Occtegrity Provider Panelist Operational, Service and Quality Standards

Clinical Requirements:

- The provider must make a differential diagnosis on each patient for each new injury or illness. Develop patient-centered treatment plans.
- Utilize evidence-based outcome questionnaires (e.g. STarT, Revised Oswestry, Back and Neck Index) to establish baseline functionality and then periodic follow-ups during the course of treatment.
- Documentation must meet standards established by licensing board. Providers are encouraged to educate patients about what to expect when they present for treatment.
- Patients should be made aware that the treatment will be focused on their presenting problem/injury and that self-care/active care may be recommended to be performed outside of the office setting.
- Patients should be advised that treatment would typically end when they have returned to pre-injury status or have reached maximum functional improvement from the method of care that you are able to able to deliver.
- When appropriate if the patient requires services that are not provided within your office perform the triage and make the appropriate referral.
- Document in the patient file all the communication with the patient and other providers.
- Discharge record must include reason for discharge and patient's health status.
- Documentation of each patient's record must meet state licensing board standards.
- All level of services that are billed must be documented in the patient file.

Data Gathering and Reporting

Measurement Methodology

Leading indicators are early process metrics that frontline team members (treating clinician) can directly influence. Leading indicators measure processes that are proven to move lagging indicators such as optimal clinical outcomes, earlier return to work, and lower total costs. Our framework of leading indicators, educational resources, and reporting tools establishes focused effort by employers and providers to create reliable care paths for the most common and highest cost conditions. For example, increasing the percentage of workers treated by the right

non-surgical care providers for back pain (leading indicator) will ultimately lower the number of inappropriate diagnostic tests and unnecessary surgical procedures (lagging indicator). Our tools inform employees at key decision points. Research demonstrates that people will select the best course of treatment when given the choice. This method ensures access to the right providers and promotes early and accurate diagnosis, treatment, and referral.

In addition and for all conditions, a small number of patients experience the poorest outcomes creating significant emotional and cost burden. Using a proven stratification tool STarT Back Screen at the initial visit, you will identify patients at risk for poor outcomes. Why do we do it? To get more care to those who need it earlier. Let's restate this. Rapid identification of at-risk patients allows us to apply better, more comprehensive solutions early and engage with at risk patients more frequently.

STarT Back Screening Tool a validated tool that can be administer before treatment begins to inform the treating clinician and/or others about the risk status of individual patients. It is predicated on the understanding that not all patients requiring treatment for nonspecific back pain are the same.

Embedding the risk assessment process and measuring our progress toward 100% compliance as a leading indicator ensures that at risk patients get the early interventions required to prevent long waits, worsening conditions, and poorer long term outcomes (lagging indicator).

Our performance executing on our leading indicators (Key Performance Indicators; KPI's) will be reported to employer and provider teams. Suggested reporting audiences and reporting frequency are outlined in this document. Reporting audiences and frequency and data sources may need to be modified in your environment to support ongoing reporting and management of this care pathway in your market.

Availability of Provider:

- Must accept new patients, must accept worker's compensation covered patients.
- Patients must be able to access care for urgent need services within 24 hours from the time of the request for appointment.
- The provider should return all urgent need telephone calls from patients within 30 minutes.
- Patients with non-urgent needs should be able access care within five (2) business days from the time of request for an appointment.
- At a minimum the office must be open for patient care on Monday, Wednesday and Friday of most weeks.

Claims Submission

- The fee schedule will be the state endorsed workers compensation fee schedule. Most employers use the services of a Third Party Administrator (TPA). The TPA pays the claim. Some TPAs have Preferred Provider Organization (PPO). You may have made arrangements to participate in the TPA PPO will receive the PPO discount. Those who are not in the PPO should not have a discount applied to the fee schedule. If your fee is discounted and you don't believe that you are a PPO member you should contact Gallagher Basset direct and inquire how the PPO relationship was established. If you have signed up with a company that has agreed to market your services they may have sold the contract to Gallagher Basset. Occtegrity cannot undo this type of relationship. If you don't want a discounted fee you have to disencumber yourself from your contracts.

Patient Confidentiality/Privacy:

- Privacy of every patient's health information is a legal requirement. HIPPA privacy rules and regulations must be followed.

- Records must be stored in such a way that they are not readily accessible to unauthorized users.