentialing Committee and/or CMS Board of Directors.

CHIROPRACTIC MANAGEMENT SERVICES, LLC
PROVIDER CREDENTIALING POLICY & PROCEDURES

GRIEVANCE PROCEDURE

DEFINITIONS

1.1: The terms contained herein shall have the same definitions as those set forth in the Chiropractor Agreement between CMS and all of its CMS Chiropractors.

GENERAL

2.1: This Grievance Procedure ("Procedure") shall be the sole method for the resolution or other disposition of any and all grievances, disputes or complaints by any Eligible Person against any CMS Chiropractor or any employees, officers, or representatives of any such CMS Chiropractor, which arise out of the relationship between the Eligible Person and the CMS Chiropractor created by the Payor Agreements ("Grievance").

FILING AND NOTICE

3.1: Eligible Persons may institute a grievance against a CMS Chiropractor by providing written notice to the CMS Chiropractor or to CMS which includes a statement of the grievance and all information, documentation, or other evidence in support of the grievance upon which the Eligible Person relies. The written notice must be given within thirty (30) business days of the date of the incident giving rise to the grievance.

3.2: In the event a CMS Chiropractor shall receive the written notice, the CMS Chiropractor shall promptly send a copy of the notice to CMS. In the event CMS shall receive the written notice, it shall promptly send a copy of the notice to each CMS Chiropractor named therein.

3.3: Within twenty (20) business days of its receipt of the written notice or copy described in 3.2, the CMS Chiropractor or CMS, as applicable, shall provide the Eligible party with written notice of

its compliance with these notification requirements.

GRIEVANCE REVIEW

4.1: Upon receipt of a written notice of a grievance filed by an Eligible Person, CMS shall promptly take all steps deemed reasonably necessary by CMS to investigate the grievance. CMS may delegate any such duty to any committee of CMS so authorized or to any Participating Chiropractor not named in the grievance.

4.2: Within thirty (30) business days of the written confirmation described above, the Participating Chiropractor and Eligible Person shall select an arbitrator, and, in the event they are not able to select an arbitrator, each party shall select its own arbitrator and such arbitrators shall together select a third arbitrator.

4.3: Within sixty (60) business days of the written confirmation described above, the arbitrator(s) shall issue a ruling. The ruling shall state the decision of the arbitrator(s) and shall direct that any party take such actions as may be necessary to comply with the ruling. The ruling shall specifically describe such actions and indicate a reasonable date by which such actions must be substantially performed. Failure to comply with a ruling shall constitute separate grievable conduct.

4.4: Within seven (7) business days of issuance of the ruling, CMS shall send a copy of the ruling to the Eligible Person and to each party that was required to have received notice of the grievance. The ruling shall be final, conclusive and binding upon the CMS Chiropractor and the Eligible Persons. The Eligible Person shall have no right to appeal the ruling, in whole or in part, to any other entity within CMS, or to any entity which has contracted with CMS.

THIS PROCEDURE SHALL NOT GOVERN THE FOLLOWING

5.1: The resolution of any allegation by an Eligible person which, in the sole judgment of CMS, constitutes a claim of malpractice against any participating Chiropractor; or the resolution of any dispute against any Payor regarding coverage or claims.

MISCELLANEOUS

6.1: Notices shall be written and personally delivered, effective on delivery, or sent by certified mail, return receipt requested, postage prepaid, effective upon receipt, addressed to the parties' last known address, or to any other address specified in writing by such party. Failure to insist upon strict compliance with any of the terms herein (by way of waiver or breach) by any of the parties hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder. This procedure shall be binding upon, and shall inure to the benefit of, the parties hereto and their heirs, personal representatives, executors, administrators, successors and assigns. This procedure shall be governed by the laws of the State of Wisconsin without giving effect to its conflicts of law provisions.

6.2: CMS reports to the appropriate authorities any instances of quality-related suspensions and terminations. Appropriate authorities including but not limited to the State Board, NPDB, and CIN-BAD.

AMENDMENT

7.1: This Grievance Procedure may be amended, in whole or in part, by the CMS Board of Directors.

CHIROPRACTIC MANAGEMENT SERVICES, LLC
PROVIDER CREDENTIALING POLICY & PROCEDURES

CHIROPRACTIC APPEAL PROCEDURE

DEFINITIONS

1.1: The terms contained herein shall have the same definitions as those set forth in the Chiropractor Agreement between CMS and all of its CMS Chiropractors.

SCOPE OF PROCEDURE

2.1: This Procedure governs the rights of a CMS Chiropractor who contests a decision by CMS to take any adverse action including but not limited to: limit, suspend, or terminate a Chiropractor Agreement by and between such CMS Chiropractor and CMS pursuant to the CMS Chiropractor Agreement.

2.2: This procedure shall govern only the appeal of any adverse action unless otherwise required by applicable law, shall not apply to the denial of an application for initial membership in CMS.

NOTICE OF TERMINATION; APPEAL

3.1: CMS shall provide the Chiropractor with written notice of any adverse action within thirty (30) business days of the decision, which shall contain the reason(s) for such action. The Chiropractor must submit to CMS a written request to appeal the adverse action within thirty (30) business days of the receipt of the notice. Failure to request an appeal within such period shall constitute a waiver of the right thereto, and the adverse action shall be conclusive and binding upon the Chiropractor and CMS. Such action(s) shall be a final decision of CMS as of the date of such waiver, and the Chiropractor shall have no further right to contest the decision.

NOTICE OF HEARING

4.1: CMS shall arrange for a hearing to be held promptly following the request for appeal. CMS

shall impanel a committee to conduct the hearing. The committee shall be composed of three (3) CMS Chiropractors: one (1) selected by the Chiropractor, one (1) selected by CMS, and one (1) selected by the other two (2) committee members. No affiliate of the terminated Chiropractor shall serve on the committee. The committee members shall appoint a chairman of the committee from their number.

CONDUCT OF HEARING

5.1: The scope of the hearing shall be limited to the matters stated in the notice of adverse action described in The Chiropractor Agreement. The hearing shall be conducted in accordance with the then current Arbitration Rules of the American Arbitration Association.

5.2: Notwithstanding the foregoing, the parties shall have the following rights: to introduce oral or written evidence, to request that witnesses testify, to cross-examine witnesses on any matter relevant to the issue of the hearing, to challenge witnesses, and to rebut any evidence. Whether or not the Chiropractor testifies in their own behalf, they may be cross-examined. The Chiropractor shall have access to all material submitted to the committee.

5.3: The Chiropractor has the burden of proving, by a preponderance of the evidence, that the adverse action lacks any substantial factual basis or that the basis or the conclusions drawn therefrom are either arbitrary or unreasonable. The Chiropractor also has a right to be represented by an attorney or another person of their choosing.

5.4: Upon the request of the Chiropractor, and at their own cost, the committee shall maintain an accurate record of the hearing by use of a court reporter, an electronic recording device and a detailed transcription or minutes of the proceedings. A copy of the record shall be provided to the Chiropractor upon request.

COMMITTEE RECOMMENDATION; CMS DECISION

6.1: The committee shall, within five (5) business days of the conclusion of the hearing, issue and notify CMS of its recommendation either to confirm or reject the adverse actions and the reason therefore, and promptly notify the Chiropractor of such recommendation. Within ten (10) business days following its receipt of the committee recommendation, the Board of Directors of CMS shall issue a final decision to either confirm or reject the adverse action, and shall provide prompt notice of such decision to the Chiropractor. All costs with respect to the hearing shall be borne by the losing party.

MISCELLANEOUS

7.1: Notices shall be written and personally delivered, effective on delivery, or sent by certified mail, return receipt requested, postage prepaid, effective upon receipt, addressed to the parties' last known address, or to any other address specified in writing by such party. Failure to insist upon strict compliance with any of the terms herein (by way of waiver or breach) by either party hereto shall not be deemed a continuous waiver in the event of any future breach or waiver of any condition hereunder. This procedure shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective heirs, personal representatives, executors, administrators, successors and assigns. This procedure shall be governed by the laws of the State of Wisconsin without giving effect to its conflicts of law provisions.

AMENDMENT

8.1: This Chiropractic Appeal Procedure may be amended, in whole or in part, by the CMS Board of Directors.

CHIROPRACTIC MANAGEMENT SERVICES, LLC
PROVIDER CREDENTIALING POLICY & PROCEDURES

PROFESSIONAL REVIEW PROGRAM

DEFINITION

1.1: Professional review is the all-inclusive term for Chiropractic review efforts. In general, it includes quality assurance, a review of utilization, a review of records, a review of appropriateness of charges, and a review of medical necessity for services rendered. Professional review is not intended to provide a basis for rationing services. Professional review allows for the establishment of norms for diagnostic, therapeutic, and appropriate practice.

GOALS

2.1: Primary concerns: accessibility of chiropractic health services in accordance with contractual obligations; assurance of quality chiropractic services to enrollees; delivery of chiropractic services at a cost which is fair to the provider, to CMS and to the Insurers.

2.2: Control of providers, covered services, outside referrals, and non-covered services should be delegated to the professional review process.

2.3: Utilization of systematic data collection of performance and patient results and provision of interpretation of such data to the practicing providers.

RESPONSIBILITIES OF CMS

3.1: CMS accepts the responsibility of the day-to-day operations of the professional review process. CMS is responsible to report the results of professional review as required by the Board of Directors.

ORGANIZATIONAL STRUCTURE

4.1: Professional review has two parts - Utilization Review and Quality Assurance.

The UR/QA Committee consists of from three to eight CMS members and shall include the CMS Chiropractic Services Director.

4.1.1: The Committee meets, on a quarterly basis, to handle UR/QA problems.

4.1.2: The Committee is responsible for the adjudication of problems, on a timely basis, arising between plan participants, providers, CMS and the Insurers.

4.1.3: The Committee is responsible for utilization review, determination of over- and under-utilization, and taking appropriate action upon the discovery of these conditions.

4.2: The Utilization Review process is divided into three parts: prepayment review, post-payment review, and policy guidelines.

4.2.1: For certain contracts, CMS requires a Treatment Plan to be completed immediately after the initial evaluation of a patient is completed and the decision to treat the patient has been made.

4.2.2: Pre-payment review deals with diagnosis, Treatment Plans, and projected utilization. This form of review is applied by the CMS Chiropractic Services Director before the initial processing of the claim form.

4.2.3: Post-payment review monitors and evaluates the quality of the services rendered. This form of review utilizes the data generated through claims processing and examines patterns developed over a period of time.

4.2.4: For certain contracts wherein Treatment Plans are utilized, claims may be rejected or reduced payment made if the Committee determines that services rendered are outside the norms established through the data review. Services will not be covered if they are not reasonable and necessary for the prevention, diagnosis, or treatment of disease, illness or injury.

4.2.5: This process establishes and promotes a level of service that is fair to both enrollees and the provider within established cost constraints.

GUIDELINES

5.1: Policy Guidelines are intended to provide CMS, the CMS Chiropractic Services Director, and the Committee with the ability to establish consistent and predictable practice patterns throughout provider network.

5.2: The guidelines are established from: assembled utilization data and suggestions and recommendations submitted by providers in the network. These suggestions and recommendations may be submitted to the Executive Director, the President, or the Chiropractic Services Director.

AMENDMENT

6.1: This Professional Review Procedure may be amended, in whole or in part, by the CMS Board of Directors.