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| **Policy:** | **Clinical Performance System – California – Department of Managed Health Care - Chiropractic** |
| **Date of Implementation:** | **March 5, 2026** |
| **Product:** | **Specialty** |

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American Specialty Health – Specialty (ASH) utilizes robust clinical quality performance analytics and monitoring programs to build and maintain a Clinical Performance System (CPS) that includes the criteria at which ASH will apply medical necessity verification; and a High Performing Provider (HPP) program that identifies high performing providers within ASH's practitioner network who meet best practice criteria and service efficiency.

ASH utilizes robust clinical quality performance analytics and monitoring programs to build and maintain the following:

- a Clinical Performance System (CPS), that includes the criteria at which ASH will apply medical necessity verification; and
- a High Performing Provider (HPP) program that identifies high performing providers within ASH's practitioner network who meet best practice criteria and service efficiency.

ASH's CPS programs are based on current clinical evidence, which is documented in ASH's Clinical Practice Guidelines (CPGs) and clinical policies which are reviewed and updated annually by peer review committees, composed of internal and external subject matter experts. ASH's CPGs have been adopted, refined, and updated over time, as the clinical evidence has developed since the inception of ASH's benefit administration programs. ASH's CPGs are reviewed at least annually, and ad hoc if circumstances require (e.g., new/revised evidence, regulatory requirements, etc.).

## Medical Necessity Verification

ASH's Clinical Performance System (CPS) is designed to balance the delivery of safe, clinically effective, and affordable care with appropriate levels of quality and medical necessity review based on peer reviewed clinical and administrative criteria. The program allows certain clinically necessary treatment/services to be rendered prior to evaluation of medical necessity by ASH. If the member requires more treatment/services than are available at the practitioner's clinical performance tier level, the practitioner will submit a Medical Necessity Review Form (MNR Form) for verification of medical necessity of those additional treatment/services by a clinical quality evaluator for those services to be eligible for reimbursement. As there is no requirement for prior authorization, services may be rendered, and post-service review may be performed within 180 days of the service being rendered or as applicable state law may describe.

Treatment/services available under the CPS are communicated to practitioners via the Practitioner Operations Manual (POM).

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

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

Each individual practitioner's performance is monitored against CPS criteria regardless of whether the practitioner is part of a group practice or professional corporation which receives reimbursement under a common tax ID number (TIN). Unless notified otherwise, practitioners are eligible for the CPS Tier 3. Credentialed practitioners are monitored at least annually and will be moved up in tier level if they continue to demonstrate compliance with all CPS criteria and will remain at their current tier or be moved down if they fail to meet criteria. ASH may conduct reviews more frequently than annually, in its sole discretion. Given this, the annual tier assignment can be changed by ASH at any time if it believes the criteria/data supports the change.

**Tier Determination Criteria and Progression**

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

- **Annual Patient Base:** *Patient base greater than or equal to 20 ASH members/patients within the one (1) to three (3) year period are considered to provide a statistically meaningful sample*
- **Malpractice Claims:** *Number and amount of malpractice settlements reported by practitioner, captured through primary source verification, or obtained via National Practitioner Data Bank (NPDB)*
- **Medical Necessity Review Alerts / Clinical Service Investigations:** *Potential alerts identified by Clinical Quality Evaluators from the clinical documentation submitted by the practitioner*
- **Quality of Care Grievances:** *A member complaint or grievance that, upon completion of the investigation, reveals improper standard(s) of practice*
- **Member Administrative Complaints:** *Validated member administrative complaints identified through Customer Service, patient satisfaction surveys, other member communications, etc.*
- **Clinical Corrective Action Plans (CAP):** *Any steps which practitioners must take to bring their practices into compliance with ASH standards*
- **State Board Action/Attestation Issues:** *Documented state board action or attestation issues (e.g., conviction of misdemeanor, felony, moral or ethical crime)*

- **Patient Office Visit Average:** *Used office visits per patient per year average based on claims data*
- **Evaluation & Management (E/M) CPT Code Use:** *Compliance with appropriate E/M CPT code use as determined by ASH clinical committees*
- **X-ray Utilization Data:** *Compliance with ASH adopted X-ray utilization Clinical Practice Guidelines (where applicable to practitioner's scope of practice)*
- **Length of Participation:** *Years of participation based on minimum of one year's claims data* available *for analysis*
- **Administrative Contract Compliance Corrective Action Plans (CAP):** *Any CAP issued for non-compliance with administrative requirements of the practitioner's contract*
- **Medical Necessity Review (MNR) Approval Rate:** *Percentage of requested care via MNR that is clinically reviewed and approved*

No criterion or tier level threshold is intended to imply an absolute level of appropriate treatment/therapy but rather, is used to determine the appropriate point at which ASH will apply its quality assurance and medical necessity review processes including the requirement to submit MNR Forms for verification of medical necessity of services. Practitioners who have consistently demonstrated patterns of utilization and quality that suggest a low level of compliance with the ASH clinical services process should have a higher level of oversight. Those with high levels of performance should have less oversight. Clinical performance tiers are summarized below; a more detailed description of the CPS can be found in the ASH services agreement or the ASH Practitioner Operations Manual (POM):

Tier 6

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

Tier 5

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

Tier 4

Practitioners who qualify for Tier 4 have an 8-visit MNR trigger allowing submission of claims for service rendered as defined in the POM without the requirement to submit MNR Forms for verification of medical necessity of services for up to 8 visits per

patient per year. (Client-specific exceptions may exist in which case details are set forth in applicable Client Summaries.) After 8 visits, an MNR form submission is required for verification of medical necessity for reimbursement of any additional services.

Tier 3

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

Tier 2

No longer applicable.

Tier 1

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

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

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

## Ongoing Clinical Services Review/Clinical Oversight

Clinical quality evaluators monitor practitioner service submissions for indications of possible under-utilization, over-utilization, and non-compliance with ASH clinical quality/medical necessity standards. The practitioner's clinical performance patterns are also evaluated on an ongoing basis through an analysis of claims data, continued

compliance with quality criteria, and appeals and grievances in order to identify quality of care and/or health and safety issues.

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

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

**CPS Criteria Changes**

ASH will monitor the data and results of the Clinical Performance System on a regular basis and may, at its sole discretion, make updates and changes to the program, including, but not limited to, discontinuing Tier changes for practitioners individually or network-wide for any period of time; increasing the frequency of review and reporting; and/or changing Tier assignment. Upon updates and changes to the CPS subject to Section 1375(b)(1) and (3), the practitioner will be notified and have the right to negotiate within 45 business days, pursuant to the Practitioner Services Agreement. The CPS quantitative and qualitative criteria are provided in the sections and tables below. In the event that a Tier change is implemented, the new tier is applied to any claims submissions after the new tier takes effect, regardless of the date of service (within that 180-day claims submission timeline allowance). ASH will update and distribute by ASHLink communications updates to CPS guidelines, measurement, and/or policies. ASH will perform, at a minimum, annual review of practitioners for reporting of practitioner practices.

**CPS Quantitative Criteria Chiropractic:**

| Quantitative Criteria | Required to Move Up in Tier | Tier Impact |
|---|---|---|
| Length of time as an ASH participating provider | Minimum of 12 months of data | If time < 12 months, then no tier change due to insufficient participation |
| Number of ASH patients treated (ASH may go back | ≥ 20 patients in the past 1-3 years | If < 20 patients, then no tier change due to insufficient patient volume |

| Quantitative Criteria | Required to Move Up in Tier | Tier Impact |
|---|---|---|
| up to three years to reach the minimum patient count) | | |
| Average number of office visits per patient per year (OV Avg) | ≤ 6.5 OV Avg | Remain in tier: > 6.5 to ≤ 7.0 OV Avg<br>Move down one tier from Tiers 4-6: > 8.5 OV Avg in any review period; or > 7.0 OV Avg in any three consecutive review periods<br>Move or limit to Tier 3: > 11.0 OV Avg in any review period<br>Move or limit to Tier 1: > 11.0 OV Avg in two or more consecutive review periods |
| Appropriate Evaluation / Management (E/M) CPT code use per date of service (DOS) [applies to Tier 6 only] | | Lower to Tier 5: ≥ 70% of DOS have E/M code and treatment billed on same date of service |
| Percentage of Requested Care Authorized [number of total visits authorized via clinically reviewed Medical Necessity Review (MNR) vs. number of total visits requested] | Tier 3 or 4:<br>≥ 5 MNR submissions within the lookback period with ≥ 90% of requested care authorized | Remain in Tier 5:<br>≥ 5 MNR submissions within the lookback period with ≥ 90% of requested care authorized |

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| X-ray Utilization Criteria* | Description of Criteria |
|---|---|
| X-ray utilization based on those Total patients treated during the review period (1 to 3 years to reach minimum required Total patients) | >60% of total patients receiving an x-ray; or<br><br>>5% of total patients receiving a full spine x-ray (e.g., 72010); or<br><br>>10% of total patients receive multiple sectional views (i.e., > 2 regions) |
| X-ray utilization based on those New patients treated during the review period (1 to 3 years to reach minimum required New patients) | >75% of new patients receiving an x-ray; or<br><br>>5% of new patients receiving a full spine x-ray (e.g., 72010); or |

| X-ray Utilization Criteria* | Description of Criteria |
|---|---|
| | >10% of new patients receive multiple sectional views (i.e., > 2 regions) |

* X-ray utilization data refers to x-rays taken by or ordered to be taken at another facility by the Practitioner. For the initial X-ray MNR assignment, the look back period may be one to three years to reach 30 patients; subsequently to remove X-ray MNR assignment, a minimum of 20 patients is required. Practitioners who meet the minimum patient requirement and have exceeded the criteria listed above may receive an X-ray MNR Requirement (SRQAR).

**CPS Qualitative Criteria:**

| Qualitative Criteria | Description |
|---|---|
| State Board Actions (SBAs): State Board or other regulatory body actions against a license | Any SBA in the past 5 years may lead to a negative tier impact |
| Corrective Action Plans (CAPs): Outline steps which provider must take to bring their practice into compliance with ASH standards | Any Clinical CAP in the past 3 three years may lead to a negative tier impact |
| | Any Administrative CAP in the past year may lead to a negative tier impact |
| Malpractice Claims: Number and amount of malpractice settlements reported by provider or captured through primary source verification or NPDB (National Practitioner Data Bank) | Any evidence of a pattern of professional negligence or any of the following within the past 5 years may lead to a negative tier impact:<br>● >2 paid claims/settlements of any amount<br>● >1 paid claim/settlement of ≥$50,000 but ≤$250,000<br>● any paid claim/settlement >$250,000 |
| Quality Management (QM) Grievances: Any member complaint or internal review that, upon completion of the investigation, reveals improper standard(s) of practice | Any QM grievance with improper standard(s) of practice in the past 3 years may lead to a negative tier impact |

**Monitoring Review and Assignment of Tiers**

On at least an annual basis, Health Services (HLS) staff review practitioner utilization and quality data. Each practitioner is assigned a Tier based on the application of CPS criteria for raising or lowering a Tier approved by the PRC. Practitioner notification of annual review data and Tier designation occurs a minimum of fifteen (15) calendar days prior to the commencement of the Tier assigned. The practitioner notification will include a report card with the CPS criteria, CPS tier assignment and the practitioner's performance data which the CPS tier assignment was based upon. Additionally, the notification will include the CPS tier designation appeal process as applicable and described in the next section.

**Appeals of CPS Tier Designation**

Practitioners have the option to appeal their annual review CPS Tier designation which may include an X-ray MNR Requirement (SRQAR). Practitioners will be afforded 30 calendar days to appeal their CPS Tier change. The 30 calendar day timeframe to appeal a CPS Tier change will begin on the date of the notification letter which is sent to the practitioner 15 calendar days before the effective date of the Tier change and extends 15 calendar days after the effective date of the Tier change. Tier appeals are considered, and a final determination adjudicated by the Quality Improvement Committee (QIC), a peer review committee. The QIC, when considering CPS Tier designation appeals, makes decisions consistent with the established ASH Tier Determination Criteria. The QIC may grant a practitioner's appeal if they determine that the ASH Tier Determination Criteria was inappropriately applied, was based on inaccurate or incomplete data, or the practitioner submits additional information which the QIC determines is sufficient to overturn how the criteria was applied.

**Identifying High Performing Providers (Clinical Quality Profiling)**

ASH implements clinical quality profiling to measure practitioners which deploy best practices within its network. Whenever possible, ASH will educate and encourage members to seek services from high performing providers within its network. ASH's high performing provider designation is designed to improve and/or ensure quality outcomes, robust patient/member access, and affordability. The ASH clinical quality profiling system evaluates various best practices High Performing Provider (HPP) criteria, including but not limited to:

**Experience with ASH's Systems and Patients**

- Volume of ASH patients
- Absence of material member clinical or administrative grievances
- Years of experience in the ASH network
- Active practitioner service agreement with ASH
- CPS Tiers 4-6*

*ASH may elect to include high-quality Tier 3 practitioners to meet GeoAccess requirements.

**Clinical Credentials**

- Active unencumbered clinical license
- No history of health and safety clinical Corrective Action Plans (CAPs)
- No open clinical CAPs
- No material malpractice cases
- No material administrative CAPS
- No credential issues (no Board actions; sanctions)
- No CMS, Medicaid, or similar sanctions
- No felonies

- No misdemeanors related to patients or practice

**Clinical Guideline Adherence and Service Efficiency Benchmarks**

- Appropriate service type
- Medical record documentation
- Accurate ICD / CPT / HCPS Coding
- Dose of care/service utilization within threshold guidelines
- Minimal use of low value services (Choosing Wisely[1] compliance)
- Case mix considerations as applicable

ASH clinical committees review these metrics for application of preferred provider patient education programs, patient redirection, and high-performing sub-networks. Upon HPP criteria changes, the practitioner will be notified and have the right to negotiate within 45 business days, pursuant to the Practitioner Services Agreement. The HPP criteria are provided in the sections and tables below. A practitioner's specific CPS Tier is not shared with patients or members; however, ASH will share whether the practitioner has been included in a preferred provider patient education program, patient redirection, and/or high performing sub-network. Should ASH identify a subnetwork of high performing providers, the network will be filed with regulators, if applicable, and meet all GeoAccess requirements. Patients are free to choose any contracted practitioner available to them based on their health plans' agreed upon network.

Clinical staff who perform medical necessity review have no administrative or fiscal incentives or encumbrances that would impact their ability to render a clinically appropriate decision. The staff who manage clinical quality profiling data analytics do not themselves render medical necessity decisions. These staff are entirely separate operational areas, with different job descriptions and duties.

**High-Performing Providers Criteria**

The High-Performing Providers (HPP) designation considers current and past credentials activity, state board actions, limitations, quality profile data, adverse events, complaints, guideline adherence, any quality actions including any corrective action plans as described below:

| Criteria | High-Performing Status | Timeframe |
|---|---|---|
| Active Clinical Licenses | No practitioner history of encumbrances | Past 5 years |
| CMS Status | No practitioner history of sanctions or limitations | Past 3 years |
| State Board Actions | No practitioner history of state board actions against a license | Past 5 years |

[1] https://www.choosingwisely.org/

| Criteria | High-Performing Status | Timeframe |
|---|---|---|
| Malpractice Claims | No practitioner history of significant malpractice claims | Past 5 years |
| Criminal Convictions | No practitioner felonies | In perpetuity |
| Misdemeanors | No practitioner misdemeanors applicable as determined by a peer review committee | Past 5 years |
| Member Grievance or Complaint | None | Past 3 years |
| Corrective Action – Administrative | ≤2 and no committee action to impact tier | Past 1 years |
| Corrective Action – Clinical | ≤2 and no committee action to impact tier | Past 3 years |
| Adverse Clinical Event | None | Past 3 years |

ASH practitioners with extensive experience treating members have a better understanding of ASH guideline requirements and the administrative systems needed to ensure a smooth and effective patient experience. ASH identifies as high quality those providers with high patient volumes who also meet the CPS expectations.

| Criteria* | High-Performing Status | Timeframe |
|---|---|---|
| CPS Tier | Tiers 4, 5, 6 | Current |
| Time In Network | At least 2 years | Current |
| ASH Network Experience | At least 2 years in network and ≥40 patients in 2-year lookback; OR<br><br>At least 5 years in network and ≥12 patients in 5-year lookback | ASH will go back 2 years and 5 years to evaluate |

* When ASH identifies a member access concern, barrier, or other care coverage need, it may include practitioners who meet all quality criteria described above but may have lower patient volume and/or shorter duration of network participation.

**High Performing Provider Designation**

On an annual basis, Health Services (HLS) staff review practitioner performance to identify and designate high performing providers. Each practitioner is designated as HPP based on criteria approved by the PRC. Practitioner notification of HPP designation occurs a

minimum of fifteen (15) calendar days prior to the commencement of the HPP designation. The practitioners will be notified with a report card with the HPP criteria, HPP designation, and the practitioner's performance data which the designation was based upon. Additionally, the notification will include high performing designation appeal process as applicable and described in the next section.

**Appeals of HPP Designation**

Practitioners have the option to appeal their annual review HPP designation. HPP appeals are considered, and a final determination adjudicated by the Quality Improvement Committee (QIC), a peer review committee. Practitioners will be afforded 30 calendar days to appeal their HPP designation. The 30 calendar day timeframe to appeal a HPP designation will begin on the date of the notification letter which is sent to the practitioner 15 calendar days before the effective date of the HPP designation and extends 15 calendar days after the effective date of the HPP designation. The QIC, when considering HPP designation appeals, makes decisions consistent with the established ASH Tier Determination Criteria. The QIC may grant a practitioner's appeal if they determine that the ASH HPP Determination Criteria was inappropriately applied, was based on inaccurate or incomplete data, or the practitioner submits additional information which the QIC determines is sufficient to overturn how the criteria was applied.

**Practitioner Services Agreement, Practitioner Operations Manual and this Policy – Issued, Amended or Renewal – Practitioner Rights**

The process and the practitioner's right to negotiate and amend proposed material changes to

- the Practitioner Services Agreement,
- the Practitioner Operations Manual, and
- this policy related to CPS and HPP programs

may be found in the Article 25 Amendments of the Practitioner Services Agreement.

An excerpt from section 25.02 of the Article is referenced below.

*25.02 Material Changes Not Covered by Section 25.01*

> *"With response to material changes to this Agreement that are not covered by section 25.01, ASH Plans shall provide at least forty five (45) business days' notice of its intent to make such changes ("Notice of Proposed Material Changes"). The Notice of Proposed Material Changes shall specifically describe the proposed changed ("Proposed Material Changes"). A reduction in the Fee Schedule or increase in the Incentive Payment Program Administrative Processing Fees will not occur more than once per calendar year."*
>
> *"If Contracted Practitioner wishes to negotiate the terms of Proposed Material Changes, Contracted Practitioner must contact ASH Plans' provider relations manager or another designed of ASH Plans in writing within the forty five (45)*

*business day notification period of his/her intent to negotiate the Proposed Material Changes ("Notice of Intent to Negotiate"). If the Parties reach agreement within forty five (45) business days of the date of Notice of Proposed Material Changes ("Notification Period") concerning the Proposed Material Changes (("Negotiated Material Changes"), ASH Plans shall incorporate the terms of the Negotiated Material Changes into the Agreement between ASH Plans and Contracted Practitioner. Contracted Practitioner shall have five (5) business days upon receipt of the revised agreement to sign the agreement and return it to ASH Plans. During the Notification Period and until ASH Plans and Contracted Practitioner finalize the Negotiated Material Changes into the Agreement, the terms of the original Agreement between ASH Plans and contracted Practitioner as modified by the Proposed Material Changes remains in effect."*

*"If the parties fail to agree to the terms of the Proposed Material Changes within forty-five (45) business days of the date of Notice of Proposed Material Changes, Contracted Practitioner shall continue to perform under the terms of the Agreement between ASH Plans and Contracted Practitioner then in effect and as modified by the Proposed Material Changes, unless the Contracted Practitioner terminates the Agreement pursuant to Section 7.01."*

*"The fact that ASH Plans agrees to Negotiated Material Changes with, and/or agrees to waive any time requirement set forth in this Article for the benefit of any person not a party to this Agreement does not impose any obligation on ASH Plans to make any similar agreement with, or offer, to Contracted Practitioner."*