Comparative Practice Patterns Review (CPR)
&
Code Audit Programs

Health Network Solutions

(Revised January 2026)

HNS

HNS is a clinically integrated network (CIN) and our mission is to make healthcare more accessible, more effective, and more affordable.

Understanding Clinical Integration

Clinical integration (CI) tends to have many definitions and is not a firm set of principles or practices. In simple terms, *clinical integration is a continuous process that supports the* ***triple aim of healthcare****:*

- Improving quality of care
- Reducing or controlling the cost of care
- Improving access to care and the overall patient experience

Our Responsibility

We all have a responsibility to help make our healthcare system more efficient.

As part of a CIN, each of us has committed to *work together* to improve the quality and cost-effectiveness of care we provide to our patients.

The HNS CPR Program

CPR Program

The HNS CPR Program
helps us to achieve two of our CI objectives:
improving quality of care and helping to control the cost of care.

CPR Program

HNS promotes the delivery of effective, cost-efficient healthcare by:

- Providing continuing education;
- Developing policies and procedures which promote effective, cost-efficient healthcare;
- Developing ‘Best Practices’ intended to improve the safety of care provided, improve quality and treatment outcomes, and ensure the delivery of cost-efficient healthcare.

CPR Program

HNS promotes the delivery of effective, cost-efficient healthcare by:

- Establishing cost-efficiency performance goals for physicians and the network as a whole and evaluating performance against these goals.

CPR Program

HNS promotes the delivery of effective, cost-efficient healthcare by:

- Regularly sharing objective and actionable data regarding the physician's individual practice patterns, the practice patterns of his/her peers in the HNS Network, and the costs of the care provided (and regularly sharing data regarding the network's performance as a whole).

- Identifying physicians whose CPRs reflect the *consistent delivery of cost-efficient care,* and rewarding those physicians via a reduction to their HNS administrative withhold;

CPR Program

HNS promotes the delivery of effective, cost-efficient healthcare by:

- Identifying sub-optimal practice patterns and providing education and counseling to improve performance, and by providing a time period to allow the physician an opportunity to improve performance;
- Taking remedial action (*up to and including termination of participation in the HNS Network*) if performance does not improve within the time period provided.

CPR Program

The Program evaluates both individual physician's and the network's aggregate performance against performance goals, identifies patterns and instances of potentially suboptimal healthcare practices, and as applicable, seeks to modify performance to improve efficiencies the CPR Program was designed to produce.

Through the use of performance tiers, financial rewards, and recognition programs, the CPR Program aligns incentives, penalizes under-performance, and rewards the delivery of cost-efficient care.

The program is designed to improve transparency; allowing members to make better-informed healthcare decisions and promote steerage to the most cost-efficient physicians.

Statistically Significant Data

To help to ensure the statistical relevance of data utilized in the CPR Program when establishing performance goals and in gauging physician and network performance, with few exceptions, the CPR Program relies on **12 consecutive months of claims data.**

To appropriately evaluate physician cost-efficiency, for each physician, as a general rule, a minimum of 50 patients per plan and per review period is required.

CPR Program Foundation

The HNS CPR Program is based on the core tenet that physicians should be able to make treatment decisions based upon their own clinical judgments.

The CPR Program
does not include medical necessity determinations.

Scope of CPR Reviews

CPR reports are statistical reviews
of the individual physician's performance relative to costs
and practice patterns and include a comparison of the physician's data to
the *collective* costs and practice patterns of his/her peers in the
HNS Network.

The program does not mandate the number or type of services physicians should provide or the length of time in which care should be provided; those decisions are determined by the treating physician. However, **HNS' Policies and Best Practices must be followed** when providing care to members whose healthcare plans contract with HNS.

The program does not include the approval or denial of the provision of, or payment for, any healthcare services.

Performance Metrics

The metrics utilized in the CPR Program,
against which physician performance is measured,
are based on the
***collective* costs and practice patterns**
of the physicians in the HNS Network.

Average Cost Per Patient (CPP)

The **average cost per patient** is the cornerstone of the CPR program's performance targets.

The CPR Program utilizes the **average cost per patient** as the primary metric when evaluating both physician and network cost-efficiency and when identifying opportunities for improvement.

Network
Average Cost Per Patient

Each year, based on claims data submitted by the entire physician network during the previous year, HNS determines the HNS Network's **average cost per patient** for each healthcare plan included in the review process**.**

The network's average cost per patient is obtained by dividing the total of all contracted allowables (costs) associated with claims submitted through HNS for a specific healthcare plan by the entire HNS physician network by the total number of patients associated with those claims for a defined period of time.

$$\frac{\text{Network's total allowables}}{\text{Network's total patients}} = \text{Network's Average Cost Per Patient}$$

Physician's Average Cost Per Patient

For each plan reviewed, the physician's average cost per patient is obtained by dividing the total of the physician's contracted allowables associated with claims submitted through HNS by the physician's total number of patients associated with those claims for a defined period of time.

$$\frac{\text{Physician's total allowables}}{\text{Physician's total patients}} = \text{Physician's Average Cost Per Patient}$$

Costs Excluded from Physician's Average Cost per Patient (S8990 – Wellness Care)

As chiropractors, we know that wellness and supportive care are essential to good health.

When measuring physician performance, costs and visits associated with wellness care (as reported using code **S8990)**, ***are removed from the calculation when determining the physician's average cost per patient*.**

Costs Excluded from Physician's Average Cost per Patient (Duplicate Claims & Corrected Claims)

In addition to the removal of costs associated with wellness care (S8990), prior to calculating a physician's average cost per patient, **costs associated with duplicate** and **corrected claims are removed**.

Target Benchmark

Because the *actual* network's average cost per patient
may fluctuate from year to year,
to ensure fair and appropriate performance evaluation,
at the beginning of each calendar year,
a target benchmark for average cost per patient
for each plan is established.

Target Benchmark

This *target benchmark* is used in evaluating performance for the coming year.

The target benchmark may *increase* each year, but will never decrease.

Establishing the Benchmarks

To establish the annual benchmark for “average cost per patient” (per healthcare plan), HNS:

- Calculates the *actual* network “average cost per patient” based on previous year claims data;
- Determines the network average using a trimmed mean approach (removing a small designated percentage of the largest and smallest values before calculating the average);
- Reviews the average case costs for the most frequently reported primary diagnoses for the previous year;
- Analyzes the impact of recent fee schedule increases on network averages;
- Reviews the actual network average for the previous five years.

HNS Target Benchmark

As a general rule,
when establishing the target benchmark,
HNS uses the highest of the following:

- The *actual* network "average cost per patient" based on previous year claims data;
- The network average using a trimmed mean approach;
- The actual network average for the previous five years.

HNS Target Benchmark

If the *actual* network average
has not increased in several years,
and there is a reasonable basis to do so,
the target benchmark may be increased.

HNS Range of Acceptance (ROA)

Variations in types of practices (“specialty” practices), patient demographics, clinical characteristics, co-morbidities, responses to treatment, as well as other factors, can impact a physician’s average cost per patient.

To appropriately allow for these variations,
when measuring physician performance
instead of using the *actual* benchmark, the CPR Program
utilizes a **range of acceptance (ROA)**
from the target benchmark.

HNS Range of Acceptance (ROA)

The ROA provides for a
151% variation from the target benchmark
for average cost per patient.

- Average costs per patient within 151% of the HNS Network average are considered indicative of cost-effective care.
- Average per patient costs in excess of 151% of the benchmark are considered indicative of sub-optimal performance.

Example 1
Cost-Efficient Care

HNS Health Care Plan	HNS Benchmark for Avg. CPP	ROA (within 151% of Benchmark)	Physician's Average CPP	% Relationship to Benchmark (should be within 151% of Benchmark)
Plan A	$500	$0 – $755	$600	120.00%

Dr. John Q. Chiropractor's average cost per patient for this healthcare plan is $600; the range of acceptance for this plan is up to 151% of the benchmark ($755).

This physician's average cost per patient is 120% from the benchmark, which is **within the HNS Range of Acceptance** for cost-efficiency.

(CPP = Cost per patient)

Example 2
Sub-Optimal Performance

HNS Health Care Plan	HNS Benchmark for Avg. CPP	ROA (within 151% of Benchmark)	Physician's Average CPP	% Relationship to Benchmark (should be within 151% of Benchmark)
Plan A	$500	$0- $755	$850	170.00%

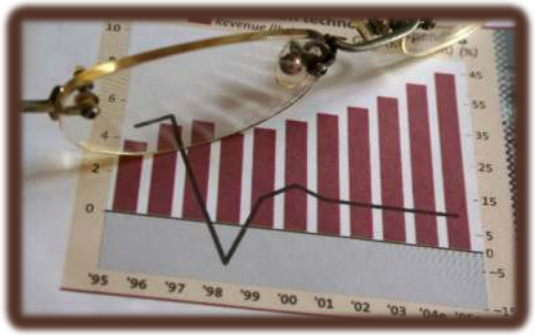
Dr. Annie B. Chiropractor's average cost per patient for this healthcare plan is $850; the range of acceptance for this plan is up to 151% of the benchmark ($755).

This physician's average cost per patient is 170% from the benchmark and is **outside of the the HNS Range of Acceptance for cost-efficiency**.

(CPP = Cost per patient)

Performance Reviews
CPR Reports

HNS regularly evaluates both the individual physician's and the network's aggregate performance against target goals and provides the results of these evaluations to all physicians in the HNS Network.



The program includes
annual and monthly performance evaluations
of individual physicians as well as the network as a whole.

Performance Reviews
CPR Reports

Physician Performance Reviews

Annual reviews are conducted in January of each year and *reflect claims data from the previous calendar year*. Results of annual reviews are sent, via email, to physicians during January of each year.

Monthly reviews are conducted on or before the 10th business day of each month. With few exceptions, *monthly reviews reflect the most recent 12 months of claims data*. Monthly reviews are sent, via email, to physicians during the first two weeks of each month.

Network Performance Reviews

Reviews of the network's aggregate performance are conducted in January of each year, and each subsequent month, and are based on claims data submitted during the previous 12-month period. Results of these reviews are compared to the target performance goals for the network and are published to all physicians each month.

Regular Reviews of CPR Reports

CPR Reports should be carefully reviewed as soon as they are received.

CPR Reports provide **meaningful and actionable data** regarding a physician's practice patterns, those of his/her peers in the HNS Network, and the costs of the care provided.

Red Alerts on the CPR

If certain practice patterns are significantly different from your peers in the HNS Network, the CPR Report will include
"*Area You May Want to Review*"
by the applicable code or category.

The inclusion of this text on the CPR is solely to make you aware of this and is not intended to suggest the utilization shown on the CPR is necessarily either problematic or inappropriate. As noted in the previous slide, the CPRs are intended to provide you with actionable and meaningful information.

Performance Measurement Plan Rankings

Based on the physician's average cost per patient, HNS assigns a performance measurement (**plan ranking**) to each physician *for each reporting period* **for each healthcare plan reviewed**.

For each plan reviewed, for each reporting period, the plan ranking reflects the relationship between the physician's actual average cost per patient and the target benchmark for the specific plan.

Performance Measurement
Plan Rankings

Because performance is reviewed each month
and plan rankings are based on the physician's performance
during each review period,
plan rankings can change from month to month.

Importance of Plan Rankings

As discussed in more detail further in this training (under "**HNS Participation Status**"), the HNS Participation Status and the HNS Administrative Withhold percentage *are based on plan rankings*.

Performance Measurement Plan Rankings

Plan rankings include:

- **Excellent** – Avg. cost per patient is within 115%; (within ROA)
- **Good** – Avg. cost per patient is between 115% & 141%; (within ROA)
- **Caution** – Avg. cost per patient is between 141% & 151%; (within ROA)
- **Probation** – Avg. cost per patient is greater than 151%; (**exceeds ROA**)
- **ID** – indicates insufficient data to gauge cost-efficiency (i.e., the physician has treated less than 50 patients during the review period for the specific plan.)

Performance Measurement
Plan Rankings

Plan rankings of **Excellent, Good,** and/or **Caution** indicate the physician's average cost per patient is *within the HNS Range of Acceptance*!

Plan Ranking of <u>Caution</u>:
Close attention should be paid to a plan ranking of **Caution**!

While a plan ranking of Caution indicates the physician's average cost per patient IS within the HNS ROA, it is on the high end of the ROA. *Should it increase to outside the HNS ROA, the physician's plan ranking will be changed to Probation, which carries the risk of termination from the HNS Network.*

Performance Measurement
Plan Ranking – **Probation**

A plan ranking of **Probation**
indicates the physician's average cost per patient is outside *the HNS Range of Acceptance and carries the risk of termination from the HNS Network.*

Plan Ranking: Insufficient Data (ID)

Plan rankings **beginning with ID**
indicate either:

- During the review period, the physician has provided care to less than 50 patients for a specific plan. As such, there is **insufficient data** to gauge cost-efficiency;

OR

- The physician has not been in the network for 12 months. As such, there is **insufficient data** to gauge cost-efficiency. (HNS requires 12 consecutive months of data to appropriately gauge cost-efficiency.)

Plan Ranking: Insufficient Data (ID)

- If the physician has not provided care to ANY patients relative to the specific plan under review, the physician will have a plan ranking of **"ID".**

- If the physician has provided care to one or more patients for the specific plan during the review period, but less than 50 patients, the **plan ranking of ID will be appended with a sub-classification** to alert the physician to what his/her plan ranking would be had the physician provided care to a sufficient number of patients (50 or more) to gauge cost-efficiency.

Plan Ranking:
ID Sub-classifications

The **sub-classification** added to plan rankings of "ID" represent the variation from the physician's average cost per patient to the target benchmark for the specific review period for each plan.

ONLY if the physician has treated ***one*** *or more patients during the review period* for the plan, *but less than 50,* the plan ranking of ID shall be appended as shown below.

ID-**Excellent:**	Avg. cost per patient is within 115%
ID-**Good**:	Avg. cost per patient > 115% & < 141%
ID-**Caution**:	Avg. cost per patient > 141% & up to 151%
ID-**Probation**:	Avg. cost per patient > 151%

Plan Ranking: Insufficient Data (ID)

Plan rankings of ID, as a general rule, do not negatively impact a physician's standing with HNS.

However, plan rankings can change during each review period so **close attention should be paid to all plan rankings of ID.**

Based on the number of patients treated during the review period, and the physician's average cost per patient for the plan, the plan ranking will change from "ID" to the applicable plan ranking *as soon as there is a sufficient amount of data to gauge cost-efficiency (50 or more patients for the specific plan).*

Plan Ranking:
ID-Caution & ID-Probation

Particular attention should be paid to any plan ranking of **ID-Caution** and/or **ID-Probation**, as these sub-classifications indicate that as soon as the physician has met the threshold for minimum number of patients (50 or more), the physician's plan ranking will change, and the new plan ranking will be based on the physician's average cost per patient for the plan.

For example, if, during a 12-month review period, a physician has 42 patients for Plan A (and a plan ranking of ID-Probation), and the next month the 12-month review shows the physician has provided care to 53 patients for Plan A, the physician's plan ranking will change from ID-Probation to "Probation" *which carries the risk of termination from the HNS Network.*

CPR Participation Status

With few exceptions,
participation status for the coming year
is assigned in January of each year during the annual CPR review and is based on previous year's claims data.

- The participation status is based on the **lowest plan ranking** during the review period (excluding plan rankings of ID).
- With few exceptions, the participation status cannot be changed until the next annual CPR review.

Changes to Participation Status

As a general rule, other than the exceptions noted herein,
the HNS Participation Status cannot be changed
until the next annual review.

- If a physician appeals his/her participation status, the internal HNS Participation status will be changed to "Pending Review" until a review has been completed and a new determination has been made. (Until the internal review process associated with the appeal is complete, CPRs will continue to show the Participation Status assigned prior to the appeal.)

- For newly credentialed physicians with a participation status of ID, *which was assigned because HNS does not yet have 12 consecutive months of claims data*, at month 12, the physician's status will be changed from ID to reflect the applicable status based on the physician's average cost per patient for all plans for the previous 12-month review period.

Changes to Participation Status

- Participation status will be changed for physicians with a status of ID, which HNS assigned *because the physician has not provided any care to any HNS patients during the review period*. At such time as there is a sufficient body of data to gauge cost-efficiency, the HNS Participation Status will be changed, and the new status will be based on the physician's average cost per patient for all plans.

- If, during any review period, CPRs indicate an average cost per patient outside of the HNS Range of Acceptance, the HNS Participation Status will be changed to Probation for a period of 12 months.

- When the physician successfully completes his/her 12-month probationary period, the participation status will be changed to reflect the participation status associated with the physician's average cost per patient during the 12- month probationary period.

CPR Participation Status

Based on the *combination* of the physician's plan rankings, HNS assigns a **Participation Status** to each physician of either:

- **Excellent**
- **Good**
- **Caution**
- **ID (Insufficient data)**
- **Probation**

CPR Participation Status
Excellent, Good, Caution

Physicians whose **participation status**
reflect an average cost per patient within the ROA
(**Excellent, Good, Caution**),
from a cost-efficiency perspective are considered
in good standing with HNS.

CPR Participation Status
Impact to HNS Administrative Withhold

As previously noted, the Participation Status determines the HNS Administrative Withhold charged to each physician.

Those physicians whose participation status indicates the physician is consistently providing cost-efficient care
will be rewarded
via a reduction to the HNS Administrative Withhold.

Evidence of the consistent delivery of cost-effective care is an average cost per patient within the HNS ROA which results in a participation status of Excellent, Good, or Caution.

CPR Participation Status
Excellent

A participation status of **Excellent** is indicative of the consistent delivery of the *most cost-efficient healthcare.*

These physicians are rewarded with the highest reduction to the HNS Administrative Withhold. In addition, physicians with a participation status of **Excellent** receive special recognition as an **HNS Center of Excellence.**

The designation is published with the physician's name in the HNS online physician directory and is designed to improve transparency; allowing members to make better-informed healthcare decisions and may promote steerage to the most cost-efficient physicians.

CPR Participation Status
ID – Insufficient Data

A participation status of “ID” (insufficient data) indicates there is insufficient data for the reporting period to gauge cost-efficiency. **As such, physicians with a participation status of ID are not eligible for a reduction to their HNS Administrative Withhold.**

- A status of ID will be assigned to all newly credentialed physicians who have been in the network less than 12 months, since the HNS CPR Program requires 12 months of data to measure cost-efficiency. At the end of this period, the CPR system will automatically assign a new participation status which shall be based on the physician’s average cost per patient for the previous 12-month period.

- A status of ID will also be assigned to any physician who has not provided care to at least 50 patients for each plan during the review process (i.e., **plan rankings** of ID with or without a subclassification.)

CPR Participation Status
ID – Insufficient Data

- A status of ID will also be assigned to any physician who has not provided ANY covered services to ANY HNS patient during the review period.

  (Participation in the HNS Network is based, in part, on business need. As such, physicians who are not routinely providing care to HNS patients will not be allowed to remain in the HNS Network.)

CPR Participation Status
Probation

Because *continued* participation in the HNS Network requires the consistent delivery of cost-efficient care, if any CPR Reports indicate an average cost per patient outside the HNS ROA, with few exceptions, the physician's participation status will immediately be changed to "Probation." The probation status remains in place for a period of 12 months.

Probation Status
carries the risk of termination
from the HNS Network.

Participation Status: Probation

Physicians with a participation status of **Probation** are provided counseling by one of the HNS Chiropractic Medical Directors and are provided an opportunity to improve performance. However, physicians who do not improve performance during the specified time frame will not be allowed to remain in the HNS Network.

Participation Status: Probation
Mandatory CE Required

Because physician education can positively influence the physician's and the network's ability to consistently deliver effective, cost-efficient care, *within the first 20 days of the probationary period,* physicians will be required to successfully complete an HNS approved six hour continuing education course designed to **help improve quality of care, treatment outcomes and cost-efficiency**.

(This free CE program is available on the HNS Website and has been approved for six CEUs by both the NC and SC Chiropractic licensing boards.)

Probation Status – Expectations

Initial 90-Day Probationary Period

During the 12-month probation period, the physician is given an **initial 90-day period** to improve performance. If the physician's average cost per patient does not improve to within the HNS ROA by the end of the 90-day period, the physician's continued participation in the network is at risk. However, if the physician has not provided care to a sufficient number of patients by the end of the 90-day period (as indicated by a plan ranking of ID), the physician may be given an extension of time.

Remaining Probationary Period

If the physician's average cost per patient improves to within the ROA by the end of the initial 90-day probationary period, but between months 4-12 of the probationary period *again exceeds the HNS ROA*, the physician's continued participation in the network is at risk.

Participation: Probation Status
Subsequent Performance

Physicians who have previously had a
participation status of **Probation**
are at risk of termination from the network if,
subsequent to the end of their 12-month probation period,
their average cost per patient ever again
exceeds the HNS ROA.

Probationary Status
Interim CPR Reports

To *ensure fair and appropriate performance assessment*, performance evaluations during the 12-month probationary period are based solely on claims data for services rendered on or after the onset of the probationary period.

CPR Reports issued during the probationary period are **"Interim" reports.**

Interim CPR Reports

"Interim" CPR Reports are sent to the physician during each month of the probationary period, and each report reflects cost and utilization data *since the onset of the probationary period.*

Interim Reports

ONLY reflect data relative to services provided and billed during the specific period.

Because HNS target benchmarks for average cost per patient are based on a minimum of 12 months of data, Interim CPR Reports compare the physician's average cost per patient to a ROA associated with the *actual* HNS Network average for the same review period.

Participation: Probation Status
HNS Administrative Withhold

HNS Administrative Withhold

If during the 12-month probation period, the physician maintains an average cost per patient within the HNS ROA, following the end of the 12-month period, the physician will be assigned a new participation status, which will be determined by his/her average cost per patient during the 12-month probationary period. At that time, the physician's administrative withhold will be based on the new participation status.

Appeals of Participation Status

Because there could be circumstances when the assigned participation status may not be appropriate, *with few exceptions,* physicians have the right to appeal their participation status *within 30 days of the date the status is first assigned.*

Exceptions:
Because HNS requires 12 consecutive months of claims data for each physician to appropriately gauge cost-efficiency, health care professionals may not appeal their participation status during the first 11 months of participation in the Network.

Further, to appropriately gauge cost-efficiency, the program requires a minimum of at least 50 patients for each plan. For this reason, participation status linked to plan rankings of ID cannot be appealed.

Appeals of Participation Status

To appeal, the physician must submit a written notice to HNS *within 30 days of the date the status is first assigned.* The notice must include the specific reasons why the physician believes reconsideration of the participation status should occur. (Health care professionals may submit copies of health care records to support their appeal.)

- *There must be a legitimate basis for an appeal.*
- *Promises to improve and maintain an average cost per patient going forward are not acceptable grounds for reconsideration of the assigned status.*
- *Disagreeing with the CPR program parameters and/or the methodology for establishing averages utilized in the CPR program is not considered an acceptable basis for reconsideration of the assigned status.*

Appeals of Participation Status

Upon the timely receipt of the notice,
HNS will change the physician's participation status to
“Pending Review” until a review has been completed and final
determination has been made.

Appeals of Participation Status

No Appeal

If the physician chooses NOT to appeal his participation status, HNS concludes the physician does not dispute the data included on the CPR, the assigned participation status, and, as applicable, understands that termination of network participation may occur if performance does not improve within the specified period of time.

Putting It All Together…

The following slide provides a summary
of the impact of plan rankings and Participation status,
and the impact to the HNS Administrative Withhold.

Putting It All Together

Combination of all plan rankings determine HNS Participation Status	HNS Participation Status	HNS Administrative Withhold	"Center of Chiropractic Excellence" Designation
All plan rankings of Excellent OR any combination of plan rankings of Excellent and/or ID	**Excellent**	**Lowest Administrative Withhold**	
All plan rankings of Good OR any combination of plan rankings of Excellent, Good and/or ID	**Good**	Reduced Administrative Withhold	N/A
All plan rankings of Caution OR any combination of plan rankings of Excellent, Good, Caution and/or ID	**Caution**	Reduced Administrative Withhold (same % as "Good")	N/A
All plan rankings of ID (Insufficient Data)	**ID**	**Standard HNS Administrative Withhold**	N/A
All plan rankings of Probation OR any combination of plan rankings of Excellent, Good, Caution, Probation and/or ID	**Probation**	**Standard HNS Administrative Withhold**	N/A

Peer-to-Peer Support

The HNS Chiropractic Medical Directors are available to all network physicians to provide initial and ongoing support.

The HNS Chiropractic Medical Directors will, at a minimum, contact physicians with a new participation status of "**Caution**" and those with a participation status of "**Probation**," and will do so within the first two weeks of the assignment of the status.

Physician outreach is intended to ensure the physician's understanding of the HNS CPR Program, the data included on CPR Reports, HNS Policies and Best Practices which promote the delivery of effective, cost-efficient care, and the physician's responsibility to comply with those policies.

Actions to Improve Performance

The following remedial actions may be taken in an effort to improve physician performance:

- Requirement to review HNS and Payor Policies and/or other pertinent information;
- Requirement to obtain additional continuing education;
- Requirement to submit copies of healthcare records for review for compliance to HNS and/or Payor Policies;
- Termination of participation;
- Reporting the physician to authoritative bodies, including licensing board, NPDB, OIG, etc.; and
- Other remedial actions as may be determined appropriate by HNS.

Termination
Failure to Meet Responsibilities

We all have a responsibility to help ensure a more efficient healthcare system and an obligation to ensure that services we provide to members of contracted healthcare plans are provided in an *effective, yet cost-efficient* manner.

HNS values the participation of each network physician and will make reasonable efforts to avoid the termination of participation of a physician. However, HNS cannot achieve its CI objectives if a physician does not consistently demonstrate his/her commitment to providing cost-efficient healthcare.

With few exceptions, physicians whose average costs per patient are not consistent with cost-efficient care, pursuant to *CPR Program parameters*, within the time frames established to demonstrate improvement, and who did not appeal their participation status, will be terminated from the HNS Network.

Appeals of Termination Decisions

With few exceptions,
physicians have the right to appeal decisions to
terminate their participation from the network.

If a physician appeals the termination decision, the physician must submit a written notice of appeal to HNS within 30 days of the date shown on the notice of termination. The written notice must include the specific reason(s) why the physician believes reconsideration of his/her network participation should occur. *(Disagreeing with HNS CPR Program and Policies is not considered an acceptable basis for reconsideration of a termination decision.)* Information regarding the appeals process, as applicable, will be included in the *Notice of Termination* issued to the physician.

Rejoining HNS Following Termination or Multiple Probationary Periods

Physicians who have been terminated from the HNS Network pursuant to the CPR Program *may be* allowed to rejoin after a period of time.

IMPORTANT:

Generally, however, physicians who are terminated from the HNS Network pursuant to the CPR Program a third time **OR** *who have been on Probation three previous times* ***will be ineligible to rejoin***.

The HNS Code Audit Program

Code Audit Program

The HNS Code Audit Program
also helps us achieve the two CI objectives of *improving quality of care and helping to control the cost of care.*

Code Audit Program

Consistent with our responsibility to promote quality and cost-efficient healthcare, and educate providers on a semiannual basis, HNS conducts reviews of Network Physicians' individual utilization of certain services (*i.e.,* CPT/HCPCS codes) that may:

- Indicate quality of care issues;
- Indicate sub-optimal utilization; and,
- Subject the physician to close scrutiny of the physician's practice patterns by contracted healthcare plans.

Statistically Significant Data

To help to ensure statistical relevance, the Code Audit Program generally requires that a physician have a minimum of 50 patients over the previous 12 months before performing a review of his/her utilization of any code.

Codes Reviewed & Review Criteria

The CPT/HCPCS codes that are reviewed, and criteria for review, are chosen based on utilization trends and data from a variety of sources, including but not limited to, the HNS Network, HNS contracted payors, CMS, and other reputable sources.

High Utilization of Codes Under Review

When high utilization of codes under review are identified per the Code Audit Program, the following occurs:

- Initial High Utilization of Code: Mandatory peer-to-peer counseling between the physician and an HNS Chiropractic Medical Director.

- High Utilization of Same Code in Second Review: If a physician *ever* triggers code criteria *for the same code a second time*, the physician will receive a letter from HNS concerning the code's utilization and next steps if he or she triggers criteria a third time.

High Utilization of Same Code in Three Semiannual Code Reviews – Medical Record Review

If a physician *ever* triggers code criteria for the same code a *third* time, HNS will request healthcare records and conduct a medical record review for compliance to HNS policies and Best Practices.

Medical Record Review:
Finding of Compliance

If a medical record review performed pursuant to the Code Audit Program finds that the physician has complied with HNS policies and best practices, then the physician will be placed on a “No Contact” list for the reviewed code for a 5-year period.

Medical Record Review:
Non-Compliance & Code Audit Probation

Importantly, however, if the record review finds *substantial non-compliance* to HNS policies and best practices for the code at issue, then:

- The physician will be placed on *Code Audit Probation* — unrelated to CPR Program — for 12 months; and,

- **The physician will be ineligible for any reduction in his/her HNS Administrative Withhold (otherwise allowed by the CPR Program) during that probation period.**

Code Audit Program Termination

If a Network Physician triggers Code Audit criteria for a code following conclusion of a Code Audit Probation period, which occurred because of that same code, the physician will be presented to the HNS Quality and Utilization Management (QUM) Committee to determine whether the physician's HNS participation should be terminated.

Appeals of Code Audit Termination Decisions

With few exceptions,
physicians have the right to appeal decisions to terminate their participation from the network.

Like with the CPR Program, if a physician appeals the termination decision rendered pursuant to the Code Audit Program, the physician must submit a written notice of appeal to HNS within 30 days of the date shown on the notice of termination. The written notice must include the specific reason(s) why the physician believes reconsideration of his/her network participation should occur. *(Disagreeing with HNS Code Audit Program and Policies is not considered an acceptable basis for reconsideration of a termination decision.)* Information regarding the appeals process, as applicable, will be included in the *Notice of Termination* issued to the physician.

HNS Best Practices: Staying Ahead of the Curve

Staying Ahead of the Curve
HNS' Performance Expectations

All HNS physicians are expected to consistently provide safe, effective, and cost-efficient healthcare to all of their patients.

HNS has developed policies and procedures, a Philosophy of Care, and 'Best Practices,' all of which promote the delivery of effective, cost-efficient healthcare and which establish HNS' performance expectations for contracted physicians. (The standards are posted on the HNS website.)

The policies and standards were developed with guidance from HNS' Professional Affairs Advisory Boards and are consistent with industry standards and the policies of contracted healthcare plans.

The following guidance is provided to help you meet these expectations.

Best Practices

1. Apply ***HNS' Philosophy of Care***.

Treat and Release:

Provide care to correct the presenting condition,
bring the patient to maximum medical improvement,
and discharge the patient from active care
with appropriate instructions regarding maintenance/supportive care,
self-care, and prevention of future occurrences.

Best Practices

2. Understand and comply with the ***HNS Best Practices: Clinical Care & Documentation Standards.***

These standards represent HNS' performance expectations for contracted physicians.

The following are a few
key best practices
which help improve
quality, treatment outcomes, and cost-efficiency.

Best Practices

- Establish and document the patient's chief complaint.
- Ensure your initial examination includes the use of standardized outcome assessment tools *to establish a functional baseline against which progress towards treatment goals can be objectively measured*.
- Develop an individualized treatment plan for each patient.
- Based on the chief complaint and clinical exam findings, establish specific treatment goals for each patient which are objective, measurable, reasonable, and intended *to improve a functional deficit.*

Best Practices

- Re-evaluate the patient every 4 weeks or 12 visits (whichever comes first).

- Always use outcome assessment tools and other objective measures *at each re-exam*, to measure progress toward treatment goals, the effectiveness of treatment, and the appropriateness of additional care.

- Use the comparison of the results of the outcome assessments, and other measurable objective findings, to determine when MMI has been reached, *then release the patient to maintenance/supportive care*.

Best Practices

- Ensure all diagnoses, all services provided, the rationale for those services, and all treatment recommendations are properly documented in the healthcare record.

- Ensure all treatment billed to payors is consistent with the chief complaint, objective clinical findings, diagnoses, treatment plan, payor corporate medical policies, and HNS Policies and HNS Best Practices.

Best Practices

3. Understand **Maintenance Care.**

"Elective healthcare that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or it may be initiated with patients without symptoms in order to promote health and to prevent future problems. This care may incorporate screening/evaluation procedures designed to identify developing risks or problems that may pertain to the patient's health status and give care/advice for these. Preventive/maintenance care is provided to optimize a patient's health.

Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur.**"** (*American Chiropractic Association*)

Best Practices

4. Understand **Supportive Care.**

"Long-term treatment/care for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral, have been considered and/or attempted."
(*American Chiropractic Association*)

Best Practices

5. Understand **Maximum Medical Improvement (MMI).**

MMI occurs
when a patient with an illness or injury reaches a state
where additional, objective, measurable improvement cannot reasonably be expected
from additional treatment and/or
when a treatment plateau in a person's healing process is reached.

Best Practices

6. Understand and comply with ***HNS Best Practices: Cultural Competency.***

HNS physicians must comply with all HNS Policies and best practices in the treatment of all patients, and this includes those with limited-English proficiency.

The goal of **HNS Best Practices: Cultural Competency**
is to ensure physicians can effectively communicate with,
and provide the highest quality of care to,
every patient, regardless of race, ethnicity, or cultural background.

HNS Administrative Withhold: Purpose and Calculation

HNS Administrative Withhold

Funding for HNS' CI Programs is provided exclusively by the administrative withhold assessed on each Network Physician. The administrative withhold provides HNS with the funds necessary to design, maintain, and implement the CI Program, related initiatives, and services.

Importantly, the withhold is not a fee for processing claims. Moreover, HNS does not receive any compensation from the insurance companies and managed care organizations that contract with HNS. *Without the administrative withhold, the HNS Network and its CI Program would not exist.*

Once there is a significant body of data to gauge a physician's cost-effectiveness, the amount of the HNS Administrative Withhold is linked to the physician's CPR Participation Status (and cost-efficiency), or results of the HNS Code Audit Program under the circumstances stated herein.

Calculation
HNS Administrative Withhold

Each Network Physician's administrative withhold is calculated against the "allowed amount" (or "contracted amount") shown on a patient's Explanation of Benefits (EOB). Specifically, the withhold is calculated against the sum of the deductible amount, the copayment/coinsurance amount, plus the amount paid by the health plan, for each service line shown on the EOB.

The allowable amount is the sum of monies due to the provider, from either the patient or the insurance company, for each covered service provided, and includes copayments, deductibles, and/or coinsurance that must be collected from the member.

The allowed amount represents the amount the payor intends for the provider to collect for the services provided, that is represented by a particular CPT or HCPCS code.

Calculation
HNS Administrative Withhold

HNS does not withhold when, per the EOB, the physician is not entitled to receive any payment, either from the member or payor, for the service shown on the EOB.

By calculating the administrative withhold against the allowed amount, physicians are assured that HNS only withholds a fee for those services for which the physician will receive payment.

The time is now; the opportunity is here.

"There has never been a time in the history of our profession with a greater opportunity to deliver conservative health care. The over-riding question is are we prepared to embrace the opportunities?"

Dr. Tony Hamm
Past President
American Chiropractic Association

Assistance & Support

We hope this training has been helpful.

If you need assistance, support, or have questions regarding the HNS CPR or Code Audit Program, please contact one of the HNS Chiropractic Medical Directors below.

Dr. Steve Binder
sbinder@binderchiropractic.com

Dr. Richard Armstrong
cpdrarm@gmail.com

HNS

Together, we're making a difference.