This document assists Providers and their office staff in administering the health care services to your patients in our plans. It includes information about how Triad operates; network and plan participation requirements; claims submission; utilization management; and network communication.
For information regarding the contents of this document, contact:

Kelli Warner, Provider Account Manager, or Rocco Labbadia, Senior Director of Clinical Operations

To request a printed copy of this document, contact:

Kelli Warner, Provider Account Manager, at 1- 800-550-0540, ext. 3164

See Document Approval & Change Record in Attachments section of this document.
# Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Triad Mission Statement &amp; Objectives</td>
<td>2</td>
</tr>
<tr>
<td>Mission</td>
<td>2</td>
</tr>
<tr>
<td>Objectives</td>
<td>2</td>
</tr>
<tr>
<td>Plan Participation</td>
<td>3</td>
</tr>
<tr>
<td>Re-Credentialing Process</td>
<td>3</td>
</tr>
<tr>
<td>Call Center</td>
<td>4</td>
</tr>
<tr>
<td>Claims</td>
<td>5</td>
</tr>
<tr>
<td>Determining Patient Participation</td>
<td>5</td>
</tr>
<tr>
<td>Claim Submission Guidelines</td>
<td>6</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>7</td>
</tr>
<tr>
<td>Background</td>
<td>7</td>
</tr>
<tr>
<td>Prior Approval of Care</td>
<td>7</td>
</tr>
<tr>
<td>Extension of Care Plan (EOC)</td>
<td>8</td>
</tr>
<tr>
<td>Provider Instructions for the Initial Care Plan</td>
<td>10</td>
</tr>
<tr>
<td>Provider Instructions for Completing the Extension of Care Plan</td>
<td>15</td>
</tr>
<tr>
<td>Triad Healthcare Discharge Summary</td>
<td>19</td>
</tr>
<tr>
<td>Clinical Supplement</td>
<td>20</td>
</tr>
<tr>
<td>Contraindications To Modalities</td>
<td>20</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>20</td>
</tr>
<tr>
<td>Electric Muscle Stimulation</td>
<td>20</td>
</tr>
<tr>
<td>Cryotherapy</td>
<td>21</td>
</tr>
<tr>
<td>Heat Therapy</td>
<td>21</td>
</tr>
<tr>
<td>Traction</td>
<td>21</td>
</tr>
<tr>
<td>Diathermy</td>
<td>22</td>
</tr>
<tr>
<td>Clinical Alerts and Indicators</td>
<td>23</td>
</tr>
<tr>
<td>Types of Care</td>
<td>25</td>
</tr>
<tr>
<td>Medically Necessary Care</td>
<td>25</td>
</tr>
<tr>
<td>Therapeutic / Rehabilitative Care</td>
<td>25</td>
</tr>
<tr>
<td>Maintenance/Preventative</td>
<td>25</td>
</tr>
<tr>
<td>Supportive Care</td>
<td>25</td>
</tr>
<tr>
<td>Clinical Goals for Supportive Care</td>
<td>25</td>
</tr>
<tr>
<td>Requesting Supportive Care</td>
<td>26</td>
</tr>
<tr>
<td>Philosophy and Rationale</td>
<td>27</td>
</tr>
<tr>
<td>Philosophy</td>
<td>27</td>
</tr>
<tr>
<td>Rationale</td>
<td>28</td>
</tr>
<tr>
<td>Insufficient Progress</td>
<td>28</td>
</tr>
<tr>
<td>Type of Care Not Medically Necessary</td>
<td>28</td>
</tr>
<tr>
<td>Number of Requested Visits (Frequency)</td>
<td>28</td>
</tr>
<tr>
<td>Number of Requested Modalities Per Visit</td>
<td>29</td>
</tr>
<tr>
<td>Radiology Guidelines</td>
<td>31</td>
</tr>
<tr>
<td>Clinical Records</td>
<td>32</td>
</tr>
<tr>
<td>Clinical Record Overview</td>
<td>32</td>
</tr>
<tr>
<td>Admittance Forms</td>
<td>32</td>
</tr>
<tr>
<td>Recording the History</td>
<td>32</td>
</tr>
</tbody>
</table>

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Triad Healthcare, Inc. Provider Manual  
PRV.PA.EM.001.001
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>70</td>
</tr>
<tr>
<td>Claims Submission</td>
<td>70</td>
</tr>
<tr>
<td>Appeals and Grievances</td>
<td>71</td>
</tr>
<tr>
<td>Utilization Management and Member Appeals</td>
<td>71</td>
</tr>
<tr>
<td>Claims Appeals</td>
<td>71</td>
</tr>
<tr>
<td>FAQ</td>
<td>71</td>
</tr>
<tr>
<td>Triad Healthcare, Inc. and VNS Fee Schedule</td>
<td>73</td>
</tr>
<tr>
<td>Claim Appeal Request Form</td>
<td>74</td>
</tr>
<tr>
<td>WellCare Medicare Advantage – NJ - Plan Specific Addendum</td>
<td>75</td>
</tr>
<tr>
<td>Plan Participation</td>
<td>75</td>
</tr>
<tr>
<td>Care Planning</td>
<td>75</td>
</tr>
<tr>
<td>Claims</td>
<td>76</td>
</tr>
<tr>
<td>Claims Submission</td>
<td>76</td>
</tr>
<tr>
<td>Appeals and Grievances</td>
<td>77</td>
</tr>
<tr>
<td>FAQ</td>
<td>77</td>
</tr>
<tr>
<td>Triad Healthcare, Inc and WellCare Fee Schedule*</td>
<td>79</td>
</tr>
<tr>
<td>Claim Appeal Request Form</td>
<td>80</td>
</tr>
<tr>
<td>Document Approval &amp; Change Record</td>
<td>81</td>
</tr>
</tbody>
</table>
INTRODUCTION

TRIAD is a national specialty IPA working in partnership with chiropractors in an effort to deliver quality, cost-effective healthcare services. TRIAD’s mission is to expand the utilization of chiropractic care for the benefit of all participants in healthcare. We believe that this mission can be achieved because clinically appropriate chiropractic care makes people healthier and happier and reduces both the short-term and long-term costs of healthcare. TRIAD opposes politically motivated and indiscriminate barriers to chiropractic care in all of its forms. These include medical gatekeepers, punitive co-pays and deductibles, specialty-based annual monetary caps on services and limitations to statutory and licensed scope of practice. We believe that preventing the patient from accessing chiropractic care diminishes the value of an insurer’s benefit plan, costs the insurer more money, robs the patient of a product that they have already purchased and significantly interferes with the rightful opportunity for the non-allopathic provider to do business. These issues must be addressed from many fronts for change to occur. TRIAD exists to address these from within the managed care industry, business to business, on a national scale.

The TRIAD provider network will deliver services to patients throughout the United States. Industry-standard credentialing requirements for network membership have been established and enhanced in an effort to provide plan access to a network of high quality providers. Participating providers are selected on the basis of an on-going credentialing review process based on standards established by accreditation organizations for managed-care companies.

TRIAD participating providers are committed to the health and welfare of their patients. Only by putting the needs of the patient first, can a healthcare provider consistently demonstrate superior clinical judgment. Accordingly, restoration of patient function and comfort and improvement to the quality of life is our highest priorities. We welcome your participation under each of TRIAD’s client plans.

This manual will assist you and your office staff in administering the healthcare services to your patients in our plans. It includes information about how TRIAD operates, network and plan participation requirements, claims submission, utilization management and network communication. As new clients are added, or if policies and procedures are revised, you will receive updated information.

Please take the few moments necessary to review all of this information. If you have questions or need assistance, please contact the TRIAD Network Services Department at 800-409-9081.
TRIAD MISSION STATEMENT & OBJECTIVES

TRIAD: From the Greek language meaning: “A group of three in harmony.” In healthcare all three participants, the payor, the provider and the patient, must work in harmony. The lack of harmony in today’s healthcare market has separated the provider from the patient from the payor. TRIAD’s providers are focused and committed to:

1. Restoration of patient function
2. Limitation of disability
3. Improvement of quality of life

MISSION

- To serve the needs of patients, plan sponsors and clients/payors through access to a national provider network, superior utilization management and exceptional customer service while providing cost effective, high quality care.
- To meet the needs of TRIAD’s provider partners in their efforts to acquire and serve patients while ensuring the highest value in healthcare delivery for all constituents.
- To achieve and maintain leadership in managed-care.

OBJECTIVES

TRIAD is committed to becoming the pre-eminent managed-care network in the United States. Therefore, TRIAD has adopted the URAC standards for our network organizational model.

TRIAD seeks to serve self-insured employers, third-party administrators, managed-care organizations, insurance companies, government healthcare programs and other third-party payors.

TRIAD will conduct all business and relationships in accordance with the highest ethical standards for honesty, integrity and reliability in dealings with clients, employees, providers, vendors and regulatory agencies.

TRIAD’s intent is to anticipate and respond to market needs with a defined set of managed-care products, networks, flexible reimbursement methodologies and effective utilization management/quality assessment programs.
PLAN PARTICIPATION

Congratulations for having the highest credentialing standards in our profession!

In order to maintain your continued network participation, please remember you must comply with the following:

- Notify TRIAD, in writing, of any changes or additions to your practice site or to the information provided on your application within 30 days of this change.
- New practice, partners and billing associates billing under the same Tax ID must be credentialed with TRIAD. Call 800-409-9081 to request applications for new associates.
- Notify TRIAD of any W-9 changes – you must call TRIAD at 800-409-9081 and request a new W-9 form.
- Re-credential (every three years). Refer to the Re-credentialing Requirements below:

RE-CREDENTIALING PROCESS

There will be a formal re-credentialing process every three years. All primary source information obtained during the initial credentialing process will be updated. TRIAD’s Credentialing Committee will consider the following information:

1. Member complaints or grievances
2. Utilization performance
3. Results of quality reviews
4. Member satisfaction survey results
5. Any changes in the provider credentials

If you have specific questions, please contact the Credentialing Department at 800-409-9081.

We are happy to welcome you to the TRIAD family of healthcare providers.
CALL CENTER

1. Communications between TRIAD and our provider network is the responsibility of our Network Services Department and is accomplished through the following mechanisms:

- **TRIAD Broadcast Faxes** are technical and clinical bulletins that are produced and distributed to the provider network relative to administrative and technical updates on an as-needed basis.
- **TRIAD Healthcare’s Web Page** can be accessed at www.triadhealthcareinc.com, TRIAD’s Web Page provides general information about TRIAD’s products and services, clients and programs.
- **TRIAD’s E-Mail Box** can be accessed at ns@triadhealthcareinc.com for general questions and concerns which are not addressed by any of the previous mechanisms and which do not involve a question specific to a patient’s claim or pre-certification process.

2. Questions and Concerns:

The majority of your questions or concerns can be answered through use of the TRIAD E-Mail Box or through direct communication with any of our Network Services staff that can be reached at the numbers listed below.

- Voice: 800-409-9081
- Fax: 800-541-0083

Specific questions relative to the status of a claim or a pre-certification request should be addressed to the Claims department or Utilization Management Department respectively. These numbers and extensions as well as the remainder of TRIAD’s Company Directory, can be accessed through our auto attendant by calling 800-409-9081.

3. Plan Participation Requirement:

TRIAD Healthcare, Inc., in conjunction with our clients, may, from time to time, require that you participate in educational programs. These programs are designed to address issues such as the quality of patient care and statutory compliance. In all instances, TRIAD’s goal is to use the information that we obtain while managing chiropractic care for the mutual benefit of all parties involved, but with particular focus on the patient. You will be notified of these programs as they are developed. You may also refer to the “Plan Specific Addendums” at the end of this manual for additional information concerning educational program requirements.
CLAIMS

To ensure efficient claims processing, it is important that your staff fully understand how to comply with TRIAD’s claims-processing requirements.

TRIAD processes claims in multiple types of managed-care environments. The procedures for claim submission will vary depending on the type of environment in which the patient is enrolled.

*Please refer to the “Plan Specific Addendums” at the end of this manual for the claims submission requirements for ALL plans. ONLY if claims submission instructions for a specific health plan are NOT included in the “Plan Specific Addendums,” should you proceed to follow the instructions below.

DETERMINING PATIENT PARTICIPATION

Determining which managed-care plan your patient is participating in is important before submitting claims.

You can easily do this by referencing the patient’s identification card.

Keep a copy of the front and back of the patient’s ID card on file for reference purposes.

If you have any questions regarding a patient’s eligibility or benefits information, call TRIAD’s Claims Department at 800-409-9081, M-F 8:00 a.m. to 5:00 p.m., Eastern Standard Time. Please have the following information ready when calling:

☐ Patient’s Member Id
☐ Patient’s Social Security Number
☐ Patient’s Name
☐ Patient’s Date of Birth
☐ Provider’s Name
☐ Provider’s Tax ID Number
CLAIM SUBMISSION GUIDELINES

* Please refer to the “Plan Specific Addendums” at the end of this manual for the claims submission requirements for ALL plans.
UTILIZATION MANAGEMENT

BACKGROUND

TRIAD Healthcare, Inc. performs utilization management for the purpose of assuring that services rendered to a patient are medically necessary. TRIAD does not use this tool for the purpose of cost control, but rather for the purpose of quality control and assurance. The following procedures are necessary in order for TRIAD to fulfill its responsibility to manage care. *Please refer to the “Plan Specific Addendums” at the end of this manual for the prior approval requirements for ALL plans.

Prior Approval of Care

The Prior Approval process may be required for health plans as identified in the “Plan Specific Addendum” section of the manual.

1. Submit a Triad ICP form by fax or *web before the second visit, or within fourteen business days of patient’s initial date of entry, whichever occurs first. ICP's should be submitted for patients returning to care with a new diagnosis or patients returning to care after an interruption of greater than ninety days.

   *Website submission is based on plan specific addendums

2. ICP’s should include the following information:

   Data Field 1) Type of patient: New, Established, or New Injury or New Episode
   Data Field 2) Patient date of entry; onset/ date of injury
   Data Field 3) Patient name; sex
   Data Field 4) Member Id #, Patient’s Social Security Number; Date of Birth
   Data Field 5) Area of Complaint
   Data Field 6) Spine Pain Radiation
   Data Field 7) Numeric Pain Rating Scale
   Data Field 8) Restrictions of Activities of Daily Living (Functional Index)
   Data Field 9) Duration of Symptoms
   Data Field 10) History of Prior Spinal Surgery
   Data Field 11) Work Capabilities
   Data Field 12) Number of Previous Episodes
   Data Field 13) Diagnosis
   Data Field 14) Evaluation and Management
   Data Field 15) Treatment Type
   Data Field 16) Number of Modalities
   Data Field 17) Number of Regions (CMT)
   Data Field 18) Contraindications to Modalities
   Data Field 19) Comments

3. A clinical peer of the treating provider performs all treatment determinations.
4. Treatment plan notification will be returned to you within one (1) business day of your submission of a completed care plan. This will include:
   a. Reference number
   b. Clinical Peer Reviewer

5. If a treatment plan cannot be certified, you will be notified within one (1) business day of the adverse decision and this will include:
   a. Principle reason for adverse determination
   b. Process for requesting an appeal of the decision

6. For episodes of care extending beyond the time frames or resources certified from the ICP, an Extension of Care (EOC) plan may be provided. Specific instructions relative to EOC submission will be included with each treatment certification letter.

**Extension of Care Plan (EOC)**

For episodes of care extending beyond the timeframes or resources certified from the ICP, an Extension of Care (EOC) plan may be provided.

1. Submit a Triad EOC form by fax or *web within three business days of the patient’s last approved date of service (for continuous care) or within three days of the patient’s date of return to care (interrupted episode or supportive care). EOC’s should be submitted for continued care plan and for patient returning to care after an interruption of less than ninety days.

   *Website submission is based on plan specific addendums

2. EOC’s should include the following information:

   Data Field 1) Begin date of service
   Date Field 2) Patient name; Member ID #
   Data Field 3) Date patient was last seen prior to date entered in question # 1
   Data Field 4) Number of visits to date for this episode
   Data Field 5) Present chief complaints
   Data Field 6) Spine Pain Radiation
   Data Field 7) Numeric Pain Rating Scale
   Data Field 8) Restrictions of Activities of Daily Living (Functional Index)
   Data Field 9) Work Capabilities
   Data Field 10) Overall improvement percentage; report changes in diagnosis
   Data Field 11) Exam code
   Data Field 12a) Treatment: CMT
   Data Field 12b) Treatment: Physical Modalities
   Data Field 12c) Treatment: Therapeutic Procedures
   Data Field 13) Combined physical modalities &/or therapeutic procedures
   Data Field 14) Number of regions (CMT)
   Data Field 15) Number of visits requested
3. A clinical peer of the treating provider performs all treatment determinations.

4. Treatment plan notification will be returned to you within one (1) business day of your submission of a completed care plan. This will include:
   
   a. Certified treatment plan
   b. Certification number
   c. Reviewer’s initials

5. If a treatment plan cannot be certified, you will be notified within one (1) business day of the adverse decision and this will include:
   
   a. Principle reason for adverse determination
   b. Process for requesting an appeal of the decision
Provider Instructions for the Initial Care Plan

Do Not Submit this Form for Pre-certification
This is for informational purposes only.

The following information is provided to you and your staff to aid in the process of filling out an Initial Care Plan to permit pre-certification for treatment. The Initial Care Plan is a two-page document that should be filled out and faxed to TRIAD the same day that the patient has been seen. If you do not receive a response from TRIAD within twenty-four (24) hours of your submission, please refax or call TRIAD at 800-409-3081. Please type or print legibly in black ink throughout the forms.

The top portion of both pages must be completed with the name of the primary treating physician providing care to this patient. Indicate your office and fax numbers with area codes. This is important, since all certifications for treatment will be sent to you at this fax number. Each page must have the patient’s name and Member ID number indicated. Please indicate the date on which the form is filled out.

Administrative Information

1. □ New Patient □ Established Patient
A patient is classified as a New Patient when they first present to your office for evaluation or if they have not had services for three years. An Established Patient has been evaluated and/or treated at your office within the past three years for any condition.

2a. Begin date of service for this request: _____/_____/(including 1st visit)
This field must indicate the very first date for the period that you are requesting prior approval. Even if the first date on which you saw your patient did not require pre-approval, you must use this date to ensure that the initial approved treatment period includes that date of service.

2b. The Onset/Date of injury _____/_____:
This is the date on which the first symptoms of or the injury responsible for your patient’s current condition occurred.

3 Patient’s last name: ___________ Last Name: ___________ First: ___________ MI: ___________
□ M □ F
Please be sure to include the name and gender of your patient in these fields. Do not include the name and gender of parents, guardians or other related individuals.

4. Member’s ID No. found on Member’s ID card: ___________ DOB: _____/_____/
Please be sure to include the insurance identification number and the date of birth of your patient in these fields. Do not include the insurance identification number and the date of birth of parents, guardians or other related individuals.
5. Pelvic Non-spinal complaint
Please check all applicable regions above to indicate where your patient has described pain or related symptoms.

6. Spine Pain Radiation:
- Level I: Pain localized to spine
- Level II: Pain radiating to the head, elbow or knee
- Level III: Pain radiating below the elbow or knee
- N/A (for non spinal complaints only)
Check the appropriate box indicating your patient’s distribution of pain. If your ONLY selection in question number 5 is Non-spinal please select only N/A in this question.

7. Numeric Pain Rating Scale (NPRS):
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)
Indicate the number that best describes your patient’s present level of pain along a numeric-rating scale from 0 to 10, where zero equals no pain, and ten equals the most severe pain. If your patient has complaints in multiple spinal regions, please indicate their pain level only for that region in which pain is most severe.

8. Restrictions of Activities of Daily Living (Functional Index):
(no limitations) 0 1 2 3 4 5 6 7 8 9 10 (bed ridden)
Indicate the number that describes your assessment of your patient’s current functional restrictions as they impact Activities of Daily Living. Zero represents no limitations and ten represents total disability.

9. Duration of symptoms:
- 0 – <3 weeks
- >3 – 6 weeks
- >6 weeks
Use this question to indicate the length of time that your patient has suffered from their current symptoms or complaints. If their current symptoms are related to a chronic or recurrent condition, please indicate the duration from the original onset of this condition.

10. History of prior spinal surgery?
- Yes
- No
  - Asymptomatic >1 year
  - Multiple recurrences of symptoms < or = 2 per year
  - Frequent recurrences of symptoms per year >2
Check the appropriate box to indicate if the patient has ever had spinal surgery, yes or no. If no, then proceed to question 11. If yes, then indicate the patient’s symptoms since surgery. Has the patient been asymptomatic for greater than one year, had recurrences lasting more than 24 hours one or two times per year, or frequent recurrences more than twice per year?
11. Physical Work Capacity as it relates to the patient’s current condition:
- No work limitations
- Capable of restricted work duty
- Unable to work
- N/A (Children, F/T students, Retirees, Permanent total disability)

In question #11 we are trying to determine if your patient’s current condition has impacted their ability to work. Please indicate your assessment of your patient’s current work capacity as it relates to THEIR normal baseline work capacity. For example, if your patient can do the same work that they could prior to the onset of their current condition, they have no work limitations related to their current condition. Select “N/A” only if your patient is not normally engaged in any type of work activity. Students, retirees and disabled individuals who normally work should be evaluated for their work capacity and this information included in question #11.

12. Number of Previous Episodes:
- 0-3
- 4-5
- >5

Please indicate the number of times your patient has experienced an episode of this condition in the past.

13. Diagnosis:

<table>
<thead>
<tr>
<th>ICD-9#:</th>
<th>Describe:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Please indicate the current ICD-9 diagnosis code with the description.

14. Exam Codes:
- 99201
- 99202
- 99203
- 99211
- 99212
- 99213
- Other* (numeric): ____________

Please indicate what exam codes you used or will use during the requested treatment period.
* When selecting “Other” please submit supporting narrative documentation.

15a. Treatment: CMT
- Activator
- Diversified
- Distraction
- Gonstead
- Thompson
- Pierce
- SOT
- Toggle
- Other: ____________

Please select what type of CMT you will be administering to your patient.

**NOTE:** The descriptions under CMT will be used for analysis unrelated to the pre-approval process.

15b. Treatment: Physical Modalities
- US – 97035
- EMS Unattended – 97014
- Diathermy – 97024
- EMS Attended – 97032
- Traction 97012
- Other CPT codes: ____________
15c. Treatment: Therapeutic Procedures
   o Massage - 97124
   o Manual Therapy Technique – 97140
   o Therapeutic exercise - 97110
   o Neuromuscular Re-education - 97112
   o Other CPT code:_____________________

Please indicate physical modalities and therapeutic procedures that you anticipate utilizing during the course of the requested treatment plan. If you plan to use a physical modality or therapeutic procedure that is not listed, please include the appropriate CPT code for that service on the line marked “Other”.

16. How many combined physical modalities and/or therapeutic procedures will be used per visit?

   o0  o 1  o 2  o 3  o Other:____________

Please indicate the number of combined modalities/procedures, not including CMT that you will be providing per office visit.

17. o 1-2 Regions - 98940  o 3-4 Regions - 98941  o 5 Regions 0 98942
    o Extra Spinal more than one region – 98943  o N/A

Please indicate the number of regions that you will be treating with CMT. Please note, generally, the number of regions considered medically necessary to treat with CMT is related to both the number of regions of patient complaint and the number of regions of diagnosed condition.

18. Requested Treatment Plan: Total number of visits requested_______(including initial visit)
   o Therapeutic/Rehabilitative Care – 30 Days
   OR
   o Supportive Care
     o 30 days
     o 60 days
     o 90 days
     o 120 days
     o 150 days
     o 180 days

Please select what type of care you will be administering to your patient. Be sure to also select a timeframe when you select “Supportive Care.” It is not necessary to select a timeframe for “Therapeutic/Rehabilitative Care” because this type of care will be approved for thirty-day periods only. You may select only ONE type of care on any given care plan. Incorrectly selecting both “Therapeutic/Rehabilitative Care” and “Supportive Care” on the same care plan will result in the form being returned to you for correction of this information and delays in the approval of care. If the type of care that you are providing to your patient changes from “Therapeutic/Rehabilitative Care” to “Supportive Care” or visa versa, as their condition requires, a new care plan must be submitted indicating the current condition of the patient and the new type of care requested.
19. I have attached additional objective clinical information to concurrent conditions, co-morbidities, contraindications, clinical alerts and or relevant clinical issues.

Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please include any other information that you would like to have taken into consideration regarding the review of their care plan.

The Physician acknowledges that this Care Plan has been personally reviewed, contains information that is truthful and accurate and has been submitted by authorized staff on behalf of Physician.
**Provider Instructions for completing the Extension of Care Plan**

*Do Not Submit this Instructional Form for Pre-certification. The modified form below is for informational purposes only.*

The following information is provided to you and your staff to aid in the process of filling out the Extension of Care Plan to permit pre-certification for treatment. The Extension of Care Plan is a two-page document that should be filled out and faxed to TRIAD the same day that the patient has been seen. If you do not receive a response from TRIAD within one (1) business day of your submission, please refax or call TRIAD at 800-409-9081. Please type or print legibly in black ink throughout the forms.

The top portion of both pages must be completed with the name of the primary treating physician providing care to this patient. Indicate your Tax ID Number, office and fax numbers with area code. This is important, since all certifications for treatment will be sent to you at this fax number. Each page must have the patient’s name and Member ID number indicated. Please indicate the date on which the form is filled out.

**Administrative Information**

1. **Begin date of service for this extension:**
   Please indicate the first date you are requesting pre-approval for this new coverage period. It is important that you do not submit an extension of care plan for additional visits until either all the visits on the previous care plan have been used or the coverage period has expired. The date that should appear in this area is the first date you plan to see your patient after the previous care plan has expired or you have exhausted all pre-approved visits.

2. **Patient Name:**___________________________ **Member ID#:________________**
   Please be sure to include the name and insurance identification number of your patient in these fields. Do not include the name and insurance identification number of parents, guardians or other related individuals.

3. **Date patient was last seen prior to the date entered in question #1:** __/__/___
   Please indicate the date that your patient was last seen, in your office, prior to the first date for which you are requesting approval on this form.

4. **Number of visits to date for this episode:**________
   Please indicate the total number of visits that you have rendered to your patient for this episode. Please be sure to enter the number of visits that you have actually rendered not the number that had been pre-approved.
5. Present chief Complaint:  o C  o T  o L  o S  o Pelvic  o Non-spinal complaint
Please check all applicable regions above to indicate where your patient has described pain or related symptoms.

6. Spine Pain Radiation:
   o Level I: Pain localized to spine
   o Level II: Pain radiating to the elbow or knee
   o Level III: Pain radiating below the elbow or knee
   o N/A (for non spinal complaints only)
Check the appropriate box indicating your patient’s distribution of pain. If your ONLY selection in question number 5 is Non-spinal, please select only N/A in this question.

7. Numeric Pain Rating Scale (NPRS):
   (no pain) o 0  o 1  o 2  o 3  o 4  o 5  o 6  o 7  o 8  o 9  o 10 (unbearable pain)
Indicate the number that best describes your patient’s present level of pain along a numeric-rating scale from 0 to 10; where zero equals no pain, and ten equals the most severe pain. If your patient has complaints in multiple spinal regions, please indicate their pain level only for that region in which pain is most severe.

8. Restrictions of Activities of Daily Living (Functional Index):
   (No limitations) o 0  o 1  o 2  o 3  o 4  o 5  o 6  o 7  o 8  o 9  o 10 (bed ridden)
Indicate the number that describes your assessment of your patient’s current functional restrictions as they impact Activities of Daily Living. Zero represents no limitations and ten represents total disability.

9. Physical Work capabilities as it relates to the patients current condition:
   o No work limitations  o Some work limitations  o Unable to work
   o N/A (Children, F/T student, Retirees, Permanent total disability)
In this question we are trying to determine if your patient’s current condition has impacted on their ability to work. Please indicate your assessment of your patient’s current work capacity as it relates to THEIR normal baseline work capacity. For example, if your patient can do the same work that they could do prior to the onset of their current condition, they have no work limitations related to their current condition. Select “N/A” only if your patient is not normally engaged in any type of work activity. Students, retirees and disabled individuals who normally work should be evaluated for their work capacity and this information included above.
10. Overall Improvement since the initial visit for this episode

(None) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (totally disabled)

Please indicate the patients’ reported overall improvement since the initial visit: 0% represents no improvement, 100% represents overall total improvement.

If there have been any CHANGES in the original diagnosis, please explain:

Resolved Diagnosis since last care plan:
ICD-9#: ______________ Describe: ____________________________________________

Additional Diagnosis identified since last care plan:
ICD-9#: ______________ Describe: ____________________________________________

Has there been a resolution/addition in the patient’s diagnosis since the submission of the prior care plan?

11. Exam Codes:
- 99211
- 99212
- 99213
- Other* (numeric):_______________*copy of exam narrative required

Please indicate what exam codes you used or will use during the requested treatment period. *When selecting “Other,” please submit supporting narrative documentation.

12a. Treatment: CMT
- Activator
- Diversified
- Distraction
- Gonstead
- Thompson
- Pierce
- SOT
- Toggle
- Other: _______________

Please select what type of CMT you will be administering to your patient.

NOTE: The descriptions under CMT will be used for the purposes of data collection and research and will not be used in the non-clinical review process.

12b. Treatment: Physical Modalities
- US – 97035
- EMS Unattended – 97014
- EMS Attended – 97032
- Traction 97012
- Diathermy – 97024
- Other CPT codes: ___________

12c. Treatment: Therapeutic Procedures
- Massage - 97124
- Manual Therapy Technique - 97140
- Therapeutic exercise - 97110
- Neuromuscular Re-education - 97112
- Other CPT code: _______________

Please indicate physical modalities and therapeutic procedures that you anticipate utilizing during the course of the requested treatment plan. If you plan to use a physical modality or therapeutic procedure that is not listed, please include the appropriate CPT for that service on the line marked “Other.”
13. How many modalities will be used per visit?

- 0
- 1
- 2
- 3
- Other:_______________________

Please indicate the number of combined modalities/procedures, not including CMT, that you will be providing per office visit.

14. o 1-2 Regions - 98940  o 3-4 Regions - 98941  o 5 Regions - 98942
    o Extra Spinal more than one region – 98943  o N/A

Please indicate the number of regions that you will be treating with CMT. Please note, generally, the number of regions considered medically necessary to treat with CMT is related to both the number of regions of patient complaint and the number of regions of diagnosed condition.

15. Requested Treatment Plan: Total number of visits requested ________

- Therapeutic/Rehabilitative Care – 30 days
  OR
- Supportive Care -
  - 30 days
  - 60 days
  - 90 days
  - 120 days
  - 150 days
  - 180 days

Please select what type of care you will be administering to your patient. Be sure to also select a timeframe when you select “Supportive Care.” It is not necessary to select a timeframe for “Therapeutic/Rehabilitative Care” because this type of care will be approved for thirty-day periods only. You may select only ONE type of care on any given care plan. Incorrectly selecting both “Therapeutic/Rehabilitative Care” and “Supportive Care” on the same care plan will result in the form being returned to you for correction of this information and delays in the approval of care. If the type of care that you are providing to your patient changes from “Therapeutic/Rehabilitative Care” to “Supportive Care” or visa versa, as their condition requires, a new care plan must be submitted indicating the current condition of the patient and the new type of care requested.

16. I have attached additional objective clinical information to concurrent conditions, co-morbidities, contraindications, clinical alerts and or relevant clinical issues.

Comments:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please include any other information that you would like to have taken into consideration regarding review of their care plan.

The Physician acknowledges that this Care Plan has been personally reviewed, contains information that is truthful and accurate and has been submitted by authorized staff on behalf of Physician.
TRIAD Healthcare Discharge Summary

Physician Name ____________________ O-( ) F-( )

Patient Name ____________________ Tax ID Number ____________________

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Provider Instructions for the Discharge Summary Form.
Do Not Submit this Instructional Form for Discharge Summary.
Refer to Page 53 of this manual for printable versions of the Discharge Summary Form suitable for reproduction and submission. The modified form below is for informational purposes only.

The following information is provided to you and your staff to aid in the process of filling out a Discharge Summary Form. The Discharge summary form is a one-page document that should be filled out and faxed to TRIAD upon discharge. The top portion must be completed with the name of the primary treating physician providing care to this patient. Indicate your office and fax numbers with area code. All correspondence with TRIAD must include your Tax ID Number. Please indicate the date on which the form is filled out.

1. Patient Name: ____________________ Sex: ____________________

2. Present Chief Complaint: [ ] C [ ] T [ ] L-S [ ] Non-Spine
What complaint has the patient presented?

3. Spinal Pain Radiation:
   - Level I: Pain localized to spine
   - Level II: Pain radiating to the elbow or knee
   - Level III: Pain radiating below the elbow or knee
   Check the appropriate box indicating the area of radiation of pain, if any.

4. Numeric Pain Rating Scale (NPRS): [ ] 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 (unbearable pain)
   Indicate the number that the patient describes his or her present level of pain along a numeric rating index from 0 to 10, where zero equals no pain and ten equals severe or unbearable pain.

5. Restrictions of Activities of Daily Living / Functional Index:
   (no limitations) - 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 (totally disabled)
   Indicate the number that the patient describes as a summary of how much the condition is currently limiting their Activities of Daily Living. Zero represents no limitations and ten represents total disability.

6. Work Capabilities: [ ] Employed [ ] Unemployed [ ] No Work Limitations
   L: Capable of restricted work duty
   U: Unable to work
   First indicate whether the patient is currently employed, unemployed. These indicate any limitation or restriction related to his or her employment by checking the appropriate box on line two. An unemployed patient may have limitations and restrictions that would affect their ability to work. If so, please indicate this by checking the appropriate box on line two.

7. To date, how does the patient describe their overall improvement since the initial visit on a scale of 0 to 100?
   (none) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% (Total)

8. What has the patient stated is their overall improvement since care began for this episode?

9. Does the patient demonstrate any physical impairment related to this diagnosis and/or episode of care?
   Y: Yes  N: No

If yes, please provide the area of impairment, the degree of impairment and the reference source used to rate this impairment:

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The Physician acknowledges that this Discharge Report has been personally reviewed, contains information, which is truthful and accurate, and has been submitted by authorized staff on behalf of physician.

Physician’s Signature ____________________ Date ____________________
CONTRAINDICATIONS TO MODALITIES

The following modalities are associated with contraindications to their use. All modalities require that the patient be able to comprehend and cooperate with treatment.

Ultrasound

It is a contraindication to apply ultrasound over/to any of the following areas or to patients with any of the following conditions or devices:

- Epiphysis of growing bones
- Reproductive organs
- Eyes
- Heart
- Pregnant uterus
- Spinal column
- Malignancies
- Celiac, mesenteric or stellate ganglia
- Acute infections
- Ischemic areas
- Peripheral vascular disease
- Metallic implant (continuous ultrasound)
- Patients with pacemakers

Electric Muscle Stimulation

Electric Stimulation; Low Volt Galvanic Stimulation; Interferential Current; High Volt Galvanic Stimulation

- Patients with a pacemaker or a coronary disease
- Directly over or through the heart
- Directly over abrasion
- Directly over, near or through a recent unhealed fracture site (stimulation of overlying muscle to contraction)
- Over or near a pregnant uterus
- Over moles or warts
- Over malignancies
- Over an infection
- Transcerebral stimulation
- Directly over or through a metal implant (low volt galvanic)
- Desensitized areas (low volt galvanic stimulation)
- Disease processes causing increased local or general metabolism (inferential current)
- Danger of hemorrhage
- Thrombosis
- Over the carotid sinus
- Patients prone to seizure

**Cryotherapy**

Contraindications for modality include the following:

- Raynauds phenomenon
- Previously frostbitten areas
- Hypersensitivity to cold
- Diabetes

**Heat Therapy**

Application of heat via conduction, such as hydrocollator packs. Contraindications for modality include the following:

- Sunburn
- Skin rashes
- Infected Wounds
- Recently formed scar
- Patients who are circulation impaired
- Patients who cannot comprehend or cooperate with care
- Over areas treated deep heat rubs
- Patients on relaxant medication

**Traction**

- Osseous neoplasm
• Advanced osteoporosis or osteomalacia
• Local osseous infection
• Severe cardiovascular or hypertensive disease
• Localized vascular disease
• Diseases of the spinal cord
• Advanced cachexia
• Pregnancy (pelvic traction)
• Severe muscular spasm (intermittent traction)
• Inflammatory arthridities (intermittent traction)
• Acute intervertebral disc syndrome (intermittent traction)
• Acute inflammation of musculoskeletal tissue (intermittent traction)

**Diathermy**

• Metallic implants
• Implanted electromedical devices; i.e., pacemakers, stimulators, etc.
• Skin surface perspiration
• Contact lenses
• Acute inflammatory conditions
• Ischemic tissue
• Pain and/r sensory deficit
• Pregnancy
• Menstruation (may alter menstrual flow)
• Young children; consideration of growing epiphysis
• Tattoos
• Synthetic Implants
CLINICAL ALERTS AND INDICATORS

The procedure that can be described by the term manual therapy, including chiropractic manipulative therapy, may vary significantly from chiropractic to chiropractor depending on the technique utilized, the individual preferences of the chiropractor and the constellation of clinical indicators. Accordingly, the following list of clinical alerts and guidelines will apply to all manual therapy procedures described in the treatment plan section of the Initial Care Plan.

- Acute rheumatoid, rheumatoid-like and non-specific arthropathies including ankylosing spondylitis characterized by episodes of acute inflammation, demineralization, ligamentous laxity with anatomic subluxation or dislocation.

**Chiropractic Manipulative therapy (CMT) is contraindicated and suspended until the acute flare up is resolved.**

- Acute fractures and dislocations, or healed fractures and dislocation with signs of ligamentous rupture or instability.

**CMT is contraindicated for the specific site or area of the fracture or dislocation. Areas distal and proximal to the involved site cannot be used as levers or a lever system with manipulation of unrelated areas.**

- Unstable os odontoidium

**High-velocity cervical spine manipulation is contraindicated.**

- Acute juvenile avascular necrosis, specifically of the weight-bearing joints.

**CMT is contraindicated at that site.**

- Benign bone tumors

**CMT is contraindicated at that site.**

- Malignancies

**Before CMT is certified or rendered, metastasis to bone must be ruled out with a negative bone scan result obtained no more than 4 week/ 1 month prior to treatment or patient is being co-managed by the treating chiropractor and the appropriate medical specialist.**

- Infection of a bone and joint

**CMT is contraindicated at that site.**

- Clinical manifestations of vertebral artery insufficiency.

**CMT is contraindicated and the patient is to be referred for appropriate medical intervention.**
• Significant aneurysm of major blood vessel.

If the patient is under the care of the appropriate medical specialist, an appropriate referral is indicated. Chiropractic care will be certified as long as the patient is being co-managed by the treating chiropractor and the appropriate medical specialist.

• Signs and symptoms of acute and myleopathy or cauda equina syndrome.

In the case if cauda equina syndrome, no chiropractic treatment is certified and an appropriate referral is required. In the case of an acute myleopathy, the chiropractic care will be certified on a clinical trial basis of up to 3x/wk for 4 weeks as long as: the source of the myleopathy is known, the type of imaging study is known, and the patient displays evidence of subjective and objective improvement. If at the end of this clinical trial, or during this clinical trial, the patient fails to show any improvement, an appropriate referral is indicated.

• Articular hypermobility or circumstances where the stability of a joint is uncertain.

CMT is contraindicated at that site.

• Post-surgical joints, especially those that might be used to provide leverage during CMT.

CMT is contraindicated if there is any instability in these joints. No prosthetic/post-surgical joints are to be used as a lever system during manipulation.

• Bone-weakening disorders.

High-velocity cervical spine manipulation is contraindicated.

• Blood dyscrasias and conditions being treated with anticoagulants.

High-velocity cervical spine manipulation is contraindicated.
TYPES OF CARE

MEDICALLY NECESSARY CARE

Care that produces the best clinical outcome for the patient in the least amount of time with the lowest risk. Triad Healthcare, Inc. manages care by condition severity and patient outcomes.

THERAPEUTIC / REHABILITATIVE CARE

The treatment necessary to establish a stationary status of the patient at maximum therapeutic benefit. That phase of therapeutic care necessary for re-education or functional restoration of an injured body system or part. It includes treatment that relieves an exacerbation, but there must be continuing documented subjective and objective signs of improvement. Guidelines for the management of therapeutic/rehabilitative care are integrated into the TRIAD Severity Index Matrix, except where noted within this document. Therapeutic care must produce minimal improvement in patient comfort and function of at least 30% within any thirty day period to be considered medically necessary.

MAINTENANCE/PREVENTATIVE

Care that is rendered to a patient whom is asymptomatic. Care is determined to be for wellness or preventive to maintain good health with no symptoms.

Please refer to the “Plan Specific Addendums” at the end of this manual for the definitions of the types of care.

SUPPORTIVE CARE

Supportive Care is defined as treatment / care for patients having reached maximum therapeutic benefit, where periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate. Supportive care follows appropriate application of active and passive elements including lifestyle modifications. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and lifestyle modifications, have been considered and attempted. Supportive care may be inappropriate when the risk of supportive care outweighs its benefits, i.e., physician dependence, somatization, illness behavior or secondary gain.

Clinical Goals for Supportive Care

Supportive Care for chronic painful conditions of the musculoskeletal system recognizes that the underlying condition is either permanent in nature or has a long natural course during which the patient is at risk for painful, debilitating episodes that can be minimized or eliminated by supportive care. Therefore, the goals of supportive care are:

1. Establish a credible, practical diagnosis, prognosis and set of patient expectations.
2. Maintain baseline, pain and function with minimal deviation.
3. Provide the safest form of care possible.
4. Provide as little passive care as possible.
5. Educate and counsel the patient to use as much appropriate self-directed, active care as possible.

**Requesting Supportive Care**

Supportive care should be requested only after a patient has reached maximum therapeutic benefit, has been fully educated on appropriate self care modifications to daily activities and work activities and has reported increased pain and/or functional loss after a period of withdrawal from care.

The use of CMT, active physical procedures and patient education is appropriate in providing supportive chiropractic care. The expected frequency and intensity of care should be much less than is typically required for therapeutic care. The expected duration of care is much longer.

Supportive care must be requested using an Extension of Care form. This form is completed similarly to when you are requesting continued therapeutic care, except you must check “Supportive Care” in type of care field as well as checking the appropriate box for the desired duration of care. Unlike therapeutic care, supportive care requests will be approved for periods exceeding thirty days. Periods of up to 180 days will be approved before another Extension of Care is required.
PHILOSOPHY AND RATIONALE

PHILOSOPHY

Chiropractic, like all disciplines that treat patients with painful musculoskeletal disorders, faces the difficult task of defining the root cause of the patient’s complaints. This is often difficult because pain is expressed very uniquely by each individual and seldom corresponds well to any specific physical problem. This is especially true with complaints of back pain. Accordingly, diagnosing and treating these patients requires skills and techniques unlike those required for any other class of complaint. As a result, there are an unusually large number of healthcare disciplines dedicated to treating these patients, as compared to the number of disciplines dedicated to the care of more definable complaints, such as chest pain and abdominal pain. In addition, the number and diversity of methods and techniques used by healthcare providers treating back pain, in particular, is staggering. Chiropractic alone, lays claim to over 200 individual techniques designed to address back pain and its causes. Most of these are mutually exclusive, none have been identified by the profession as superior to any other (best practice) and all are available for use by any licensed chiropractor at their discretion without any specific training or certification. Appreciating this, the chiropractor remains one of the most reliable healthcare providers for the patient with back pain, frequently getting good results and almost always generating the highest levels of patient satisfaction.

To summarize, chiropractic works, but it may be more of an art form than a science.

Nevertheless, we practice in an environment dominated by science and are often expected to define, explain and justify our work from that perspective. This has forced many of us to explain our methods and good outcomes in ways that conform to the industry’s model, but are not accurate or consistent among individual providers. As a result, we largely remain a mystery, which has clearly become a double edged sword. On one hand, we cannot be categorized, pigeon holed or tied down as a profession. On the other hand, those who wish to understand, embrace and support us cannot do so.

Triad is a managed care company. We acknowledge that chiropractic care is appropriate for most neuromusculoskeletal conditions. We acknowledge that clinical guidelines cannot be validly applied to an individual patient’s care. We recognize and accept that all techniques accepted by the profession must be available to the chiropractor in applying their art. We insist that chiropractors be recognized for their full scope of practice. We are committed to supporting the patient’s choice of healthcare provider. We at Triad Healthcare Inc. are focused on defining medical necessity in one simple way, care is medically necessary when it resolves the patient’s complaint, safely, effectively and efficiently.

Triad has the responsibility to manage the care provided by over 7,000 chiropractors from around the United States. To do this responsibly, we have looked to develop common ground on which all chiropractors stand. We have developed two concepts:

1. A Set of Universal Clinical Outcomes to define the results that we are striving to achieve with our care. These are: resolution of pain and restoration of function as defined by a patient’s unique activities of daily living and work activity.
2. *A Common Clinical Language* to define the common components of that care. These include: duration, frequency and intensity of care.

**RATIONALE**

**Insufficient Progress**

Triad manages care for multiple allied specialties using a methodology that requires only one thing from the provider - to achieve reasonable progress towards resolution of pain and function using only the medically necessary duration, frequency and intensity of care. Our expectations, supported by the literature and by professional consensus, are that therapeutic care must produce minimal improvement in patient comfort and function of at least 30% within any thirty day period to be medically necessary. Some patients may improve more rapidly as is commonly communicated in the case and ethnographic studies in the professional chiropractic literature. Some patients may improve more slowly, but it is unusual that this rate of progress will yield lasting therapeutic benefit. Triad uses standard measures reported by the chiropractor at thirty day intervals to calculate minimal improvement against this expected minimum. Care failing to achieve minimal progress levels is denied for “insufficient progress.”

**Type of Care Not Medically Necessary**

Therapeutic care must yield a minimum amount of progress towards the resolution of the patient’s complaint of pain and functional loss. At times, a patient will respond, incompletely, to therapeutic care. This usually occurs because the underlying condition is either permanent in nature or self resolving with a long natural course. In both cases, supportive care may benefit the patient. Less often, patients respond, incompletely because they require additional therapeutic care of a different type or from a different provider. When no additional therapeutic care is indicated because the patient has complaints stemming from a permanent or chronic condition, and maximum therapeutic benefit has been achieved, supportive care may be appropriate.

**Number of Requested Visits (Frequency)**

Prior approval of a number of visits by a chiropractic reviewer represents the application of general medical policy, an estimate and best clinical judgment. Development of a treatment plan by a provider represents application of the provider’s knowledge base, clinical experience and personal bias, and is also an estimate. It is often reported to us that the provider has a better perspective to make this estimate because it is the provider who has actually examined the patient. Sometimes this is true, sometimes it is not. Regardless, it is Triad’s policy to offer benefit of doubt to the treating chiropractor when it comes to the approval of the number of planned visits. To do this we approve visits based on the number we believe is necessary to yield a minimal degree of patient improvement. Sometimes, this number is less that the chiropractor has requested for a thirty day period. Regardless, we strongly recommend that you apply the approved visits at the frequency you believe is most necessary for the patient. It is our expectation that your judgment is most likely to result in the required amount of improvement. When you have used the approved number of visits, regardless of the time required to do this, additional visits may be approved by submitting an Extension of Care Plan. Triad’s policy is to evaluate the amount of progress that the care has yielded to date to determine if continued care is likely to result in further meaningful
therapeutic gains. Ultimately, the number of visits necessary to achieve good clinical outcomes varies greatly from patient to patient and this method allows approval for the number of visits necessary to achieve these outcomes in an individualized, patient centered manner. In short, the most important factor going into our decisions to approve continued care, is patient response to the care already provided. If the care provided has demonstrated significant improvement, continued care will be approved until the patient’s complaints are resolved or maximum therapeutic benefit has been established. Triad uses no industry guidelines or financial models to impact our medical management determinations regarding frequency of care. We apply policy created and approved by practicing chiropractors and principles focused on medical necessity as defined by safe, effective and efficient patient centered care.

**Number of Requested Modalities Per Visit**

Chiropractic is uniquely effective because of the therapeutic benefit of the chiropractic manipulative treatment.

Historic chiropractic utilization strongly suggests that regardless of the physical modalities and procedures rendered chiropractic manipulative treatment is rendered on every chiropractic visit with minimal exception.

Historically, the use of modalities by chiropractors has been aggressively challenged from within the profession with a minority but not insignificant number of practitioners who practice chiropractic completely without the use of concurrent physical modalities and procedures.

There is no documentation in the medical literature to suggest that these providers treat either a different class of patient or condition than those providers who use physical modalities and procedures or that there is a difference in the clinical outcome between the two. Therefore, the chiropractic profession through its practice, literature, and structure does not offer consensus that the use of physical modalities and procedures is necessary to provide patients with high quality or effective chiropractic care.

The use of physical modalities and procedures in chiropractic practice is unique and distinct from the practice of physical therapy because physical modalities and procedures are rendered concurrent to or in conjunction with chiropractic manipulative treatment. As a result of this, the clinical rationale used by physical therapists for physical modalities and procedures is not logically transferred to chiropractic practice and the use of these physical modalities and procedures must be viewed for the value that they offer the patient as an adjunct to chiropractic manipulative treatment.

The medical literature defining the appropriate use of physical modalities and procedures is not applicable to the chiropractic practice because in no instance in the medical literature is the use of physical modalities concurrent or in conjunction with the chiropractic manipulative treatment.

Adjunctive physical modalities and/or therapeutic procedures are defined as services rendered in conjunction with or concurrent to the primary treatment, the chiropractic manipulative treatment.

The purpose for delivering adjunctive physical modalities and procedures is to improve the clinical efficacy, effect and application of chiropractic manipulative therapy in the presence of factors that may impair its effect.
Factors that may impair the delivery of CMT include initial patient fear of the chiropractic manipulative therapy and/or extreme patient pain and the associated physical concomitants such as muscle spasm.

The factors that may impair the effect of the CMT include muscular de-conditioning (strength/endurance), muscular imbalances or in-coordination and/or ligamentous instability. Physical modalities and therapeutic procedures are only considered adjunctive to the effect of the CMT when there is an established therapeutic value to their use and this value is measurable and includes a defined outcome.

For these reasons, the use of adjunctive physical modalities and procedures in conjunction with chiropractic manipulative treatment is best justified as medically necessary when only one such adjunct is used and only for a period of time during which the factors complicating the delivery or the effect of the chiropractic manipulative therapy should be reasonably expected to exist. The use of multiple adjuncts has not been established as medically necessary in chiropractic literature nor has the use of such adjuncts for extended periods of time.
RADIOLOGY GUIDELINES
Refer to Plan Specific Addendum

All diagnostic imaging services for NEW patients are to be based on clinical necessity.

When no recent radiographs of the area in question are available from another provider, it may be appropriate to expose new films if at least one of the following is documented in the record:

- Significant subjective pain/impairment findings specific to the area to be imaged;
- Significant objective findings specific to the area to be imaged;
- History indicating the possibility of infection, neoplasm, fracture, inflammatory process, or other potential contraindication for manipulative therapy;
- Recent significant trauma (any age); recent mild trauma (patient over 50); history of long-term steroid use, osteoporosis, patient over age 70.

All diagnostic imaging services for ESTABLISHED patients are to be based on clinical necessity. When no recent radiographs of the area in question are available from another provider, it may be appropriate to expose new films if at least one of the following is documented in the record:

- Significant worsening in subjective pain/impairment findings specific to the area to be imaged;
- Significant worsening in objective findings specific to the area to be imaged;
- Significant new injury / aggravation in a previously images area;
- Significant pain / impairment findings in an area nor previously imaged;
- History indicating the possibility of infection, neoplasm, fracture, inflammatory process, or other potential contraindication for manipulative therapy;
- Lack of response to treatment of problems not previously imaged;
- Previous imaging showed possible fracture or pathology.

Diagnostic Imaging Procedures

Triad is in full accord with, and promotes the parameters for, the imaging utilization guidelines published in the Guidelines for Chiropractic Quality Assurance and Practice Parameters (Aspen, 1993). Compliance will be expected. Clinical indications for imaging should be thoroughly documented in the case record.
CLINICAL RECORDS

CLINICAL RECORD OVERVIEW

- Clinical records should contain S.O.A.P. (Subjective, Objective, Assessment, Plan/Procedure) or equivalent information.
- Use black ink for clarity and quality of copying if handwriting is not legible, records should be typed.
- Notes should be timely, brief, and include all pertinent data.
- Standard abbreviations are acceptable.
- Copies of all correspondence regarding a case, including return-to-work notes, referral letters, reports, telephone communication, written authorization to release information, consent to treat forms, etc. should be maintained.

ADMITTANCE FORMS

Admittance forms constitute the basis of subjective information to which the clinician adds objective data leading to his or her diagnostic impression and subsequently to a reasonable and necessary treatment plan.

While the patient initially completes admittance forms, they must be reviewed thoroughly by the clinician. Areas of vague or incomplete information must be completed, clarified, or expanded to become clinically significant.

While it is reasonable for a chiropractic assistant to aid the patient in completing admittance forms, the treating doctor must thoroughly review pertinent data with the patient prior to the examination process.

RECORDING THE HISTORY

Clear and legible entry in the patient chart record of all significant history findings is required to document the level of history performed. An adequate history will appropriately identify the region to be examined and the extent of the condition. Pertinent negative and positive responses should be recorded in each category of the history.

- **Presenting Complaints**
  
  This section of the record documents both the primary and secondary complaints. It should detail the location and type of pain, severity, frequency, radiating pain, alteration of physiological function and alteration or impairment of function in work, play or daily living.

- **History of Primary Complaint**

  The patient’s complaints should be noted by detailing the date and type of onset (gradual or sudden) and the causable incident or accident mechanism and physical forces involved, as well as exacerbation and causes. Previous treatment, diagnostic procedures as well as results should also be noted.
• Health History

Past injury, illness, disability, work history, surgeries, pregnancies, family and psycho-social history, review of available records, systems review, etc. Focus is on past incidents that directly influence the area of chief complaint.

RECORDING EXAMINATION FINDINGS

Negative, positive and “not positive but significant” findings should be documented in the record. Negative findings are important because they show normal response and allow the examiner’s focus to shift logically elsewhere. Positive findings and elicited responses should be recorded. For example, your record might show Lasegue’s / SLR test was performed to 20 degrees causing pain to extend down the posterior thigh to the knee. Merely stating “Lasegue’s positive” is inadequate to express the true nature and extent of the finding.

CLINICAL RECORDS CONTENTS

• Problem List

A problem list should index the patient’s current problems, complaints, risk factors and/or diagnoses. The problem list may also include plans for diagnosis or treatment of each patient problem. The problem list helps to maintain the doctor’s focus on patient needs and the treatment plan. As problems are resolved, resolution may be noted on the problem list.

• Subjective Data (History)

This refers to patient symptoms and includes all information given in the course of consultation and treatment that has relevance to the clinical condition. It should detail the location and type of pain, severity, frequency, radiating pain, alteration of sensory or motor function, and impairment of function in work, play or daily living.

• Objective Data (Examination)

This category includes your clinical findings based on various examination and diagnostic procedures. Include all descriptive terms for intensity (e.g.: mild-moderate-sever) and quality (sharp-dull-burning-aching, etc.). This data should be entered in the record and is support for necessary care.

• Assessment (Clinical Decision Making)

This is your impression of the patient’s condition or response to treatment. The assessment should correlate the objective and subjective information of that day and explain discrepancies and changes in patient status. Assessment will also be updated after re-examinations, exacerbations or as new diagnostic information becomes available.
• Procedure / Plan (Management)

Following the assessment of the patient and formulation of the impression, a plan for follow-up procedures should be established. This is essentially an outline of what you intend to do for the patient. Include diagnostic and treatment procedures, active home activities and any referral plans. Under subjective, patient compliance and response to such recommendations should be noted since it may impact upon the authorization of future care.

REQUESTING CLINICAL RECORDS

Clinical records will be requested when clinical issues cannot be resolved telephonically or when a payor requests a review of the clinical record. TRIAD will request only that information necessary for the review. TRIAD reimburses at rates set by applicable statute for clinical files requested unless otherwise required by contract or law.

STATEMENT OF CONFIDENTIALITY

The participating providers and their employees shall comply with all applicable state and federal Patient Privacy and Confidentiality Laws.
OBJECTIVES & STANDARDS FOR THE PRACTICE OF CLINICAL CHIROPRACTIC

OBJECTIVES & STANDARDS

Objective 1

To establish a satisfactory relationship with the patient and determine the nature of the patient’s health problem.

Standard 1

As a healthcare provider and as a portal entry to healthcare delivery system, the chiropractic physician shall:

1. Accept responsibility for the chiropractic care and management of the patient’s condition;
2. Recognize professional capabilities and limitations in himself/herself;
3. During the initial patient interview and consultation, employ measures of observation to profile the patient’s health problem;
4. Continue with the patient and/or refer to another healthcare provider.

Objective 2

To elicit from patient a case history to determine if the patient has a health problem amenable to the application of clinical chiropractic diagnostic or therapeutic procedures, or whether referral to another healthcare provider is indicated.

Standard 2

The chiropractic physician shall document a thorough case history on each patient and provide a permanent record of the findings:

1. An understanding of the patient’s chief complaint, past and present health pattern, and psycho-social factors;
2. A basis for the specific need of the physical and objective diagnostic examinations;
3. Recognition that in the best interest of the patient, referral or consultation may be necessary before further clinical investigation takes place.

Objective 3

To arrive at a provisional clinical diagnosis by evaluating evidence using differential diagnostic assessment, diagnostic tests and X-rays when indicated. This includes an attempt to identify problems unrelated to the chief complaints.
Standard 3

The chiropractic physician, within the statutory scope of practice, shall:

1. Utilize appropriate diagnostic procedures, techniques and instrumentation used in the academic and clinical training received in and through state approved colleges of chiropractic;
2. Recognize concomitant conditions, establish any interrelationships, directing the proper referral and recording in the case record.

Objective 4

To use judgment in ascertaining the appropriate course of chiropractic care.

Standard 4

The chiropractic physician, in determining an appropriate plan for care, shall:

1. Provide patients with only those appropriate treatment methods that are determined to have chiropractic necessity and are within the scope of practice allowed by state law/regulations;
2. Inform the patient in non-technical terms of all anticipated practices and procedures including the probability of success, and the result to be anticipated with and without the proposed plan for care;
3. Record and date the treatment plan in the case record and any additions or deletions that may occur.

Objective 5

To monitor the patient to ensure that progress is as expected and to make appropriate changes in management as required.

Standard 5

The chiropractic physician, in providing appropriate care, shall:

1. Institute the appropriate chiropractic management and treatment. This includes treatment of the disorder, the relief of discomfort, and alleviating of environmental, causal and irritating factors where possible;
2. Modify treatment to the needs of individual patients;
3. Monitor and assess the patient’s progress resulting from treatment, and record such information in the patient’s case record file in a form that is legible and allows interpretation by others;
4. Recognize the need for periodic objective reassessment of the patient to appropriately modify the diagnosis, prognosis, and treatment plan including any necessity for consultation and referral;
5. Identify and provide proper information and education to modify lifestyle and/or health habits that will enhance the well-being of the patient.
Objective 6

To discharge the patient at the endpoint of treatment when all evidence of disease and dysfunction has been eliminated or no further improvement in the patient’s condition can be reasonably expected. This responsibility may include the follow-up care of the patient when necessary.

Standard 6

The chiropractic physician, in determining limits to a patient’s therapeutic care, shall:

1. Evaluate the patient’s clinical progress;
2. Plan effective follow-up care by referral, or by counseling and instructing the patient and his or her family, if necessary, regarding causative and aggravating factors, management and prognosis for the problem, including preventative measures.

TRIAD'S POLICY ON INTRA-PROFESSIONAL / INTER-PROFESSIONAL REFERRAL

With respect to consultation and referral as a primary contact physician, the Doctor of Chiropractic recognizes the need for intra-inter-professional consultation and referral of patients that may require specialized testing and/or treatment based on the diagnosis, when clinical judgment indicates or when additional appropriate care appears necessary.
APPEALS AND GRIEVANCES

COMPLAINTS

Triad Healthcare Inc. encourages open communication and expressions of satisfaction and dissatisfaction. A complaint, suggestion, or compliment can be submitted by phone or in writing. All complaints are researched and resolved in a timely manner.

PATIENT CARE/CLAIMS PAYMENT APPEALS

Please refer to the “Plan Specific Addendums” at the end of this manual for the Appeals and Complaint policies for ALL plans.

CREDENTIALING

1. You may make a verbal or written appeal. All parties are encouraged to communicate issues of concern to the appropriate TRIAD personnel as identified in the Network Services section of this manual. We encourage you to attempt to reach a solution by telephone with the appropriate TRIAD staff.

2. A level 1 appeal can be initiated, at any time, by completing the attached Appeal Referral Form (see page 58) and submitting it to TRIAD’s Credentialing department fax number 888-844-6645.

3. Upon receipt, you will be contacted by a member of our Credentialing staff and will be given further information about your appeal/grievance.

TRIAD PROVIDES MULTIPLE LAYERS OF APPEAL

1. If you are not satisfied with the result of the standard level 1 as rendered by the Credentialing Department, you may request a second level appeal.

2. All Level 2 appeals are re-investigated and evaluated by our Medical Quality Improvement Committee.

CONFIDENTIALITY

All parties involved in the Appeal Procedure shall hold any and all information regarding the provider, the patient of the provider and this Appeal Procedure in the strictest confidence and shall not voluntarily disclose to others any portion of such confidential information, except as required by applicable law.
NO RETALIATION

No provider shall be terminated from the TRIAD network or be penalized by TRIAD solely because such provider filed a grievance or an appeal as permitted by the policies and procedure of TRIAD or by applicable law and regulations.
DEFINITIONS

1. **Accessibility:** A member’s ability to obtain healthcare, taking into consideration the availability of healthcare services, their acceptability to the member, the location of the healthcare services, the availability of convenient transportation, the hours of operation, the cost of care and other factors.

2. **Active Care:** Modes of treatment/care requiring “active” patient involvement, participation and responsibility on the part of the patient.

3. **Administrative Non-Certification:** The non-certification of requested care due because of non-compliance with TRIAD’s policies and procedures.

4. **Adverse Determination:** A determination by an insurer or its designee that the healthcare services furnished or proposed to be furnished to a covered person are:

   - Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
   - Benefit coverage or payment is therefore denied, reduced, or terminated.

5. **American Board of Clinical Specialists (ABCS):** Organized originally in 1933 as the Advisory Board of Clinical Specialists, the ABCS (1970), in collaboration with the American Clinical Association (ACA), is the recognized certifying agent for establishing and maintaining standards of clinical specialization and pattern of training.

6. **Ancillary Procedures:** All therapeutic procedures other than spinal manipulation, as permitted by individual state law/regulations and appropriate for patient management.

7. **Appeals Consideration:** Clinical review conducted by appropriate clinical peers, who were not involved in peer clinical review, when a decision not to certify a requested admission, procedure or service has been appealed. Sometimes referred to as “third-level review.”

8. **Care Goals:** Patient progress under a regime of care should lead to the increasing of the active (exercise, etc.) aspects of care and the decreasing of passive care. Chronically should be prevented whenever possible with increased emphasis on active care. More aggressive in-office interventions may be necessary during the acute or severe phase. Progressively declining frequency is expected, leading to discharge of the patient, or conversion to elective care. It shall be the provider’s responsibility to identify and document the point at which maximum therapeutic benefit has been accomplished. Therapeutic motivation, goals and fiscal responsibility are different for elective care than for therapeutically necessary care. After reaching the point of maximum improvement, patient discharge occurs and/or elective care begins with proper disclosure and informed patient consent.

9. **Case Management:** A collaborative process that accesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.
10. **Certification:** A determination by a network that an admission, extension of stay or other healthcare service has been reviewed and, based on the information provided, meets the requirements for clinical necessity, appropriateness, level of care or effectiveness under the auspices of the applicable health benefit plan.

11. **Chiropractic Information Network-Board Action Database (CIN-BAD):** CIN-BAD is an on-line service of the Federation of Chiropractic Licensing Boards. CIN-BAD provides information on chiropractors that have public records of actions by chiropractic regulatory licensing boards and/or exclusions from Medicare/Medicaid reimbursement by Health and Human Services.

12. **Chiropractic Necessity:** Appropriate care is proper and necessary for the diagnosed condition, when it is shown to be curative or rehabilitative for the condition, and reflects accepted standards of good practice within the scope of practice allowed by state law / regulations. Care that will not be certified for reimbursement that includes care that is inappropriate for a given condition; care that presents risks in excess of expected benefits; care that is obsolete, experimental or investigational.

13. **Chronic Care:** A patient’s condition is considered chronic when it is not expected to completely resolve (as would an acute condition) but when continued therapy can be expected to result in some functional improvement.

14. **Clinical Director:** A doctor of chiropractic, doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice in at least one (1) state in the United States who is an employee of or a party to a contract with a network, and who has responsibility for clinical oversight of the Network’s utilization management, credentialing, quality management and other clinical functions.

15. **Clinical Peer:** A physician or other health professional that holds an unrestricted license and is in the same or similar specialty as typically manages the clinical condition, procedures or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, e.g., the same licensure category as the ordering provider.

16. **Clinical Rationale:** A statement, which provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient’s condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

17. **Clinical Review Criteria:** The written screens, decision rules, clinical protocols or guidelines used by the Network as an element in the evaluation of clinical necessity and appropriateness of requested admissions, procedures and services under the auspices of the applicable health-benefit plan.

18. **Clinical Trial:** is defined as a test of the effectiveness of a therapeutic application over a period of thirty (30) days.

19. **Complaint:** An oral or written expression of dissatisfaction by a member regarding a specified problem or issue without a request for a formal grievance or appeals hearing.

20. **Concurrent Review:** Utilization management conducted during a patient’s hospital stay or course of treatment, sometimes called continued-stay review.
21. **Council on Chiropractic Education (CCE):** The CCE’s Commission on Accreditation accredits institutions/programs offering the Doctor of Chiropractic (DC) degree. Accreditation is a status granted by the Commission on Accreditation of the Council on Chiropractic Education to institutions that have been found to meet the state standards for chiropractic programs and institution’s and also has satisfactorily addressed the institutions mission, goals and objectives.

22. **Coverage Denial:** An insurer’s determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person’s health benefit plan.

23. **Credentialing Verification:** The process by which specific criteria for a healthcare practitioner are verified for use in determining the initial and ongoing approval for network participation.

24. **Disciplinary Action:** The overall process of conducting a proceeding that addresses network problems and issues with individual network providers. Such a proceeding includes due process for the provider and may result in sanctions imposed on the provider by the Network.

25. **Elective Care:** Treatment/care requested by the patient, designed to promote optimum function.

26. **Emergency:** A serious medical condition resulting from injury, sickness or mental illness which arises suddenly and requires immediate care and treatment, generally within 24 hours of onset, to avoid jeopardy to the life or health of a person as determined by a prudent lay person or as mandated by state law.

27. **Episode of Care:** Care related to a specific diagnosis or condition for duration of time necessary to resolve the condition or reach maximum therapeutic benefit (MTB). The duration of time necessary for a patient, who re-enters the office after discharge or MTB, with a non-traumatic same or similar complaint arising out of activities of daily living (ADL), to be classified as a new episode of care, is three (3) months. All new episodes of care are required to go through the pre-certification process the same as a new patient.

28. **Established Patient:** A patient who has previously treated with the doctor but has not been seen in the past three months. All established patients are required to go through the pre-certification process the same as new patients.

29. **Exacerbation:** An exacerbation is a temporary, marked deterioration of the patient’s condition due to an acute flare-up of the condition being treated. Treatment of a patient, who experiences repeated exacerbations during active care, may indicate that the patient has reached maximum therapeutic benefit.

30. **Existing Patient:** A patient that is currently being treated with a doctor and is covered under a TRIAD contract at the time the doctor is credentialed into the network. All care on “existing” patients from the time the doctor is in the network must be certified by utilizing the “Initial Care” form with all case notes and reports.

31. **Expedited Appeal:** A request by telephone for additional review of a determination not to certify imminent or ongoing services requiring a review conducted by a clinical peer who was not involved in the original decision not to certify.
32. **Facility Rendering Service:** The institution/organization in which the requested admission, procedure or service is provided. Such facilities may include, but are not limited to, hospitals, outpatient surgical facilities, individual practitioner offices, rehabilitation centers, residential treatment centers, skilled nursing facilities, laboratories and imaging centers.

33. **Federation of Chiropractic Licensing Boards (FCLB):** FCLB is a non-profit organization established as the professional association for governmental regulatory boards responsible for chiropractic licensure.

34. **Grievance:** A formal written request by a member for a hearing by the Network regarding: 1) a complaint about care or services received from the Network or from a network provider, or, 2) an appeal of a decision made by the Network with regard to the provision of a requested service.

35. **Health Professional:** An individual who: 1) has undergone formal training in a healthcare field; 2) holds an associate or higher degree in a healthcare field, or holds a state license or state certificate in a healthcare field, and, 3) has professional experience in providing direct patient care.

36. **HEA CCMC-SAP Program:** The Health Education Associates Comprehensive Chiropractic Managed Care Self-Assessment Program is a multi-disciplinary program designed to enhance and strengthen knowledge and understanding while maximizing the efficient delivery of high quality patient-centered, outcomes-focused healthcare.

37. **ICAP: Interactive Clinical Assessment Program:** A multi-disciplinary program designed to enhance and strengthen knowledge and understanding while maximizing the efficient delivery of high quality, patient-centered, outcomes-focused healthcare.

38. **Impairment of Daily Function:** An inability to completely and/or adequately perform activities of work, play, or daily living because of loss or limitation of function.

39. **Initial Clinical Review:** Clinical review conducted by appropriate licensed or certified health professionals. Initial clinical review staff may approve requests for admissions; procedures and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to peer clinical review for certification or non-certification. Sometimes referred to as “first level review.”

40. **Maintenance/Preventative Care:** A regimen designed to provide for the patient’s continued well-being or for maintaining the optimum state of health while minimizing recurrence of the clinical status. Includes treatment procedures considered necessary to prevent the development of clinical status.

41. **Maximum Therapeutic Benefit (MTB):** Following 4 to 8 weeks of the patient’s symptoms/condition having reached a plateau, the patient will be considered at MTB.

   **NOTE:** Reimbursement for care beyond MTB (supportive or maintenance care) is dependent upon policy language and plan benefits.

42. **Non-Certification:** A determination by a network that an admission, extension of stay or other healthcare service has been reviewed and, based on the information provided, does not meet the
clinical requirements for clinical necessity, appropriateness, level of care or effectiveness under the auspices of the applicable health benefit plan.

43. **Non-Clinical Administrative Staff**: Staff who do not meet the definition of health professional.

44. **NPDB**: The National Practitioner Data Bank contains adverse licensure action reports on physician and dentists (including revocations, suspensions, reprimands, censures, probation and surrenders for quality purposes); adverse clinical privilege actions against physicians and dentists; adverse professional society membership actions against physicians and dentists; and clinical malpractice payments made on all health practitioners.

45. **Palliative Care**: Relieves the symptoms of an exacerbation but results in no net improvement in the patient's stationary condition.

46. **Passive Care**: Application of treatment/care modalities by the provider to the patient, who “passively” receives care.

47. **Patient-Specific Information**: Information that is sufficient to allow identification of an individual patient.

48. **Peer Clinical Review**: Clinical review conducted by appropriate health professionals when a request for an admission, procedure or service was not approved during initial clinical review. Sometimes referred to as “second level review.”

49. **Primary Verification**: Verification by the network of a healthcare practitioner’s qualifications and credentials based on evidence obtained from the issuing source of the credential.

50. **Principal Reason(s)**: A clinical or non-clinical statement describing the general reason(s) for the non-certification determination (“lack of clinical necessity” is not sufficient to meet this).

51. **Professional Liability**: Refers to a healthcare practitioner’s history of any pending or settled litigated malpractice suits because of the improper or negligent treatment of a patient resulting in damage or injury to the patient.

52. **Prospective Review**: Utilization management conducted prior to a patient’s admission, stay or other services or course of treatment. Sometimes called “pre-certification review.”

53. **Provider Contract**: A legal written agreement between a licensed healthcare facility, physician or other healthcare provider and a network or health plan.

54. **Provider-Specific Information**: Information that is sufficient to allow identification of an individual provider.

55. **Quality of Care**: The extent to which services provided by the Network and by network providers are consistent with current standards of care and contribute to optimum health outcomes.

56. **Quality of Service**: The extent to which services provided by the Network and by network providers meet the reasonable expectations of members for timely, efficient and courteous services.
57. **Reconsideration:** A request by telephone for additional review of a utilization review determination not to certify, performed by the Peer Reviewer who reviewed the original decision, based on submission of additional information or a peer-to-peer discussion.

58. **Recurrence:** A recurrence is a return of symptoms of a previously treated condition that has been quiescent for 60 or more day and may require the reinstitution of therapy.

59. **Rehabilitative Care:** That phase of therapeutic care necessary for re-education or functional restoration of an injured body system or part. It includes treatment that relieves an exacerbation, but there must be continuing documented subjective and objective signs of improvement.

60. **Retrospective Review:** Review conducted after service(s) have been provided to the patient.

61. **Review of Service Request:** Review of information submitted to the Network for healthcare services that do not need clinical necessity certification nor result in a non-certification decision.

62. **Risk Management:** An educational offering designed to assist the provider in minimizing the potential of losses. Such a program may include the identification, analysis and evaluation of areas of potential loss as well as addressing specific incidents that may result in loss.

63. **Sanctions:** Penalties imposed by the Network on network providers who typically fail to abide by network administrative and clinical management requirements, criteria or standards. Such penalties may include fines, requiring the practitioner to participate in a specific program of remedial education or suspension or termination of the practitioner’s network participation status.

64. **Scripted Clinical Screening:** A screening process that includes: 1) accepting structured clinical data (including diagnosis codes, procedures and procedure codes); 2) asking scripted clinical questions; 3) accepting responses to scripted clinical questions; and 4) taking specific action.

   It excludes: a) applying clinical judgment or interpretation; b) accepting unstructured clinical information; c) deviating from the script; d) engaging in unscripted clinical dialogue; e) asking clinical follow-up questions, and, f) issuing non-certifications.

65. **Second Opinion:** Requirement of some health plans to obtain an opinion about the clinical necessity and appropriateness of specified proposed services by a practitioner other than the one originally making the recommendation.

66. **Secondary Verification:** Verification by the Network of a healthcare practitioner’s qualifications and credentials based upon evidence obtained by legitimate means other than direct contact with the issuing source of the credential (i.e., copies of licenses and data base queries from established secondary sources).

67. **Standard Appeal:** A request to review a determination not to certify an admission, extension of stay or other healthcare services conducted by a Peer Reviewer who was not involved in any previous non-certification pertaining to the same episode of care.

68. **Structured Clinical Data:** Clinical information that is precise and permits exact matching against explicit clinical terms, diagnoses or procedure codes or other explicit choices, without the need for interpretation.
69. Supportive Care: Treatment/care for patients having reached maximum therapeutic benefit, where periodic trials of therapeutic withdrawal fail to sustain previous therapeutic gains that would otherwise progressively deteriorate. Supportive care follows appropriate application of active and passive elements including lifestyle modifications. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and lifestyle modifications, have been considered and attempted. Supportive care may be inappropriate when the risk of supportive care outweighs its benefits, i.e., physician dependence, somatization, illness behavior, or secondary gain.

70. Therapeutic Care: The treatment necessary to establish a stationary status of the patient at maximum therapeutic benefit.

71. Therapeutic Necessity: For the purpose of defining the necessity of chiropractic services administered under TRIAD contracts: Medical Necessity, Chiropractic Necessity and Therapeutic Necessity shall be considered equivalent terms; and Therapeutic Care and Curative Care shall be considered equivalent terms; and Maximum Medical Improvement, Maximum Chiropractic Improvement or Maximum Therapeutic Benefit shall be considered equivalent terms. A healthcare condition exists in the presence of impairment (illness/injury) evidenced by recognized signs and symptoms, and likely to respond favorably to the treatment/care planned.

72. Treatment Plan: A written description of intended therapeutic actions divided according to relevant treatment/care goals and prognosis.

73. Unrelated Diagnoses: Two or more diagnoses not related to one another for which treatment is rendered during the same office visit. (i.e., cervical spine strain/sprain and a medial epicondylitis; lumbar spine strain/sprain and tendonitis of the elbow).

74. Utilization Management (UM): Evaluation of the clinical necessity, appropriateness, and efficiency of the use of healthcare services, procedures and facilities under the auspices of the applicable health benefit plan; sometimes called “utilization review.”

75. Written Notification: Correspondence transmitted by mail, facsimile or electronic medium.
ATTACHMENTS
INITIAL CARE PLAN FORM

Physician Name and Tax ID Number __________________________________________
Office Number (____) __________________________ Fax Number (____) ____________

1. □ New Patient □ Established Patient

2a. Begin Date of Service for this request: ____/____/____ (including initial visit)

2b. Onset / Date of Injury: ____/____/____

3. Patient Last Name: _____________ First: _____________ MI: _____________ M ______ F __

4. Member ID No. found on Member's ID card: _______________ DOS: ____/____/____

5. Present Chief Complaints: □ C □ T □ I □ S □ Deboric □ Non Spinal

6. Spine Pain Radiation:
   □ Level I: Pain localized to spine
   □ Level II: Pain radiating to the head, elbow or knee
   □ Level III: Pain radiating below the elbow or knee
   □ N/A

7. Numeric Pain Rating Scale (NPRS):
   (no pain) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (unbearable pain)

8. Restrictions of Activities of Daily Living (Functional Index):
   (no limitations) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (totally disabled)

9. Duration of symptoms: □ 0 – <3 weeks □ >3 – 6 weeks □ >6 weeks

10. History of prior spinal surgery? □ Yes □ No
    □ Asymptomatic >1 year □ Multiple occurrences of symptoms < or = 2 per year
    □ Frequent recurrences of symptoms per year >2

11. Physical Work Capacity as it relates to the patient's current condition
    □ No work limitations □ Some work limitations □ Unable to work
    □ N/A (Children, PT student, Retirees, Permanent total disability)

12. Number of Previous Episodes: □ 0-3 □ 4-5 □ >5

13. Diagnoses
    ICD-9 No.: __________________________ Describe: __________________________
    ICD-9 No.: __________________________ Describe: __________________________
    ICD-9 No.: __________________________ Describe: __________________________
    ICD-9 No.: __________________________ Describe: __________________________

14. Exam Codes:
    □ -99201 □ -99202 □ -99203
    □ -99211 □ -99212 □ -99213
    □ - Other*(numeric)__________________ *copy of exam narrative is NOT required

Revised 01/03/2005

1 (of 2)
EXTENSION OF CARE PLAN FORM

1. Begin date of service for THIS EXTENSION: __/__/___

2. Patient Name: ______________________ Member ID No.: ______________________

3. Date Patient was last seen prior to the date entered in question 1 above: __/__/___

4. Number of Visits to date for this episode: ______________

5. Present Chief Complaints: □ C □ T □ L □ S □ Pelvic □ Non Spinal

6. Spine Pain Radiation:
   □ Level I: Pain localized to spine
   □ Level II: Pain radiating to the head, elbow or knee
   □ Level III: Pain radiating below the elbow or knee
   □ N/A

7. Numeric Pain Rating Scale (NPRS):
   (No pain) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (unbearable pain)

8. Restrictions of Activities of Daily Living / Functional Index:
   (no limitations) □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (totally disabled)

9. Physical Work Capabilities as it relates to the patient's current condition:
   □ No work limitations □ Some work limitations □ Unable to work
   □ N/A (Children, F/T student, Retiree, Permanent total disability)

10. To date how does the patient describe their overall improvement since the initial visit for this episode on a scale of 0 to 100:
    (none) □ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100% (Totally recovered)

If there is a CHANGE in the original diagnoses, please list below:
   Resolved diagnoses since last care plan:

   ICD9 No.: ______________________ Describe: ________________________________

   ICD9 No.: ______________________ Describe: ________________________________

Additional Diagnoses identified since last care plan:

   ICD 9 No.: ______________________ Describe: ________________________________

   ICD 9 No.: ______________________ Describe: ________________________________

11. Exam Codes:
    □ - 99211 □ - 99212 □ - 99213
    □ - Other* (numeric): ______________________ *copy of exam narrative required

Revised 01/03/2005

1 (of 2)
DISCHARGE SUMMARY FORM

Physician Name ____________________________ O-( ) _____________ F-( ) _____________ SS#: __________________

1. Patient Name: ____________________________ SS#: __________________

2. Present Chief Complaint: ☐ C ☐ T ☐ L ☐ L & S ☐ Other: ____________________________

3. Spine Pain Radiation:
   ☐ Level I: Pain localized to spine
   ☐ Level II: Pain radiating to the elbow or knee
   ☐ Level III: Pain radiating below the elbow or knee

4. Numeric Pain Rating Scale (NPRS):
   (no pain) ☑ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☑ 10 (unbearable pain)

5. Restrictions of Activities of Daily Living / Functional Index:
   (no limitations) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☑ 10 (totally disabled)

6. Work Capabilities:
   ☐ Employed ☐ Unemployed ☐ No work limitations
   ☐ Capable of restricted work duties ☐ Unable to work

7. To date how does the patient describe their overall improvement since the initial visit on a scale of 0 to 100:
   (none) ☑ 0% ☑ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☑ 100% (total)

If there has been a CHANGE in the original diagnosis, please list below:

ICD9#: ____________________________ Describe: ____________________________
Associated with: ICD9#: ____________________________ Describe: ____________________________
Complicated by: ICD 9#: ____________________________ Describe: ____________________________
Secondary Dx: ____________________________

8. Does the patient demonstrate any physical impairment related to this diagnosis and/or episode of care?
   ☑ Yes ☐ No

If yes, please provide the area of impairment, the degree of impairment and the reference source used to rate this impairment.

The Physician acknowledges that this Discharge Report has been personally reviewed, contains information, which is truthful and accurate, and has been submitted by authorized staff on behalf of Physician.

Physician’s Signature ____________________________ Date ____________

Revised 01/05/2005
TRIAD APPEAL AND GRIEVANCE REQUEST FORM

DATE: /______/______

APPELLANT’S NAME: ____________________________________________

ADDRESS: ____________________________________________________

TELEPHONE NUMBER
   BUSINESS: (___)________________________
   HOME: (___)________________________
   FAX: (___)________________________

Please provide the reason for requesting this appeal or investigation of your grievance. Include original issue/complaint, statement of original issue and brief summary.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

I authorize and direct TRIAD Healthcare, Inc. to investigate the issues described above. I authorize any party identified above to release information pertaining to this investigation to TRIAD’s Clinical Director upon her/his written request.

____________________________________________________        _____/_____/_____
Name                                                                          Signature  Date

This is to acknowledge your grievance or request for appeal was received by TRIAD Healthcare, Inc. on: _____/_____/

____________________________________________________
Signature                                     TRIAD Healthcare, Inc.
PLAN SPECIFIC ADDENDUMS
PLAN PARTICIPATION

Participation in Aetna Health Plans has been opened up to all providers in the following northern New Jersey counties:

- Bergen
- Hunterdon
- Morris
- Somerset
- Warren
- Essex
- Middlesex
- Ocean
- Sussex
- Warren
- Hudson
- Monmouth
- Passaic
- Union

TRIAD Healthcare Providers that are currently non-participating with Aetna will need to complete the following documents:

- Aetna Contract
- Addendum to the Aetna contract

Aetna providers that are currently non-participating with Triad will need to complete the following documents:

- Triad Healthcare provider agreement
- Addendum to the Aetna contract

SUBMISSION GUIDELINES FOR CARE PLANS

Participating providers have the option, at their sole discretion, to request prior approval from Triad in advance of providing services to patients, by submitting a care plan and other relevant clinical information to Triad. Upon receipt of such documentation, Triad will determine which requested services are medically necessary and notify you of such determination. This will enable you to review which services are approved and considered to be medically necessary by Triad, prior to rendering services to your patient.

1. An Initial Care Plan (ICP) is not required for pre-approval of treatment. If you elect to submit an ICP, it must be submitted via fax (866-225-1033) within 14 business days of patient’s Initial Date of Entry or before the second visit, whichever occurs first.

---

1 A care plan may be required under Medicare. Please ensure plan rules are complied with in order to ensure proper claims adjudication and reimbursement.
2. An **Extension of Care Plan** (EOC) is not required for continuation of care. If you elect to submit an EOC, it must be submitted within three (3) business days of the patient’s last approved date of service (for continuous care) or within three (3) business days of the patient’s date of return to care (interrupted episode).

If you would prefer an electronic version of the ICP or EOC form, please call our Customer Service department at 800-409-9081 and we will send you an electronic version. You can also visit our Provider Extranet at our website www.Triadhealthcareinc.com to download care plan forms.

Treatment determinations are returned to the provider submitting the care plan within two (2) business days of submission of a completed care planning form.

Instructions for completing a Care Plan can be found in the provider manual. ICP and EOC forms can be reproduced and used from the form section of this manual located under the Attachments section.

**Please Note:** Prospective review is based on the request for anticipated services over a specified coverage period. If you elect to submit a care plan (ICP/EOC), you should adhere to the timeframes communicated above. If prospective requests are received outside of the timeframes specified above, Triad will review the services retrospectively, by requesting that claims and medical documentation be submitted to support the services rendered.

**CLAIMS**

Please note the following with respect to Triad’s new claims processing protocols:

1) Triad **will not** require pre-authorization for services to patients.

2) In the event that you bill for services that have not been reviewed through the pre service care plan process, Triad will not deny your claim for choosing not to use the pre service care plan option. When Triad receives your claim, if needed in order for Triad to determine the medical necessity of the service(s) you provided, Triad will request, via letter to you, all of the medical records and medical documentation (initial exam narrative, re-evaluations, daily treatment records along with any other relevant information) that detail the member’s presenting condition, the member’s progress/response to treatment as compared to the member’s initial evaluation baseline and the member’s expected prognosis/outcome to treatment that supports the medical necessity for the date/s of visit/s in question, and in the interim, the billed service(s) will be pended. You will not receive a remittance advice at that time. Triad will send one reminder to you to submit the requested medical records/clinical documentation on any pended claim. Once the medical records are received, Triad will review your claim against such documentation and render a clinical determination following Triad’s current Medical Policies and Procedures. Failure to furnish such requested information within the time frames outlined in the request will result in denial of the pended services due to lack of evidence to substantiate their medical necessity. Any services denied for this reason are subject to appeal as defined in your determination letter and claim remittance advice.
Claim Submission

Where do I submit claims?

Electronic Submission

1. Triad Healthcare Inc. has partnered with MD On-Line, a leading health care technology company to facilitate electronic claims submission.*
2. (2) Triad claims can be individually entered free of charge. To access this benefit, log on to www.triadhealthcareinc.com/providers and click the “Submit” button under Online Solutions. This will route you to MD On-Line’s portal for Triad Providers. Please include Triad’s address (see below) and electronic payer ID# 39181.

Paper Claims

Submit paper CMS 1500 forms to:

Triad Healthcare, Inc.
Claims Department
PO Box 904
Plainville Ct. 06062-0904

To learn more about Triad’s claim submission process please call: 1-800-409-9081, selects the Aetna option, then select option #2 (claims department).

*To learn more about MD On-Line’s products for submitting Triad claims electronically FREE OF CHARGE please call: 888-499-5465

Providers have 180 days to submit claims from the date of rendered services. To learn more about Triad’s claim submission process, please call: 1-800-409-9081, select the Aetna option, and then select option #2 (for Triad’s Claims Department).
APPEALS AND GRIEVANCES

Medical Necessity/Utilization Management Denial Appeals

The following process pertains to the Aetna / Triad contract only

All member appeals should be sent to the appropriate address (see below) based on the member product.

For additional information about the appeal process, please refer to the denial letter, which includes submission timeframes.

You may request another copy of the denial letter by calling Triad’s Network Services Department at 1-800-409-9081.

Medicare

Aetna Medicare Advantage
Grievances and Appeals
PO Box 14067
Lexington, KY 40512

Commercial

Aetna Health Inc.
Customer Resolution Team
PO Box 14625
Lexington, KY 40512

NJ Prompt Pay/Administrative Denial Appeals

All providers may initiate an administrative claim appeal on or before the 90th calendar day following receipt of the claims determination. These Appeals should be completed using the Health Care Provider Application to Appeal a Claims Determination Form (NJ Only) and mailed or faxed to Triad (see below). This Form can be found on pages 62 & 63 of the provider manual or you can visit our Provider Extranet at our website @ www.triadhealthcareinc.com under the Forms & Instructions section.

Triad Healthcare, Inc.
Appeals Department
PO Box 902
Plainville, CT 06062-0904
Fax: 860-793-3317

If you disagree with Triad’s administrative claim appeal decision, you may obtain an external review by initiating an arbitration proceeding within 90 calendar days of receipt of an uphold notice. The New Jersey Department of Banking & Insurance has contracted with MAXIMUS, Inc. as the Arbitration Organization (AO) to operate the Program for Independent Claims Payment Arbitration (PICPA). Health
care providers may submit an Application for Arbitration online at https://njpicpa.maximus.com. For more information, please contact MAXIMUS by phone, fax or mail at:

MAXIMUS, Inc.
Attn: New Jersey PICPA
50 Square Dr., Suite 210
Victor, NY 14564
P#: (585) 425-5326
F#: (585) 425-5296
FAQ

What about PCP referrals?

Triad’s programs do not require a PCP referral for chiropractic care. However, any Aetna plans that currently require a PCP referral will continue to do so.

What about X-ray services?

All services including x-ray will be reviewed for medical necessity. When Triad receives your care plan these services may be approved, modified or denied.

What about Supportive Care?

There will be no change to the existing Aetna policy regarding supportive care. Currently Aetna’s policy is that supportive care is not a covered benefit.

What about maintenance care?

There will be no change to the existing Aetna policy regarding maintenance care. Currently Aetna’s policy is that maintenance care is not a covered benefit.
**TRIAD HEALTHCARE, INC. SAMPLE FEE SCHEDULE**

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</table>

*The fees represented are subject to change based upon the terms and conditions of Plan Contracts, Plan payment policies, or your Provider Agreement.

TRIAD Healthcare Inc. rev 8-10-06
HEALTH CARE PROVIDER APPLICATION TO APPEAL A CLAIMS DETERMINATION FORM

New Jersey Department of Banking and Insurance
Health Care Provider Application to Appeal a Claims Determination

Submit to: Triad Healthcare, Inc.
If by mail, at: PO Box 902
Plainville, CT 06062
If by courier service, at: 80 Spring Ln.
Plainville, CT 06062
If by fax, at: 860-793-3317

You have the right to appeal Our¹ claims determination(s) on claims you submitted to Us. You also have the right to appeal an apparent lack of activity on a claim you submitted.

DO NOT submit a Health Care Provider Application to Appeal a Claims Determination IF:

- Our determination indicates that We considered the health care services for which the claim was submitted not to be medically necessary, to be experimental or investigational, to be cosmetic rather than medically necessary or dental rather than medical. INSTEAD, you may submit a request for a Stage 1 UM Appeal Review. For more information, contact: Triad Healthcare, Inc. at 1-800-409-9081.
- Our determination indicates that We considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services are not covered under the terms of the relevant health benefits plan, or because the person is not Our member. INSTEAD, you may submit a complaint. For more information, contact: Triad Healthcare, Inc. at 1-800-409-9081
- We have provided you with notice that we are investigating this claim (and related ones, as appropriate) for possible fraud.

You MAY submit a Health Care Provider Application to Appeal a Claims Determination IF Our determination:

- Resulted in the claim not being paid at all for reasons other than a UM determination or a determination of ineligibility, coordination of benefits or fraud investigation
- Resulted in the claim being paid at a rate you did not expect based upon the payment agreement between you and Us
- Resulted in the claim being paid at a rate you did not expect because of differences in Our treatment of the codes in the claim from what you believe is appropriate
- Indicated that We require additional substantiating documentation to support the claim and you believe that the required information is inconsistent with Our stated claims handling policies and procedures, or is not relevant to the claim

You also MAY submit a Health Care Provider Application to Appeal a Claims Determination IF:

- You believe We have failed to adjudicate the claim, or an uncontested portion of a claim, in a timely manner consistent with law, and the terms of the contract between you and Us, if any
- Our determination indicates We will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from Us or another carrier for the services
- You believe we have failed to appropriately pay interest on the claim
- You believe Our statement that We overpaid you on one or more claims is erroneous, or that the amount We have calculated as overpaid is erroneous
- You believe we have attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that We have under-priced the current claim)

¹ A carrier’s contractors (organized delivery systems and other vendors) are subject to the same standards as the carrier when performing functions on behalf of the carrier. Use of the words We, Us or Our includes our relevant contractors.
**YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED**

<table>
<thead>
<tr>
<th>1. Provider Name:</th>
<th>2. TIN:</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>3. Provider Group (if applicable):</td>
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<tr>
<td>4. Contact Name:</td>
<td>5. Title:</td>
</tr>
<tr>
<td>6. Contact Address:</td>
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</tr>
<tr>
<td>7. Phone:</td>
<td>8. Fax:</td>
</tr>
<tr>
<td>1. Patient Name:</td>
<td>2. Ins. ID:</td>
</tr>
<tr>
<td>1. Claim #: (if known):</td>
<td>2. Date of Service:</td>
</tr>
<tr>
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</tr>
<tr>
<td>3. Have you attached a copy of (check the appropriate response):</td>
<td></td>
</tr>
<tr>
<td>a. the assignment of benefits?</td>
<td>Yes</td>
</tr>
<tr>
<td>b. the Consent to Representation in Appeals of Utilization Management Determinations and Authorization to Release of Medical Records for UM Appeal and Arbitration of Claims? (Not required for this appeal, but <strong>required if the matter goes to arbitration</strong>)</td>
<td>Yes</td>
</tr>
<tr>
<td>c. Claim filing method (check only one):</td>
<td></td>
</tr>
<tr>
<td>a. electronic (submit a copy of the electronic acceptance report from Our clearinghouse or Us)</td>
<td></td>
</tr>
<tr>
<td>b. facsimile (submit a copy of the facsimile)</td>
<td></td>
</tr>
<tr>
<td>c. mail or courier service (submit a copy of the delivery confirmation evidence)</td>
<td></td>
</tr>
<tr>
<td>4. Read the following and check the condition(s) that describe this appeal:</td>
<td></td>
</tr>
<tr>
<td>a. Action has not been taken on this claim</td>
<td></td>
</tr>
<tr>
<td>b. Dispute of a denied claim → provide <strong>date of denial</strong>:</td>
<td>/</td>
</tr>
<tr>
<td>c. Claim was paid but not in a timely manner (provide more information):</td>
<td></td>
</tr>
<tr>
<td>d. Claim was paid, but the amount is in dispute (not including interest)</td>
<td></td>
</tr>
<tr>
<td>e. Dispute of carrier’s allegations of overpayment or amount of overpayment</td>
<td></td>
</tr>
<tr>
<td>f. Dispute of carrier’s offset amount against this claim</td>
<td></td>
</tr>
</tbody>
</table>

In an attachment, explain why you dispute handling of the claim. Be specific about billing codes. Also, submit (copies only):

- The relevant HCFA 1500(s) or UB92(s)
- The relevant Explanation(s) of Benefits or Remittance Advice
- A statement specifying the line items that you are appealing
- Information We previously requested that you have not yet submitted, if available
- Itemization of the contract provisions you believe We are not complying with, if any
- Pertinent correspondence between you and Us on this matter
- A description of pertinent communications between you and Us on this matter that were not in writing
- Relevant sections of the National Correct Coding Initiative (NCCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- Other documents you may believe support your position in this dispute

Signature: ____________________________  Date: __/__/____

DOB/CAP/OCR 07/06
[Triad: COR/QM.PM.007.001 (05/06/2009)]
PLAN PARTICIPATION

<table>
<thead>
<tr>
<th>Type of Business</th>
<th>Medicare Advantage in the State of New York.</th>
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</thead>
<tbody>
<tr>
<td>Triad Program</td>
<td>Chiropractic Benefit Management including Clinical Data Collection, Care Planning, Healthcare Coaching, Provider Network Management, and Claims Administration.</td>
</tr>
<tr>
<td>Summary</td>
<td>Triad has assisted WellCare deliver its chiropractic benefit to their Medicare Advantage members in New York State since May 7, 2007.</td>
</tr>
</tbody>
</table>

CARE PLANNING

Does the program require PCP referral?

This program does not require a PCP referral.

Where do I call for patient eligibility information?

Eligibility can be verified directly with Triad effective Monday, May 7th 2007 by calling our customer service representatives at 800-409-9081.

What services do I need to report to Triad?

Similar to Triad’s other programs, all chiropractic services must be reported utilizing the appropriate Care Plan (Initial or Extension of Care). As a traditional Medicare-based program, Triad can only approve medically necessary chiropractic manipulative therapy of the spine for eligible members and providers. You may bill the patient for non-covered services so long as that patient is notified in writing in advance of the delivery of that service in accordance with Medicare guidelines. Triad will utilize the data you provide in our proposal to amend the chiropractic benefit towards fee for service in our quest to promote full statutory scope of chiropractic care. Responsible reporting can make a difference.

When do I need to submit a care plan?

As with Triad’s other programs, Initial Care Plans (ICP’s) must be submitted before the patient’s second visit, or within fourteen (14) days of the initial visit, whichever occurs first. The initial care plan should include services provided during the initial visit, in addition to the services you are planning to render. You may elect to include additional information (i.e. SOAP notes) to Triad Healthcare Inc. for review.
Where do I obtain Care Plan forms?

The Initial Care Plan and Extension of Care forms are the same as those previously provided to you. Forms can also be downloaded in PDF format from the Forms & Instructions section on Triad’s provider web portal, http://www.triadhealthcareinc.com/providers.

How do I get my Care Plan forms to Triad Healthcare Inc?

Care Plan Forms must be faxed to Triad at 866-225-1033. We are currently working on enhancements to our web portal to better service you. Please feel free to contact us with any suggestions you might have to enhance our interaction.

When do I start submitting Care Plans to Triad Healthcare, Inc?

Please submit Care Plans for new or established WellCare Medicare Advantage members on or after Monday, May 7th, 2007 for services rendered on or after that date.

CLAIMS SUBMISSION

Where do I submit claims?

Electronic Submission

1. Triad Healthcare Inc. has partnered with MD On-Line, a leading health care technology company to facilitate electronic claims submission.*
2. Triad claims can be individually entered free of charge. To access this benefit, log on to www.triadhealthcareinc.com/providers and click the “Submit” button under Online Solutions. This will route you to MD On-Line’s portal for Triad Providers. Please include Triad’s address (see below) and electronic payer ID# 39181.

Paper Claims

Submit paper CMS 1500 forms to:

Triad Healthcare, Inc.
Claims Department
PO Box 904
Plainville Ct. 06062-0904

To learn more about Triad’s claim submission process please call: 1-800-409-9081, select the WellCare option, then select option #1 (claims department).

*To learn more about MD On-Line’s products for submitting Triad claims electronically FREE OF CHARGE please call: 888-499-5465

Providers have 180 days to submit claims from the date of rendered services.
I’m already contracted with another EDI Vendor for claim submission. Can I continue to submit claims through my current vendor?

You will need to contact your current vendor to determine if they can route your Triad claims to MD Online. If not, most either convert these claims to paper or allow for direct claim printing to submit to Triad Healthcare, Inc.

APPEALS AND GRIEVANCES

The following process pertains to the WellCare / Triad contract only.

All Member Appeals and Prospective (UM) denial of treatment mail to:

WellCare
Attn: New York Appeals Department
PO Box 31368
Tampa, FL 33631-3368

All Participating Provider Claims, Administrative, and Retrospective (UM) denial of treatment mail to:

Triad Healthcare, Inc.
Appeals Department
PO Box 902
80 Spring Lane
Plainville, CT 06062
Fax to 860-793-3317

For additional information about the appeal process please refer to the denial letter. You may request another copy of the denial letter by calling Triad’s Network Services Department 1-800-409-9081.

FAQ

Where can I obtain a fee schedule?

A fee schedule has been provided in this information package.

Why is the fee schedule so high?

Triad has long advocated for reasonable reimbursement based upon the value of services provided. Appropriately delivered chiropractic care is essential to the patients that require chiropractic services. An unfortunate common reaction to escalating health care costs is to reduce the reimbursement of the treating provider. This creates imbalance in the health care delivery system, and alienates the very provider who was contracted to provide that service. Triad views our network of participating providers as one of our strongest assets.

Why do I have to complete the entire Care Plan when only spinal CMT is covered?
This process is consistent across all of Triad’s contracts. Consistent processes tend to be easier for providers to administer. This process also allows Triad to communicate to both the provider and the insured that non-covered services may be billed to the patient (following appropriate Medicare protocols), enforcing your advance notice to your patient of their financial responsibility for non-covered services. As previously noted, reporting this information to Triad enables us to recommend future enhancements to the fee schedule to benefit both the health plans membership and the providers who care for them.

Are my services going to be limited?

In general, the definition and limitation of covered services are embedded in your patient’s summary of benefits and evidence of coverage (also referred to as the certificate of coverage). Although each health plan has their unique coverage limitations, many share common language that defines the parameters of covered and non-covered services. Most, if not all, have provisions which exclude coverage for services which are not found to be medically necessary. Triad is responsible for determining the medical necessity of services rendered, and provides the assistance of clinical coaches to assist and discuss determinations with our network providers. There is no maximum number of medically necessary spinal CMT which can be rendered per year.

How can I get a provider manual and appropriate forms?

Triad’s complete provider manual, forms and instructions can be downloaded in PDF format from www.triadhealthcareinc.com/providers.

Why is the fee schedule the same for all 3 levels of spinal manipulation (CMT)?

WellCare’s current fee schedule for chiropractic services is based upon a global fee of $40 per visit (for all services rendered on that date) minus the patient’s applicable co-payment (currently $30). The new fee schedule is consistent with this structure with two important changes:

1. WellCare has lowered the patient’s co-payment for covered chiropractic manipulative therapy from $30.00 per visit to $15.00 or less per visit. The specific amount of the co-payment for each patient can be determined when verifying eligibility by calling Triad on or after May 7, 2007
2. The $40 reimbursement is no longer a global fee. WellCare has restructured their Medicare Advantage Program reimbursement to apply only to spinal CMT. You may bill your patient for non-covered services so long as you follow established Medicare guidelines (e.g., providing written notice to your patient and obtaining their signature of consent in advance of receiving non-covered services).

Can a WellCare Medicare Advantage Member seek chiropractic care from any chiropractor?

Covered chiropractic services for WellCare’s New York Medicare Advantage members are only available through Triad’s network of participating providers who also participate with Medicare. If you currently participate with both Triad and Medicare and have not received a packet, please update your Medicare status with Triad’s network management department and a packet will be sent to you accordingly.

Who do I contact to obtain reimbursement for non-covered services?

In the event that a member requires or requests a service that is not a Chiropractic Covered Service, the IPA Provider must inform the Member that the Member will be personally responsible for all fees related
to the service and the estimated fee for the service, and obtain an executed acknowledgement of financial responsibility from the Member or the Member’s legal representative. Only if these steps have been taken shall the IPA Provider be entitled to bill the Member and collect for such services. Reimbursement for non-covered services are payable by the member once you follow appropriate Medicare guidelines. Since this is a Medicare Advantage Program limiting chiropractic coverage to spinal CMT, your patient may have coverage for other services provided by other health care providers. The member may contact WellCare’s member services department at the number on the back of their identification card to obtain other coverage information.
TRIAD HEALTHCARE, INC AND WELLCARE FEE SCHEDULE*

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</table>

* The fees represented are subject to change based upon the terms and conditions of Plan Contracts, Plan payment policies, or your Provider Agreement.
CLAIM APPEAL REQUEST FORM

DATE: _____________

APPELLANT’S NAME: __________________________

Health plan: ___________________________  ID#___________________________________

Reference Numbers being appealed: ______________________________________________

ADDRESS: ______________________________________________________________

TELEPHONE NUMBER: BUSINESS: ___________________________

HOME: ___________________________

FAX: ___________________________

Please provide the reason for requesting this appeal.
Include original issue/complaint, statement of original issue and brief summary.

List CPT Codes being appealed: _________ For Dates of Service: _______________

List CPT Codes being appealed: _________ For Dates of Service: _______________

List CPT Codes being appealed: _________ For Dates of Service: _______________

List CPT Codes being appealed: _________ For Dates of Service: _______________

(USE ADDITIONAL FORMS FOR ADDITIONAL CPT/DATES OF SERVICE)

PLEASE SUBMIT ANY ADDITIONAL SUPPORTING DOCUMENTATION, SUCH AS:
OFFICE NOTES, MEDICAL RECORDS, DIAGNOSTIC STUDIES

________________________________________________________________________

I authorize and direct TRIAD Healthcare, Inc. to investigate the issues described above. I authorize any party identified above to release information pertaining to this investigation to TRIAD Healthcare, Inc. upon her/his written request.

________________________________________________________________________

Name
Signature ____________________________ Date __________

Please indicate that you have sent all necessary clinical information to review this appeal   Yes   No

Will you be submitting additional information with this appeal   Yes   No

Please submit this form and all documentation in writing to the above address or fax to 860-793-3317.

TRIAD QM Department

MS-04-099
Ver052907
PLAN PARTICIPATION

<table>
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<tr>
<th>Client Name</th>
<th>Visiting Nurses Services Choice (VNS).</th>
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</thead>
<tbody>
<tr>
<td>Type of Business</td>
<td>Medicare Advantage.</td>
</tr>
<tr>
<td>Triad Program</td>
<td>Chiropractic Benefit Management including Clinical Data Collection, Care Planning, Healthcare Coaching, Provider Network Management, and Claims Administration.</td>
</tr>
<tr>
<td>Summary</td>
<td>Triad began assisting VNS Choice deliver its chiropractic benefit to VNS Choice Medicare Advantage members in the following New York counties: Bronx, Brooklyn, New York, Queens, and Richmond in June 21, 2007.</td>
</tr>
</tbody>
</table>

CARE PLANNING

Does the program require PCP referral?

This program does not require a PCP referral.

Where do I call for patient eligibility information?

Eligibility can be verified directly with Triad effective June 21, 2007 by calling our customer service representatives at 800-409-9081.

What services do I need to report to Triad?

Similar to Triad’s other programs, all chiropractic services must be reported utilizing the appropriate Care Plan (Initial or Extension of Care). Although this is a Medicare Advantage program Triad has worked with VNS to offer additional services to include reimbursement for other medically necessary services within your scope of practice.

When do I start submitting Care Plans to Triad?

Please submit Care Plans for new or established VNS Choice Medicare Advantage members on or after June 21, 2007 for services rendered on or after that date.

When do I need to submit a care plan?
Recall that Initial Care Plans (ICP) must be submitted before the patient’s second visit, or within fourteen (14) days of the initial visit, whichever occurs first. The Initial Care Plan should include services provided during the initial visit, in addition to the services you are planning to render. You may elect to include additional information (i.e. SOAP notes) to Triad Healthcare Inc. for review.

**Where do I obtain Care Plan forms?**

The Initial Care Plan and Extension of Care forms are the same as those previously provided to you. Forms can also be downloaded in PDF format from the *Forms & Instructions* section on Triad’s provider web portal, [http://www.triadhealthcareinc.com/providers](http://www.triadhealthcareinc.com/providers).

**How do I submit my Care Plan forms to Triad?**

Care Plan Forms must be faxed to Triad at 866-225-1033. We are currently working on enhancements to our web portal to better serve you. Please feel free to contact us with any suggestions you might have.

**CLAIMS**

**Claims Submission**

**Where do I submit claims?**

**Electronic Submission**

1. Triad Healthcare Inc. has partnered with MD On-Line, a leading healthcare technology company to facilitate electronic claims submission.

   Use one of MD On-Line’s electronic claims submission solutions: WebLink, WinLink or LINK1500 to submit TRIAD claims FREE OF CHARGE. Please include Triad’s address (see below) and electronic Payer id#39181.

2. Log on to Triad’s Provider Extranet and submit claims through an online claim form.

**Paper Claims**

Submit paper CMS 1500 forms to:

Triad Healthcare, Inc.
Claims Department
PO Box 904
Plainville CT 06062-0904

To learn more about Triad’s claim submission process please call: 1-800-409-9081 and select option #2 (claims department).
*To learn more about MD On-Line’s products for submitting Triad claims electronically FREE OF CHARGE please call: 888-499-5465

Providers have 180 days to submit claims from the date of rendered services.

**I’m already contracted with another EDI Vendor for claim submission. Can I continue to submit claims through my current vendor?**

You will need to contact your current vendor to determine if they can route your Triad claims to MD On-line. If not, most either convert these claims to paper or allow for direct claim printing to submit to Triad Healthcare Inc.

**APPEALS AND GRIEVANCES**

The following process pertains to the VNS / Triad contract only.

For additional information about the appeal process please refer to the denial letter.

**Utilization Management and Member Appeals**

VNS Choice Select  
Grievance and Appeal Department  
1250 Broadway  
11th Floor  
New York, NY 10001

**Claims Appeals**

Triad Healthcare, Inc.  
Appeals Department  
PO Box 902  
Plainville, CT 06062-0904  
Fax: 860-793-3317

You may request another copy of the denial letter by calling Triad’s Network Services Department 1-800-409-9081.

**FAQ**

**Can a VNS Medicare Advantage Member seek chiropractic care from any chiropractor?**

Covered chiropractic services for VNS’s New York Medicare Advantage members are only available through Triad’s network of participating providers who also participate with Medicare. If you currently participate with both Triad and Medicare and have not received a packet, please update your Medicare status with Triad’s network management department and a packet will be sent to you accordingly.
Who do I contact to obtain reimbursement for non-covered services?

In the event that a member requires or requests a service that is not a Chiropractic Covered Service, the IPA Provider must inform the Member that the Member will be personally responsible for all fees related to the service and the estimated fee for the service, and obtain an executed acknowledgement of financial responsibility from the Member or the Member’s legal representative. These steps must be taken to bill the Member and collect for such services.

What is the reimbursement under the VNS plan and where can I obtain a fee schedule?

You will be reimbursed utilizing the enclosed Triad fee schedule. The fees represented are subject to modifications based upon the terms and conditions of Plan Contracts, Plan Payments Policies, or your Provider Agreement.
# TRIAD HEALTHCARE, INC. AND VNS FEE SCHEDULE

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CLAIM APPEAL REQUEST FORM

DATE: _____________

APPELLANT’S NAME: __________________________

Health plan: ___________________________  ID#: ___________________________

Reference Numbers being appealed: ____________________________________________

ADDRESS: __________________________________________________________________

TELEPHONE NUMBER: BUSINESS: ___________________________

                        HOME: ___________________________
                        FAX: ___________________________

Please provide the reason for requesting this appeal.
Include original issue/complaint, statement of original issue and brief summary.

List CPT Codes being appealed: __________  For Dates of Service: __________
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List CPT Codes being appealed: __________  For Dates of Service: __________
List CPT Codes being appealed: __________  For Dates of Service: __________

(USE ADDITIONAL FORMS FOR ADDITIONAL CPT/DATES OF SERVICE)

PLEASE SUBMIT ANY ADDITIONAL SUPPORTING DOCUMENTATION, SUCH AS:
OFFICE NOTES, MEDICAL RECORDS, DIAGNOSTIC STUDIES

________________________________________________________________________________________

I authorize and direct TRIAD Healthcare, Inc. to investigate the issues described above. I authorize any party identified above to release information pertaining to this investigation to TRIAD Healthcare, Inc. upon her/his written request.

Name___________________________________________
Signature_________________________  Date__________________

Please indicate that you have sent all necessary clinical information to review this appeal  Yes  No

Will you be submitting additional information with this appeal  Yes  No

Please submit this form and all documentation in writing to the above address or fax to 860-793-3317.

TRIAD QM Department
PLAN PARTICIPATION

<table>
<thead>
<tr>
<th>Type of Business</th>
<th>Medicare Advantage</th>
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<tbody>
<tr>
<td>Triad Program</td>
<td>Chiropractic Benefit Management including clinical Data Collection, Care Planning, Healthcare Coaching, Provider Network Management, and Claims Administration.</td>
</tr>
<tr>
<td>Summary</td>
<td>Triad will assist WellCare Deliver its Chiropractic Benefit to their Medicare Advantage Members in New Jersey State beginning January 1, 2008.</td>
</tr>
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CARE PLANNING

Does the program require PCP referral?

This program does not require a PCP referral.

Where do I call for patient eligibility information?

Eligibility can be verified directly with Triad effective Monday, January 1, 2008 by calling our customer service representatives at 800-409-9081.

What services do I need to report to Triad?

Similar to Triad’s other programs, all chiropractic services must be reported utilizing the appropriate Care Plan (Initial or Extension of Care). As a traditional Medicare-based program, Triad can only approve medically necessary chiropractic manipulative therapy of the spine for eligible members and providers. You may bill the patient for non-covered services so long as that patient is notified in writing in advance of the delivery of that service in accordance with Medicare guidelines. Triad will utilize the data you provide in our proposal to amend the chiropractic benefit towards fee for service in our quest to promote full statutory scope of chiropractic care. Responsible reporting can make a difference.

When do I need to submit a care plan?

As with Triad’s other programs, Initial Care Plans (ICP’s) must be submitted before the patient’s second visit, or within fourteen (14) days of the initial visit, whichever occurs first. The initial care plan should include services provided during the initial visit, in addition to the services you are planning to render. You may elect to include additional information (i.e. SOAP notes) to Triad Healthcare Inc. for review.
Where do I obtain Care Plan forms?

The Initial Care Plan and Extension of Care forms are the same as those previously provided to you. Forms can also be downloaded in PDF format from the Forms & Instructions section on Triad’s provider web portal, http://www.triadhealthcareinc.com/providers.

How do I submit my Care Plan forms to Triad Healthcare Inc?

Care Plan Forms must be faxed to Triad at 866-225-1033. We are currently working on enhancements to our web portal to better service you. Please feel free to contact us with any suggestions you might have to enhance our interaction.

When do I start submitting Care Plans to Triad Healthcare, Inc?

Please submit Care Plans for new or established WellCare Medicare Advantage members on or after Monday, January 1, 2008 for services rendered on or after that date.

CLAIMS

Claims Submission

Where do I submit claims?

Electronic Submission

1. Triad Healthcare Inc. has partnered with MD On-Line, a leading health care technology company to facilitate electronic claims submission.*

2. Triad claims can be individually entered free of charge. To access this benefit, log on to www.triadhealthcareinc.com/providers and click the “Submit” button under Online Solutions. This will route you to MD On-Line’s portal for Triad Providers. Please include Triad’s address (see below) and electronic payer ID# 39181.

Paper Claims

Submit paper CMS 1500 forms to:

Triad Healthcare, Inc.
Claims Department
PO Box 904
Plainville Ct. 06062-0904

To learn more about Triad’s claim submission process please call: 1-800-409-9081, select the WellCare option, then select option #1 (claims department).
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Providers have 180 days to submit claims from the date of rendered services.

I’m already contracted with another EDI Vendor for claim submission. Can I continue to submit claims through my current vendor?

You will need to contact your current vendor to determine if they can route your Triad claims to MD On-line. If not, most either convert these claims to paper or allow for direct claim printing to submit to Triad Healthcare Inc.

APPEALS AND GRIEVANCES

The following process pertains to the WellCare / Triad contract only.

All Member Appeals and Prospective (UM) denial of treatment mail to:

WellCare
Attn: New Jersey Appeals Department
PO Box 31368
Tampa, FL 33631-3368

All Participating Provider Claims, Administrative, and Retrospective (UM) denial of treatment mail to:

Triad Healthcare, Inc.
Appeals Department
PO Box 902
80 Spring Lane
Plainville, CT 06062
Fax to: 860-793-3317

For additional information about the appeal process please refer to the denial letter.
You may request another copy of the denial letter by calling Triad’s Network Services Department 1-800-409-9081.

FAQ

Where can I obtain a fee schedule?

A fee schedule has been provided in this information package.

Why is the fee schedule so high?

Triad has long advocated for reasonable reimbursement based upon the value of services provided. Appropriately delivered chiropractic care is essential to the patients that require chiropractic services. An unfortunate common reaction to escalating health care costs is to reduce the reimbursement of the treating provider. This creates imbalance in the health care delivery system, and alienates the very provider who
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This process is consistent across all of Triad’s contracts.

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In general, the definition and limitation of covered services are embedded in your patient’s summary of benefits and evidence of coverage (also referred to as the certificate of coverage). Although each health plan has their unique coverage limitations, many share common language that defines the parameters of covered and non-covered services. Most, if not all, have provisions which exclude coverage for services which are not found to be medically necessary. Triad is responsible for determining the medical necessity of services rendered, and provides the assistance of clinical coaches to assist and discuss determinations with our network providers. There is no maximum number of medically necessary spinal CMT which can be rendered per year.

**How can I get a provider manual and appropriate forms?**

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**Who do I contact to obtain reimbursement for non-covered services?**

In the event that a member requires or requests a service that is not a Chiropractic Covered Service, the IPA Provider must inform the Member that the Member will be personally responsible for all fees related to the service and the estimated fee for the service, and obtain an executed acknowledgement of financial responsibility from the Member or the Member’s legal representative. Only if these steps have been taken shall the IPA Provider be entitled to bill the Member and collect for such services. Reimbursement for non-covered services are payable by the member once you follow appropriate Medicare guidelines. Since this is a Medicare Advantage Program limiting chiropractic coverage to spinal CMT, your patient may have coverage for other services provided by other health care providers. The member may contact WellCare’s member services department at the number on the back of their identification card to obtain other coverage information.
TRIAD HEALTHCARE, INC AND WELLCARE FEE SCHEDULE*

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CLAIM APPEAL REQUEST FORM

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APPELLANT’S NAME: ________________________________

Health plan: ___________________________ ID# ___________________________

Reference Numbers being appealed: ___________________________________________

ADDRESS: ______________________________________________________________

TELEPHONE NUMBER: BUSINESS: ___________________________

                     HOME: ___________________________
                     FAX: ___________________________

Please provide the reason for requesting this appeal.
Include original issue/complaint, statement of original issue and brief summary.

List CPT Codes being appealed: __________ For Dates of Service: __________

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List CPT Codes being appealed: __________ For Dates of Service: __________

List CPT Codes being appealed: __________ For Dates of Service: __________

(USE ADDITIONAL FORMS FOR ADDITIONAL CPT/DATES OF SERVICE)

PLEASE SUBMIT ANY ADDITIONAL SUPPORTING DOCUMENTATION, SUCH AS:
OFFICE NOTES, MEDICAL RECORDS, DIAGNOSTIC STUDIES

I authorize and direct TRIAD Healthcare, Inc. to investigate the issues described above. I authorize any party identified above to release information pertaining to this investigation to TRIAD Healthcare, Inc. upon her/his written request.

Name ___________________________________________

Signature ___________________________________________ Date __________

Please indicate that you have sent all necessary clinical information to review this appeal  Yes  No

Will you be submitting additional information with this appeal  Yes  No

Please submit this form and all documentation in writing to the above address or fax to 860-793-3317.

TRIAD QM Department
**DOCUMENT APPROVAL & CHANGE RECORD**

Document Approval & Change Record

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