(Minnesota only)

CHIROPRACTIC CARE OF MINNESOTA, INC.
CERTIFICATE OF MEMBERSHIP AND
PARTICIPATING PROVIDER AGREEMENT

The undersigned chiropractor, whose licensee(s) to practice chiropractic is(are) in good standing, and all license numbers are listed below, hereby agrees to all terms, conditions and provisions of the attached CHIROPRACTIC CARE OF MINNESOTA, INC. PARTICIPATING PROVIDER AGREEMENT. By checking the box below, the undersigned chiropractor elects to participate in the HealthPartners Workers' Compensation Addendum to this Agreement. The undersigned chiropractor further agrees and understands that this agreement shall not be given effect until it has been countersigned by the appropriate officer of Chiropractic Care of Minnesota, Inc.

_____
PROVIDER SIGNATURE

Date: _____

_____
D.C. License No. (*Additional State, if any*)

_____
Printed/Types Social Security Number

CLINIC (if applicable):

_____
Printed/Typed Clinic Name

_____
Printed/Typed City, County, State, Zip Code

BY: _____
Clinic Signature

ITS: _____
Clinic Position

_____
PROVIDER Printed,/Typed Full Name

_____
Minnesota D.C./Chiropractic License No.

_____
D.C. License No. (*Additional State, if any*)

_____
Printed/Typed Individual NPI

_____
Printed/Typed Group NPI

_____
Printed/Typed Street Address

_____
Printed/Typed Business Phone Number

_____
Printed/Typed Federal Tax ID Number

ACCEPTED BY:
CHIROPRACTIC CARE OF MINNESOTA, INC.

BY: _____

ITS: Chief Clinical Officer

Date: _____

☐ **I elect to participate in the HealthPartners Workers' Compensation Addendum to this Agreement.**

Complete the below section *if* the Mailing Address is **different** from the Clinic Address:

_____

Printed/ Typed Mailing Street Address

_____

Printed/Typed Mailing City

_____

Printed/Typed Mailing County

_____

Printed/Typed Mailing State

_____

Printed/Typed Zip Code

CHIROPRACTIC CARE OF MINNESOTA, INC.
PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is by and between Chiropractic Care of Minnesota, Inc., a Minnesota non-profit corporation ("CCMI"), and the chiropractor whose signature appears on a Certificate ("Doctor").

WHEREAS, CCMI has contracted with various health plan companies to administer the provision of chiropractic services to their various Enrollees; and

WHEREAS, Doctor is an individual licensed to practice chiropractic under applicable Minnesota or other state law, whose license is in good standing and who desires to provide chiropractic services to health plan company Enrollees; and

WHEREAS, CCMI contracts as needed with selected doctors that meet CCMI's credentialing standards and whose practices are located within the service areas of the various health plan companies;

NOW THEREFORE, in consideration of the mutual promises contained herein, CCMI and Doctor hereby agree as follows:

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Agreement and to all amendments and additions:

1. "Agreement" means this Participating Provider Agreement, the Certificate, all Plan Summaries, schedules and exhibits, Rules and Regulations and any amendments to any of the foregoing as issued by CCMI from time to time.

2. "Benefit Contract" means any health benefit contract issued by a health plan company or other entity which provides coverage to its Enrollees. The Benefit Contract constitutes the agreement between the health plan company and the Enrollees regarding benefits, exclusions, and other conditions to the coverage of Chiropractic Services.

3. "Chiropractic Necessity" means, in the judgment of CCMI, its peer reviewer, or a peer panel authorized by CCMI, Chiropractic Services that are:

   a. appropriate and consistent with the diagnosis and which, in accordance with accepted chiropractic standards, cannot be omitted without adversely affecting the Enrollee's condition; and

   b. not chiefly custodial, maintenance or elective care, as defined the Enrollee's Benefit Contract or CCMI's Rules and Regulations.

4. "Chiropractic Services" means the services, class of services or education provided to an Enrollee by the Doctor including encounters with the Doctor, chiropractic manipulations and adjustments, adjunctive therapy, examinations, tests, x-rays and diagnostic and therapeutic procedures.

5. "Chiropractor" means any Doctor of Chiropractic who is duly licensed and qualified to engage in the practice of chiropractic under the laws of the state of Minnesota and/or the other state(s) listed on the Certificate.

6. "Co-payment" means the amount or charge the Enrollee is required to pay for Chiropractic Services in accordance with the Enrollee's Benefit Contract.

7. "Deductible" means the annual amount of charges for health services (including Chiropractic Services), as provided in the Enrollee's Benefit Contract, which the Enrollee is required to pay in advance of any coverage by the health plan company.

8. "Doctor" means a chiropractor who has been credentialed by CCMI and has entered into a CCMI Participating Provider Agreement that includes one or more Plan Summaries for an Enrollee's Benefit Contract.

9. "Enrollee" means an individual properly enrolled ("member") for coverage and eligible to receive Chiropractic Services under a health plan company Benefit Contract.

10. "Health plan company" means a health plan company and/or a managed care organization as those terms are defined in Minnesota Statutes Section 62Q.0l and 62Q.733.

11. "Participating Health Care Provider" means a health care provider, including Doctors, substitute doctors, and others (e.g. M.D., PT,) who has entered into or is subject to a participation agreement with the subject health plan company to provide health care services to Enrollees.

12. "Payor" means a health plan company, employer, employee organization, third party administrator or other entity (including CCMI) which is responsible for direct payment for Chiropractic Services under a particular Benefit Contract.

13. "Plan Summary" means the documents issued by CCMI which describe: fee schedules, withholds, administrative procedures and other information regarding a Benefit Contract, any of which CCMI may change at any time and from time to time at its sole and absolute discretion; and benefits descriptions and Member eligibility requirements, which may be changed by the health plan company at any time and from time to time in its sole and absolute discretion.

14. "Rules and Regulations" means the procedures and requirements, including administrative and credentialing requirements, protocols, operations manuals, practice guidelines, remedial measures, and any other quality improvement measures, which CCMI, its designees, or a health plan company may adopt from time to time, and may require participating Doctors to follow in performing services pursuant to this Agreement.

ARTICLE II
DUTIES AND OBLIGATIONS

1. Provision of Chiropractic Services. Doctor shall provide Chiropractic Services to Enrollees in accordance with the Enrollees' Benefit Contracts, CCMI and health plan company Rules and Regulations (including health plan company and CCMI standards for timely access to care and Enrollee services that meet or exceed Centers for Medicare & Medicaid Services ("CMS") standards, policies and procedures that allow for individual medical necessity determinations, and the CMS requirement that Doctor consider Enrollee input into any proposed treatment plan), in a manner consistent with professionally recognized standards of care and practice of the community in which Chiropractic Services are rendered, and in a manner so as to assure efficient, quality care and treatment. Doctor shall provide Chiropractic Services to all Enrollees in a non-discriminatory manner regardless of the type of Benefit Contract governing the Enrollee's coverage, and without regard to the race, religion, gender, sexual orientation, color, national origin, age, health status (including but not limited to disability, medical history, genetic information, claims experience, receipt of health care, medical condition including mental as well as physical illness, conditions arising out of acts of domestic violence, evidence of insurability, suspected or actual presence of the HIV virus or other communicable disease), or public assistance status. Doctor will accept Enrollees as new patients on the same basis as Doctor provides such services to and accepts as new patients who receive coverage under other benefit plans or health insurance policies (non-CCMI programs). Doctor is not obligated to provide Enrollees with any service which he or she does not normally provide to others and shall not provide services which he or she is not authorized by law to provide. Doctor's primary concern under this Agreement shall be the quality of services provided to Enrollees. Nothing stated in this Agreement shall be interpreted to diminish this responsibility. Doctor agrees that s/he will deliver all covered Chiropractic Services for the duration of the eligibility of each Enrollee treated by Doctor under any CCMI program in which Doctor is participating, even if such period extends beyond the term of this Agreement, but in no event for a period extending for more than one (1) year beyond the termination of this Agreement.

2. Limitations on Participation. Doctor acknowledges and agrees that CCMI may determine at any time, in its sole and absolute discretion, that the participation of Doctor in some CCMI programs may not be appropriate due to the geographic area(s) served by either the Doctor or the particular health plan company or Payor, or for such other reasons as CCMI or the health plan company may reasonably determine. CCMI makes no representations or guarantees concerning the number of Enrollees, if any, that will access Doctor.

3. Referrals. Doctor agrees that all patient presentations or medical conditions which require treatment but which are not appropriate for chiropractic treatment under generally accepted standards of chiropractic treatment and/or CCMI or the health plan company standards of practice, shall be referred to an appropriate Participating Health Care Provider, as determined by the Plan Summary, the Benefit Contract or the health plan company rules and regulations. Doctor understands that the health plan companies have procedures approved by CMS to identify Enrollees with complex or serious medical conditions, assess those conditions and use medical procedures to diagnose and monitor them on an ongoing basis, and implement treatment plans that are appropriate to

those conditions that includes an adequate number of direct access visits to specialists consistent with the treatment plan and that are time-specific and updated periodically by the health plan companies. Failure to refer Enrollees consistent with the above procedures may result in the Doctor being responsible for all costs associated with services rendered to the member by an inappropriate or non-participating provider.

4. Enrollee Eligibility. The continued eligibility of Enrollees to obtain Chiropractic Services shall be in accordance with the pertinent health plan company Benefit Contract. Before providing Chiropractic Services to an Enrollee, Doctor shall verify eligibility in accordance with the applicable Plan Summary. Doctor shall not be entitled to payment from any Payor for services provided to any person who is not an eligible Enrollee at the time such services were delivered. Health plan company retains the right of final verification of eligibility. A health plan company's verification supersedes any authorization of care, Plan Summary and/or claims payment review made by CCMI.

5. Collection of Co-payments and Other Charges. Doctor shall not bill or attempt to collect from an Enrollee for services provided unless such services are non-covered services under the Enrollee's Benefit Contract (such as custodial, maintenance or elective care). The Enrollee may be billed for such services only if the Enrollee is notified prior to receipt of the services that the services are not covered, and, after such notice and prior to receipt of the services, the Enrollee agrees in writing to pay for such services. Doctor, additionally, has the right and obligation to collect all applicable co-payments, coinsurance amounts, deductibles or amounts exceeding an Enrollee's benefit limits. Doctor agrees and understands that if s/he fails to charge and/or collect all deductibles, co-payments and other amounts due Doctor by Enrollee, CCMI may require Doctor to return all fees paid by CCMI or waive all claims submitted to CCMI by Doctor for services rendered to the Enrollee. Failure to comply with this provision may result in termination of this Agreement by CCMI.

6. Restrictions on Claims Against Enrollees. Pursuant to Federal regulation 42 CFR § 422(g)(l)(i) and Minnesota Statutes § 62D.123, subdivision 1.:

DOCTOR AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST AN ENROLLEE OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THIS AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS; (1) NONPAYMENT BY THE HEALTH PLAN COMPANY OR (2) BREACH OF THIS AGREEMENT, OR (3) BREACH OF THE AGREEMENT BETWEEN CCMI AND THE HEALTH PLAN COMPANY. THIS PROVISION DOES NOT PROHIBIT DOCTOR FROM COLLECTING COPAYMENTS OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF THE HEALTH PLAN COMPANY ENROLLEES. THIS PROVISION DOES NOT

APPLY TO SERVICES PROVIDED AFTER THIS AGREEMENT TERMINATES. THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE DOCTOR AND THE ENROLLEE OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THIS AGREEMENT. FOR PURPOSES OF THIS PROVISION, NONPAYMENT BY THE HEALTH PLAN COMPANY SHALL INCLUDE NONPAYMENT BY ANY HEALTH PLAN COMPANY OR CCMI IN THE EVENT OF THE INSOLVENCY OF THE HEALTH PLAN COMPANY OR CCMI. DOCTOR AGREES THAT IN THE EVENT OF THE INSOLVENCY OF EITHER A HEALTH PLAN COMPANY OR CCMI, DOCTOR SHALL CONTINUE TO PROVIDE ENROLLEES WITH CHIROPRACTIC SERVICES FROM THE DATE OF SUCH INSOLVENCY FOR THE DURATION OF THE BENEFIT CONTRACT PERIOD FOR WHICH PREMIUM PAYMENT HAS BEEN MADE BY ENROLLEES.

7. Compliance and Licensure Requirements. Doctor shall maintain, without material restriction, all federal, state, and local licenses and permits required to provide health services (including Chiropractic Services) under this agreement, and to fully comply with all applicable state and federal statutes, and state, federal, health plan company and CCMI rules and regulations in the provision of health services. Doctor shall cooperate with health plan companies and CCMI in all efforts to achieve and/or maintain regulatory compliance. Upon either Doctor's actual knowledge or receipt of notice of any change in taxpayer LD. numbers, name, address, phone number or other demographic information, Doctor shall immediately notify CCMI in writing.

   Doctor shall notify CCMI in writing within five (5) days of notice or knowledge of any termination, suspension, restriction, stipulation, limitation, qualification or other disciplinary action, corrective action plan or investigation regarding Doctor's license, certifications, staff privileges at any health care facility, or participation status with any third-party Payor or health plan company or network. Doctor shall notify CCMI of any other information or situations that may impact the care or continuity of care of any Enrollee, including, but not limited to, the health status of Doctor.

8. Coordination of Benefits. Health plan company and CCMI benefits are determined after the determination of benefits of any other plan of insurance, health coverage, workers' compensation, liability insurance, no-fault auto insurance, or other insurance to which the Enrollee may be entitled. It is the responsibility of the Doctor to cooperate fully in the identification of any benefits for health care that the Enrollee may be entitled to, the furnishing of information to CCMI or the health plan company or such other health benefits Payor, and the recovery of payments through coordination of benefits or subrogation. When an Enrollee is eligible for coverage of Chiropractic Services under one or more other Benefit Contracts or plans, payment for Chiropractic Services shall be coordinated with such other contracts or plans. The order and extent of payment shall be determined in accordance with the coordination of benefits provisions of the Enrollee's Benefit Contract. Any payments recovered or saved through coordination of benefits or subrogation relating to claims that have been paid by CCMI or a health plan company shall belong to CCMI or the health plan company.

9. Access to Books and Records. During the term of this Agreement and for ten (10) years following termination of this Agreement or, in the event of an audit or the possibility of fraud, such longer time as provided by federal regulations, CCMI, health plan companies, the federal Department of Health and Human Services, the Comptroller General, CMS, and any other duly authorized agents or designees of any state or federal authority having competent jurisdiction, at reasonable hours and upon reasonable notice and demand, shall have access to all of Doctor's or any transferee's books, records and information related to health services provided under this Agreement, reconciliation of benefit liabilities, determinations of amounts payable, all to the extent required or permitted by applicable law and without further authorization by any Enrollee, including but not limited to books, contracts, medical records, patient care documentation, financial information relating to health services provided pursuant to this Agreement, and to Enrollee records and records of account. All such records and information will be maintained by doctor in accordance with applicable state and federal law. Furthermore, Doctor agrees to make available Doctor's premises, physical facilities and equipment and all records relating to Enrollees, and any other relevant information the entities identified above may deem necessary.

10. Release of Records. Doctor shall release to an Enrollee, CCMI, a health plan company, or any entity identified in the foregoing paragraph 9, all information and records or copies of records regarding the examination or treatment on an Enrollee within seven (7) calendar days from the date such request is made, or sooner if necessary to comply with laws, or related to the resolution of Enrollee complaints. Doctor shall provide such records at no charge to CCMI, the Enrollee, any government entity, or the health plan company. CCMI and health plan companies are authorized to release information in their possession or obtained pursuant to this provision pertaining to Doctor and Enrollees treated by Doctor as is necessary to comply with state or federal laws and regulations, and CCMI's agreements with health plan companies.

11. Privacy and Security of Patient/Enrollee Information and Records. Doctor agrees to: maintain reasonable and appropriate administrative, technical and physical safeguards to insure the integrity and confidentiality of all Enrollee data and information; protect against any reasonably anticipated threats or hazards to the security or integrity of Enrollee data and information; protect against unauthorized uses or disclosures of all Enrollee data and information; and ensure compliance with such measures by Doctor's officers, employees, agents and business associates, if any. The collection, creation, receipt, maintenance or dissemination by Doctor of all Enrollee data, in any form or medium (e.g., whether paper or electronic) (including medical records) shall be done: in an accurate and timely manner; ensuring timely access by Enrollees to their records and information that pertains to them; in compliance with any applicable state and federal statutes and regulations, whether it be the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other state or federal regulations, court orders, or subpoenas. Doctor ensures that unauthorized individuals cannot gain access to, or alter patient records.

Pursuant to HIPAA and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"), Doctor agrees:

a. Not to use or further disclose Enrollee Protected Health Information ("PHI") other than as permitted or required by this Agreement, and further agrees not to use or

further disclose PHI in a manner that would violate requirements of HIPAA and its implementing regulations ("HIPAA Regulations") or the HITECH Act;

b. To report to CCMI any use or disclosure of PHI not provided for by this Agreement of which it becomes aware, and shall ensure that any agents, including any subcontractor, to whom Doctor provides PHI, agrees to the same restrictions and conditions that apply to Doctor with respect to such information;

c. That upon any termination of this Agreement, to extend the protections of this Section 11 to such PHI and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible;

d. To develop, implement, maintain and use appropriate administrative, technical and physical safeguards, in compliance with Social Security Act § 1173(d) (42 U.S.C. § 1320d-2(d)), 45 C.F.R. § 164.530(c)) and any other implementing regulations issued by the U.S. Department of Health and Human Services;

e. That upon receipt of notice from CCMI, to promptly amend or permit CCMI or health plan company access to amend any portion of the PHI which Doctor created or received from CCMI or health plan company so that CCMI and/or health plan company may meet its amendment obligations under 45 C.F.R. § 164.526;

f. That with the exception of disclosures of PHI made for the purposes specified in 45 C.F.R § 164.528(a)(1)(i)-(ix), to document and report each disclosure, if any, Doctor makes of any PHI Doctor has created for CCMI or any health plan company or received from CCMI or any health plan company within five (5) days of the discovery of the disclosure. Doctor shall cooperate with CCMI in investigating the disclosure and in meeting CCMI's or any health plan company's obligations under the HIPAA regulations and HITECH Act. In the event of any such disclosure, Doctor shall:

    i. Identify the nature of the non-permitted access, use or disclosure, including the date of the breach and the date of discovery of the breach;

    ii. Identify the PHI accessed, used or disclosed as part of the breach (e.g. full name, social security number, date of birth etc.);

    iii. Identify who made the non-permitted access, use or disclosure and who received the non-permitted disclosure;

    iv. Identify what corrective action Doctor took or will take to prevent further non-permitted access, uses or disclosures;

    v. Identify what Doctor did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure; and

    vi. Provide such other information, including a written report, as CCMI may reasonably request.

Doctor acknowledges and agrees that in the event Doctor breaches this Section 11, CCMI may terminate this Agreement upon written notice to Doctor and/or report such breach by Doctor to the United States Department of Health and Human Services.

12. HIPAA Security. Doctor agrees that:

a. Doctor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Enrollee electronic Protected Health Information ("e-PHI") that Doctor creates, receives, maintains or transmits on behalf of CCMI or any health plan company, as required by 45 C.F.R. Part 164 (the "Security Rules").

b. Doctor shall ensure that any agent, including a subcontractor, to whom Doctor provides e-PHI agrees to implement reasonable and appropriate safeguards to protect e-PHI, and

c. Doctor shall report to CCMI any security incident involving e-PHI of which Doctor becomes aware. The Security Rules define a "Security Incident" as an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, involving e-PHI that is created, received, maintained or transmitted by or on behalf of Party. Since the Security Rules include attempted unauthorized access, use, disclosure, modification or destruction of information, CCMI needs to have notification of attempts to bypass electronic security mechanisms. Therefore, the Parties agree to the following reporting procedures:

Security Incidents that result in unauthorized access, use, disclosure, modifications or destruction of information or interference with system operations ("Successful Security Incidents") and for Security Incidents that do not so result ("Unsuccessful Security Incidents").

i. For Unsuccessful Security Incidents, the Parties agree that this paragraph constitutes notice of such Unsuccessful Security Incidents.

ii. For Successful Security Incidents, Doctor shall give notice to CCMI not more than five (5) days after Doctor learns of the Successful Security Incident.

13. Confidentiality. Doctor shall maintain in confidence during the term of this Agreement and for seven (7) years subsequent to its termination, unless HIPAA or other applicable law requires a longer period of time: (1) all Enrollee information, including health care information; and (2) all quality assessment and utilization review information; and (3) all financial, fee, and payment information relating to this Agreement. Further, Doctor shall utilize his or her best efforts to protect such information from any unauthorized disclosure by any person, and shall refrain from using or allowing others to utilize such information in any way that is detrimental to CCMI or a health plan company, including but not limited to, competitive disadvantage of CCMI or a health plan company. This

provision does not apply to any disclosures to an Enrollee necessary or appropriate for the diagnosis and care of that Enrollee, except to the extent such disclosure would otherwise violate Doctor's legal or ethical obligations.

14. Enrollee Data. Doctor agrees to comply with all requests by CMS, the Minnesota or other state department of health ("MDH"), a health plan company and/or CCMI for information that CMS or MDH requires, the health plan company or CCMI intends to release to purchasers of health care coverage, enrollees and other consumers, including without limitation, CCMI-specific and Doctor-specific quality, outcomes and patient satisfaction data. Doctor consents to the release by health plan companies and CCMI of such information and agrees not to attempt to prohibit or restrict the release of such information. Doctor agrees to provide CCMI, a health plan company, MDH, and CMS all information necessary for the reporting and submission obligations to MDH or CMS, including, but not limited to: all data necessary to characterize the context and purposes of each encounter between an Enrollee and Doctor; patterns of utilization of Doctor's services; the availability, accessibility and acceptability of Doctor's services; changes in the health status of Enrollees; and other matters that CMS or MDH may require. Doctor certifies that all Enrollee encounter data shall be accurate, complete and truthful.

15. Communications with Enrollees. Doctor has the right and is encouraged by CCMI to discuss with each Enrollee his or her pertinent details regarding the diagnosis of the Enrollee's condition, the nature and purpose of any recommended procedure, the potential risks and benefits of any recommended treatment, and any reasonable alternatives to such recommended treatment. Doctor may discuss CCMI's and health plan company's provider reimbursement methodology (including a good faith estimate of the reimbursement the Doctor expects to receive for services) with an Enrollee or patient, subject to Doctor's general contractual and ethical obligations not to make false or misleading statements. CCMI has the right to disclose to any Enrollee the reason(s) for modifications or denials relating to authorizations such as, by way of example and not limitation, failure to promptly and adequately document Chiropractic Necessity.

16. Requirements Related to the Receipt of Federal Funds. Doctor understands some payments received by Doctor for certain Enrollees (e.g. Medicare or Medicaid patients) are from Federal or State funds. Therefore, Doctor understands and agrees to comply with: Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990, 42 U.S.C. 12101, et.seq., the Minnesota Human Rights Act; all as may be amended from time to time.

ARTICLE III
PAYMENT FOR COVERED SERVICES

1. Schedule of Payments. Subject to the terms of Article IV and other provisions of this Agreement, Payor will promptly pay clean claims of Doctor for covered Chiropractic Services provided to Enrollees in accordance with Plan Summaries that are part of this Agreement, as issued from time to time by CCMI. In the event of any conflicts between a Plan Summary and a Benefit Contract, the Benefit Contract controls. Doctor shall promptly report in writing to CCMI any overpayments to Doctor by CCMI or a health plan company. CCMI or health plan company may deduct overpayments of any type from future payments owed to doctor, together with an explanation of the action taken.

2. Claims Against Health Plan Companies and Others (Payors). Except as required by a Plan Summary, Doctor shall under no circumstance bill or attempt to collect (for any Chiropractic Service covered under a Benefit Contract) from a health plan company, any third party, including without limitation (i) any insurer or other Payor on behalf of an Enrollee, (ii) any alleged tortfeasor, or (iii) such alleged tortfeasor's insurer or other Payor. However, Doctor shall be responsible for collecting applicable deductibles or co-payments, if any, from Enrollees, as specified in Article II, sections 5 and 6.

3. Submission of Claims. Doctor shall submit claims and other required information in the form and within the time frames set forth in accordance with the procedures as stated in the applicable Plan Summary, or applicable Rules or Regulations. Claims submission procedures may be changed at any time at the discretion of CCMI, its designee or a health plan company. Standard claim forms (e.g. CMS 1500) shall be used for claims. Doctor understands that claims may be returned unpaid to Doctor for failure to follow correct submission procedures. Doctor further understands that an Enrollee may not be charged or billed for any charges denied because of late submission of claims by Doctor and that all such charges must be waived by Doctor.

4. Claims Subject to Quality Improvement and Utilization Management Programs. Payment for claims shall be subject to the Quality Improvement programs of the health plan companies and CCMI, including authorization, concurrent and retrospective peer review. All coding must be in compliance the federal departments of Health and Human Services and CMS, with the Rules and Regulations of CCMI, its designees, and health plan companies regarding coding guidelines such as CPT, IDC-9CM and HCPCS, as interpreted by CCMI, its designees, or a health plan company. Failure to comply with the requirements of this Agreement, particularly this Article III and Article IV, may result in non-payment.

5. Financial Risk-Sharing. Doctor agrees that CCMI, or a health plan company, may withhold a percentage of all amounts payable for risk-pools. Withhold percentages are listed in the pertinent Plan Summary, or as may be determined from time to time by CCMI, or a health plan company. Proceeds from a risk-pool will be used in the event of higher than expected utilization or costs. Funds remaining in a risk-pool, if any, may be distributed annually to each Doctor in that risk-pool in an amount equal to the aggregate determined payout amount, multiplied by the percentage that the Doctor's total withheld amount bears to the total withheld amount of all Doctors in the risk-pool. The withhold may be adjusted at any time, as determined in CCMI's, or the health plan company's, sole and absolute discretion. Doctor agrees to participate in any future, different financial risk sharing arrangement that may be determined to be in the best interests of CCMI and/or the Enrollees of the various health plan companies.

6. Provider Taxes. Amounts paid to Doctor by a Payor will be inclusive of all taxes imposed on Doctor's receipt of such amounts, including taxes for which Doctor has authority to transfer the additional tax-related expense to a third party, such as the gross revenues tax imposed on providers pursuant to Minn. Stat. Chapter 295. In the event legislative or regulatory action determines that any such tax does not apply to such payments, payments to Doctor will exclude the tax amount, and the Payor may recover from Doctor all amounts paid to Doctor attributable to such tax. In the event legislative or regulatory action increases or decreases the amount of such tax, reimbursements to Doctor will be increased or decreased according to applicable law to reflect such change.

ARTICLE IV
QUALITY IMPROVEMENT, UTILIZATION MANAGEMENT, PERFORMANCE IMPROVEMENT

1. Doctor shall comply with all CCMI and health plan company procedures, including quality improvement, credentialing, medical management, treatment authorization, concurrent monitoring, peer review, utilization management, Enrollee complaint or grievance, remedial measures, and any other similar programs and procedures established by health plan companies and/or CCMI from time to time, including but not limited to the following:

   A. All treatment plans must be authorized and shall be subject to review by the Credentialing, Quality Improvement, peer review, and remedial measures committees of CCMI. CCMI and health plan companies have the right to verify the clinical accuracy of all submitted information and claims. Doctor shall be responsible for obtaining any authorization required to release medical information to CCMI or a health plan company. Doctor agrees to abide by the decisions of CCMI, including all authorization and review processes of CCMI and health plan companies. Doctor agrees that any act, omission, or decision for which review has not been requested in accordance with procedures established by CCMI, its designees, or health plan companies for review of such act, omission or decision is final.

   B. Doctor agrees to promptly notify CCMI in writing of all Enrollee or Enrollee related complaints received, and the resolution of the complaint, if any. If a complaint is not resolved by Doctor in a manner satisfactory to the Enrollee or complaining party, CCMI and/or health plan company will follow their procedures to resolve any such complaints.

   C. Doctor agrees to participate in and cooperate fully with such programs as are established by CCMI and/or health plan companies to assess, evaluate and improve: the ongoing performance of CCMI and its participating doctors related to the provision of health services; the provision of services designed to improve the health of Enrollees, Enrollee satisfaction or administrative efficiency; including without limitation, quality assurance, practice guidelines, health improvement, utilization management, and credentialing programs. Doctor understands and agrees that the credentialing processes of CCMI, its designees, and the health plan companies are audited periodically by health plan companies, CMS, NCQA, and other credentialing bodies on an ongoing basis as required by CMS regulations, and the requirements of the credentialing bodies. Doctor further understands and agrees that s/he must comply with all applicable Medicare, Medicaid laws and regulations and instructions from CMS and state regulators.

2. Special Projects. Doctor shall cooperate with CCMI and the health plan companies in the ongoing evaluation of the delivery of Chiropractic Services and shall, if requested by either CCMI or a health plan company, furnish relevant information and periodically participate in special studies and/or programs which attempt to assess or improve the quality, availability and accessibility of Chiropractic Services rendered to Enrollees.

3. Falsifying Information. Doctor agrees to submit only accurate information in the presentation of Enrollees' conditions, health history, diagnosis, objective and subjective findings and all other information on the patient report forms and throughout the entire authorization, utilization review, and claims processes. Doctor agrees that if s/he presents false, inaccurate, or misleading information in any way or at any step in the process, CCMI may require doctor to return all fees paid by CCMI, or to waive all charges made to CCMI by Doctor for any services rendered to Enrollees treated by Doctor under this Agreement. Failure to comply with this provision may result in termination of this Agreement, participation in any program, and/or membership in CCMI. Doctor Agrees that CCMI may contact any or all Enrollees directly in any manner without prior notice by CCMI to Doctor to verify any information submitted by Doctor to CCMI.

4. Professional Liability Insurance. Doctor has procured and shall maintain at all times, at Doctor's sole expense, general and professional liability insurance in amounts and coverage levels satisfactory to CCMI and health plan companies, as determined from time to time (and as may be specified in Plan Summaries) by CCMI or health plan companies to provide protection against any claims, liabilities, damages and judgments, including malpractice or negligence, that arise out of Chiropractic Services provided, or to be provided, by doctor and/or his or her employees or agents in the discharge of his or her or their professional responsibilities to Enrollees under this Agreement. The professional liability insurance required under this section shall be either (a) occurrence, or (b) claims made with an extended period reporting option {"tail" coverage), and under such other terms and conditions as may be required by CCMI or a health plan company. Doctor agrees to make CCMI a Certificate Holder on all professional liability insurance, and shall immediately notify CCMI in writing in the event of: i) changes to Doctor's liability insurance; ii) upon receipt of notice or knowledge of a change or restriction of any kind in Doctor's coverage; or iii) notification of the assertion of any claim against the Doctor, including claims for which Doctor agrees to any out-of-court settlement.

5. Mutual Hold Harmless. Doctor and CCMI shall indemnify, defend and hold each other harmless from any and all claims, losses, liabilities, damages, costs and expenses of all kinds (including reasonable attorneys fees), made by or alleged to be owing to any Enrollee or health plan company, by reason of any act or omission caused or alleged to have been caused by the other or any agent or employee of the other or other persons within the other's control or responsibility.

ARTICLE V
MARKETING, ADVERTISING, AND PROMOTION CONTROL

1. Use of Names and Service Marks. CCMI, the health plan companies, and Doctor each reserve the right to control the use of their own names, symbols, trademarks and service marks presently existing or hereafter established, except that Doctor authorizes CCMI and the health plan companies to use his or her name, including organization names, addresses and phone numbers in a reasonable manner for purposes of informing Enrollees, and purposes of promotion and advertising. Doctor may only identify himself or herself in any promotion or advertising as a participating provider in CCMI, but may not engage in any promotion or advertising of CCMI, its programs or health plan company participation.

2. Marketing and Promotion. The health plan companies have the sole responsibility for all advertising and promotion and for solicitation of Enrollees for their programs. However, Doctor agrees to display any notices approved and provided by the health plan companies and/or CCMI in appropriate places in the Doctor's facilities to indicate the availability of the Doctor's services through CCMI and the health plan company. CCMI make no representations and does not guarantee the inclusion of doctor into, timeliness of adding Doctor to, or the accuracy of any information contained in any network directories identifying Participating Providers issued by any health plan company.

3. Service Marks of CCMI and Health Plan Companies. Doctor agrees that s/he will not use the names, symbols or service marks of any health plan company or CCMI, including the ChiroCare® mark, in advertising or promotion or otherwise without prior opportunity for review and prior written consent by CCMI or the health plan company.

ARTICLE VI
DURATION AND TERMINATION OF AGREEMENT

1. Term. If this Agreement amends, follows, or replaces an existing Participating Provider Agreement between Doctor and CCMI: all new or revised provisions of the Participating Provider Agreement required by law or government regulation shall be effective upon receipt of this document by Doctor; the remainder of any changes, additions or revisions of the Participating Provider Agreement shall be effective forty-five (45) days after receipt by Doctor. In all other cases this agreement shall be effective upon signature on the Certificate by both Doctor and CCMI. After becoming effective, this Agreement shall remain in effect through December 31 of the calendar year of receipt by Doctor, and shall automatically renew for successive one (1) calendar year periods unless terminated as provided hereunder.

2. Automatic Termination. This Agreement shall terminate automatically and immediately upon: (i) termination of either Doctor's license to practice chiropractic in Minnesota or other state, regardless of the reason for the termination; (ii) death, disability or retirement of Doctor; or exclusion by Doctor or any employee of Doctor from participation in Medicare under section 1128 or 1128A of the Social Security Act or exclusion from any other State or Federal health care program. Applicable Plan Summaries or other attachments to or amendments of this Agreement shall terminate immediately upon termination of the applicable agreement between CCMI and the subject health plan company, regardless of the reason for the termination. Termination of this agreement or participation in any program (as evidenced by a Plan Summary) may be immediate upon notice to Doctor by CCMI or a health plan company in the event that CCMI or a health plan company has reason to believe or receives evidence of potential for significant patient harm or fraudulent or illegal conduct on the part of Doctor or Doctor's employees or other agents.

3. Restriction, Suspension, or Termination by CCMI. CCMI may terminate this Agreement, or Doctor's participation in any individual program(s) (evidenced by any Plan Summary) without cause as of the end of any calendar month, upon at least one hundred twenty (120) days written notice to Doctor. Doctor may terminate this Agreement as of the end of any calendar month, upon at least one hundred twenty (120) days written notice to

CCMI. However, either CCMI or any health plan company may, at its discretion, defer the effective date of any termination for up to twelve (12) months for some or all Enrollees served by Doctor until the renewal date of an Enrollee's benefit year. During such additional period of time, Doctor shall be paid as provided for in this Agreement and continue to render Chiropractic Services to Enrollees. CCMI or any health plan company may, at any time, restrict, suspend, or terminate Doctor's participation in any program or under any Benefit Contract for breach of this Agreement or a health plan company's or CCMI's belief that the best interests of an Enrollee or Enrollees requires such action. Restriction, suspension or termination by CCMI shall proceed under CCMI's procedure for the application of remedial measures, which includes written notice to Doctor of the reasons for the action, including, if relevant, the standards and the profiling data used to evaluate Doctor, the numbers and mix of Doctors CCMI needs. Doctor will notify Enrollees of pending termination of participation in an accurate and timely fashion, including the end date, and cooperate with CCMI and health plan company transition of care protocols.

4. Proprietary Information. All information furnished to doctor by CCMI or its designees, including, but not limited to, coding guidelines, fee schedules, forms, documents, program information, manuals, Utilization Review and Quality Improvement information, Enrollee and Participating Health Care Provider lists, copyrighted and trademark material, remains the property of and proprietary to CCMI or its designees (all of the foregoing is "Proprietary Information"). All such Proprietary information is only to be used by Doctor in connection with the performance of Doctor's obligations under this Agreement and only in the manner provided for in this Agreement. Doctor shall not disclose or use any Proprietary Information for Doctor's own benefit or others, whether during the term of this Agreement or after termination of this Agreement, except as permitted in writing by CCMI. Doctor shall have no ownership rights in said Proprietary Information, including, but not limited to copying, use or distribution of said Proprietary information. Upon termination of this Agreement, doctor will return all Proprietary information in Doctor's possession in a manner to be specified by CCMI. Doctor shall cooperate with CCMI and its designees in maintaining the confidentiality of such Proprietary Information at all times during and after termination of this Agreement.

5. Continuity of Care Prior Obligations. Termination of participation in any program or of this Agreement shall not relieve Doctor of obligations with respect to Chiropractic Services furnished prior to the termination date. Upon termination of this Agreement, CCMI may require Doctor to provide continuing care to any Enrollee then receiving Chiropractic Services until the earlier of: i) the completion of the treatment program or discharge from treatment; or ii) the effective date of transfer of such Enrollee to another Participating Provider chiropractor, in which event Doctor shall inform CCMI of such transfer. Payment for any continued treatment shall be at the then applicable rates as provided for in the applicable Plan Summary. All provisions of this agreement, including treatment authorization of all care, will remain in effect during this transition period.

ARTICLE VII
MISCELLANEOUS

I. Relationship of the Parties. The relationship of CCMI and Doctor is and shall continue to be that of independent contractors, and neither shall be construed to be employees, agents

or representatives of the other. Doctor shall be free to contract with any other plan or entity for the delivery of Doctor's services.

2. Doctor's Warranties. Doctor represents and warrants to CCMI that s/he is, and for the term of this Agreement will remain: licensed to practice chiropractic in the State of Minnesota and/or other states Doctor is now or will be treating Enrollees; included in participation in Medicare under section 1128 or 1128A of the Social Security Act and all other State and Federal health care programs; and that no license ever held by doctor to practice chiropractic in any state has been revoked, suspended, limited, or restricted in any way at any time except as has been immediately and fully disclosed in writing to CCMI by Doctor. Doctor further warrants that s/he does not now and shall not in the future employ or contract with any individual that has been excluded from: participation in Medicare under section 1128 or 1128A of the Social Security Act; or participation in any other State or Federal health care program.

3. Conflicts. In the event there is a conflict between or among this Agreement, a Plan Summary, a Benefit Contract, Rules and Regulations of CCMI or its designees, or the applicable procedures, financial terms, or rules and regulations of any health plan company's particular program, the Benefit Contract shall control with respect to the provision of care to Enrollees, except as otherwise provided by the agreement or arrangement between CCMI and the health plan company. Health plan companies rules and regulations shall control over the remaining provisions, and, in all other situations, the rules and regulations of CCMI and its designees shall control.

4. Assignment. This Agreement shall bind the successors of either party to this Agreement, but it may not be assigned or transferred by Doctor. Doctor's rights and obligations under this agreement are personal, and may not be assigned or delegated in any way. This also means that Doctor shall not be entitled to any payment (either from any Payor or Enrollee) for treatment of any Enrollee by any other chiropractor, unless the treating chiropractor has been fully credentialed and accepted as a Participating Health Care Provider by CCMI. Any assignment or attempted assignment by Doctor of this agreement or any right or obligation of Doctor under this agreement shall be void. CCMI shall have the absolute right to: (1) assign any or all of its rights and/or duties hereunder; or (2) enter into an agreement to join any other entity as a party to this Agreement, thereby entitling such entity to avail itself of the rights of CCMI and binding such entity to all of the responsibilities of CCMI under this Agreement, unless otherwise limited by the terms of the joinder Agreement.

5. Insolvency. In the event of insolvency of any Payor, health plan company, or self-insured employer whose benefit plan is administered by CCMI, a health plan company or other Payor, and that Payor is unable to meet its financial obligations under the Agreement between it and CCMI, or CCMI is unable to meet its financial obligations under this Agreement, Doctor agrees to hold CCMI and the health plan company or other Payor harmless from any and all liability related to Chiropractic Services covered under this Agreement. Doctor must notify CCMI within five (5) days of his or her bankruptcy or order appointing a receiver for Doctor, or order approving a petition seeking reorganization under bankruptcy laws.

6. Government Filing. If required by a health plan company, the health plan company or CCMI may file this Agreement with the appropriate regulatory agency.

7. Waiver/Severability. Failure of CCMI or a health plan company to exercise any option upon breach of any term or condition of this Agreement by Doctor shall not operate to bar the right of CCMI or the health plan company to exercise any option on subsequent breach of this Agreement. Each provision of this Agreement is intended to be several. If any provision hereof is waived, deemed illegal or invalid for any reason whatsoever, such waiver, illegality or invalidity shall not affect the validity and/or enforceability of the remainder of this Agreement.

8. Headings. Article, section and paragraph headings herein are intended for ease of reference only and shall neither be considered a part of this Agreement nor used in the interpretation of this Agreement.

9. Binding Effect, Amendment and Governing Law. This Agreement is and its provisions are effective as set forth in section 1 of Article VI, and supersedes and replaces any prior Participating Provider agreements, oral or written, pertaining in whole or in part to Doctor's participation in any program or provision of Chiropractic Services under any Benefit Contract. This Agreement may be executed by signing of the attached Certificate and in several counterparts, each of which shall be deemed to be an original and all of which shall constitute one and the same instrument. This Agreement may be amended unilaterally by CCMI as necessary or appropriate due to changes in state or federal law or applicable accreditation guidelines, upon demand by a state or federal agency, or, for non-material amendments, as otherwise necessary or appropriate to respond to external legal, industry or community trends. Any such amendments shall be effective as of the date legally required or demanded, or, for non-material amendments, at such other date identified by CCMI in a written notice to Doctor, but no earlier than forty-five (45) days from receipt by Doctor. This Agreement shall be interpreted and governed as to application and effect by the internal laws of the State of Minnesota, not merely its choice of laws rules.

UCare

Medicare Fee Schedule-Effective 1/1/2017

CPT Code	Description	Fee
CHIROPRACTIC MANIPULATIVE TREATMENT:		
98940	Chiropractic manipulative treatment; spinal, one to two regions	$24.00
98941	Spinal, three to four regions	$30.00
98942	Spinal, five regions	$36.00

Chiropractic x-rays, therapies, exams, supplies and lab services are not covered under this program.

UCare

Medicaid Fee Schedule-Effective 1/1/2017

CPT Code	Description	Fee
CHIROPRACTIC MANIPULATIVE TREATMENT:		
98940	Chiropractic manipulative treatment; spinal, one to two regions	$19.69
98941	Spinal, three to four regions	$28.78
98942	Spinal, five regions	$37.37
NEW PATIENT EXAMS:		
99201	Problem focused history and examination --straightforward	$30.00
99202	Expanded history and examination – straightforward	$45.00
99203	Detailed history and examination – low complexity	$60.00
99204	Comprehensive history and examination – moderate complexity	$65.00
ESTABLISHED PATIENT EXAMS:		
99211	Problem focused history and examination -- brief	$15.35
99212	Problem focused history and examination - straightforward	$30.00
99213	Expanded history and examination – low complexity	$45.00
99214	Detailed history and examination – moderate complexity	$50.00
PROCEDURES:		
97810	Acupuncture	$25.50
97811	Acupuncture, additional 15 minutes	$18.93
97813	Acupuncture with electrical stimulation	$27.27
97814	Acupuncture with electrical stimulation, additional 15 minutes	$21.46
RADIOLOGY:		
CPT Code	**Description**	**Fee**
72020	Spine, single view	$15.40
72040	Spine, cervical, AP and lateral (includes APOM)	$23.48
72050	Spine, cervical, comprehensive, AP and lateral, four views	$31.56
72052	Spine, cervical, complete, AP and lateral, seven views	$39.89
72070	Spine, thoracic, AP and lateral	$23.98
72072	Spine, thoracic, AP and lateral plus swimmer's view	$24.49
72074	Spine, thoracic, complete with obliques, minimum of four views	$27.77
72080	Spine, thoracic, thoracolumbar, AP and lateral	$21.46
72081	Spine (e.g. scoliosis), one view	$27.27
72082	Spine (e.g. scoliosis), two or three views	$44.18
72083	Spine (e.g. scoliosis), four or five views	$47.97
72100	Spine, lumbosacral, AP and lateral	$24.74
72110	Spine, lumbosacral, complete, oblique views	$34.59
72114	Spine, lumbosacral, complete, bending views	$44.18
72120	Spine, lumbosacral, bending only, minimum of four views	$28.53

RADIOLOGY (CONTINUED):		
CPT Code	**Description**	**Fee**
72170	Pelvis, AP only	$22.47
72190	Pelvis, three views	$27.01
72200	Sacroiliac limited	$19.94
72202	Sacroiliac joints, three views	$23.23
72220	Sacrum and coccyx, minimum of two views	$19.69

Chiropractic therapies (other than acupuncture), supplies and lab services are not covered under this program. This published schedule is not intended to fully detail all covered codes; additional services may be payable if covered under the member's benefit plan.

UCare Commercial

Choices and Fairview Choices

Fee Schedule-Effective 1/1/2017

NEW PATIENT EXAMS:		
CPT Code	**Description**	**Fee**
99201	Problem focused history and examination --straightforward	$30.00
99202	Expanded history and examination – straightforward	$45.00
99203	Detailed history and examination – low complexity	$60.00
99204	Comprehensive history and examination – moderate complexity	$65.00
ESTABLISHED PATIENT EXAMS:		
CPT Code	**Description**	**Fee**
99211	Problem focused history and examination -- brief	$20.00
99212	Problem focused history and examination - straightforward	$30.00
99213	Expanded history and examination – low complexity	$45.00
99214	Detailed history and examination – moderate complexity	$50.00
CHIROPRACTIC MANIPULATIVE TREATMENT:		
CPT Code	**Description**	**Fee**
98940	Chiropractic manipulative treatment; spinal, one to two regions	$29.00
98941	Spinal, three to four regions	$33.00
98942	Spinal, five regions	$36.00
98943	Extraspinal – one or more regions	$22.50
MODALITIES:		
CPT Code	**Description**	**Fee**
97012	Traction, mechanical	$12.00
97014	Electrical stimulation-unattended	$12.00
97024	Diathermy	$6.00
97026	Infrared	$6.00
97032	Electrical stimulation-manual	$12.00
97035	Ultrasound	$10.00
PROCEDURES:		
CPT Code	**Description**	**Fee**
97110	Therapeutic exercise	$20.00
97140	Manual therapy	$12.00
97530	Therapeutic activity	$20.00

RADIOLOGY:		
CPT Code	**Description**	**Fee**
71010	Chest; Single View, Frontal	$22.00
71015	Chest; Stereo, Frontal	$29.00
71020	Chest, Two Views, Frontal And Lateral;	$29.00
71021	Chest, Two Views, Frontal And Lateral; With Apical Lordotic	$36.00
71022	Chest, Two Views, Frontal And Lateral; With Oblique	$41.00
71030	Chest, Complete, Minimum Of Four Views;	$40.00
71035	Chest, Special Views (Eg, Lateral Decubitus, Bucky Studies)	$34.00
71100	Ribs, Unilateral; Two Views	$29.00
71101	Ribs, Unilateral;Including Posteroanterior Chest,Minimum 3Views	$36.00
71110	Ribs, Bilateral; Three Views	$37.00
71111	Ribs, Bilateral;Including Posteroanterior Chest,Minimum 4 Views	$50.00
71120	Sternum, Minimum Of Two Views	$28.00
71130	Sternoclavicular Joint Or Joints, Minimum Of Three Views	$35.00
72020	Spine, single view	$22.00
72040	Spine, cervical, a/p and lateral (includes APOM)	$30.00
72050	Spine, cervical, comprehensive, a/p and lateral, four views	$50.00
72052	Spine, cervical, complete, a/p and lateral, seven views	$54.00
72070	Spine, thoracic, a/p and lateral	$31.00
72072	Spine, thoracic, a/p and lateral plus swimmer's view	$36.00
72074	Spine, thoracic, complete with obliques, four views	$42.00
72080	Spine, thoracic, thoracolumbar, a/p and lateral	$33.00
72081	Spine (e.g. scoliosis), one view	$35.00
72082	Spine (e.g. scoliosis), two or three views	$35.00
72083	Spine (e.g. scoliosis), four or five views	$36.00
72100	Spine, lumbosacral, a/p and lateral	$35.00
72110	Spine Lumbosacral, complete, oblique view	$45.00
72114	Spine, lumbosacral, complete, bending view	$58.00
72120	Spine, lumbosacral, bending only, four views	$40.00
72170	Pelvis; One Or Two Views	$25.00
72190	Pelvis; Complete, Minimum Of Three Views	$35.00
72200	Sacroiliac limited	$28.00
72202	Sacroiliac joints, three views	$30.00
72220	Sacrum and coccyx	$28.00
73000	Clavicle, Complete	$25.00
73010	Scapula, Complete	$25.00
73020	Shoulder, one view	$24.00
73030	Shoulder, complete, two views	$30.00
73050	Acromioclavicular joints, bilateral	$32.00
73060	Humerus, two views	$28.00
73070	Elbow, a/p and lateral	$26.00
73080	Elbow, complete, three views	$28.00
73090	Forearm, a/p and lateral	$26.00
73092	Upper Extremity, Infant, Minimum Of Two Views	$27.00

RADIOLOGY (CONT):		
CPT Code	**Description**	
73100	Wrist, a/p and lateral	$25.00
73110	Wrist, complete, three views	$27.00
73120	Hand, two views	$25.00
73130	Hand, complete, three views	$27.00
73140	Fingers, two views	$23.00
73501	Hip, unilateral with pelvis, one view	$25.25
73502	Hip, unilateral with pelvis, two to three views	$30.50
73503	Hip, unilateral with pelvis, minimum of four views	$34.00
73521	Hip, bilateral with pelvis, two views	$30.25
73522	Hip, bilateral with pelvis, three to four views	$31.00
73523	Hip, bilateral with pelvis, minimum of five views	$32.00
73551	Femur, one view	$25.25
73552	Femur, two views	$28.75
73560	Knee, two views	$27.00
73562	Knee, three views	$30.00
73564	Knee, complete, including obliques	$33.00
73565	Knee, both, standing, anteroposterior	$25.00
73590	Tibia and Fibula, A/P and lateral	$27.00
73592	Tibia and Fibula, lower extremity, infant	$25.00
73600	Ankle, a/p and lateral	$25.00
73610	Ankle, complete, three views	$27.00
73620	Foot, a/p and lateral	$25.00
73630	Foot, complete, three views	$27.00
73650	Calcaneus, two views	$24.00
73660	Toes, two views	$21.00
76140	X-ray Consult	$25.00
ORTHOTIC PROCEDURES AND DURABLE MEDICAL EQUIPMENT (DME)		
CPT Code	**Description**	**Fee**
E0860	Home Traction Unit-Overdoor, Cervical	$30.00
E0890	Home Traction Unit-Att to Footboard, Pelvic	$59.25
E1805	Dynamic Adjustable Wrist Extension/Flex Device	$26.00
L0120	Cervical Collar--Flexible, Non-adjustable (Foam)	$14.00
L0628	Lumbar Flex Support	$30.00
L1810	Knee Orthosis--Elastic With Joints (Prefab)	$65.00
L1902	Ankle Foot Orthosis (Prefab)	$45.00
L1906	Ankle Foot Orthosis--Multiligamentus Ankle Support (Prefab)	$22.00
L3650	Shoulder Orthosis--Figure 8, Abduction Restrain (Prefab)	$47.40
L3660	Shoulder Orthosis--Figure 8, Abduction Restrain (Canvas Prefab)	$46.00
L3908	Wrist Hand Orthosis--Cock Up, Non-Molded (Prefab)	$16.00

This fee schedule is not a guarantee of coverage, final coverage will be determined by each member's benefit contract. This published schedule is not intended to fully detail all covered codes; additional services may be payable if covered under the member's benefit plan.

HealthPartners

Fee Schedule-Effective 1/1/2017

NEW PATIENT EXAMS:				
CPT Code	**Description**	**Commercial Fully & Self-Insured**	**Medicare**	**Medicaid**
99201	Problem focused history and examination --straightforward	$30.00	NC	$30.00
99202	Expanded history and examination – straightforward	$45.00	NC	$45.00
99203	Detailed history and examination – low complexity	$60.00	NC	$60.00
99204	Comprehensive history and examination – moderate complexity	$65.00	NC	$65.00
ESTABLISHED PATIENT EXAMS:				
CPT Code	**Description**	**Commercial Fully & Self-Insured**	**Medicare**	**Medicaid**
99211	Problem focused history and examination -- brief	$19.00	NC	$15.35
99212	Problem focused history and examination - straightforward	$30.00	NC	$30.00
99213	Expanded history and examination – low complexity	$45.00	NC	$45.00
99214	Detailed history and examination – moderate complexity	$50.00	NC	$50.00
CHIROPRACTIC MANIPULATIVE TREATMENT:				
CPT Code	**Description**	**Commercial Fully & Self-Insured**	**Medicare**	**Medicaid**
98940	Chiropractic manipulative treatment; spinal, one to two regions	$29.75	$28.75	$19.69
98941	Spinal, three to four regions	$34.00	$33.50	$28.78
98942	Spinal, five regions	$37.50	$37.50	$37.37
98943	Extraspinal – one or more regions	$21.50	NC	NC
MODALITIES:				
CPT Code	**Description**	**Commercial Fully & Self-Insured**	**Medicare**	**Medicaid**
97012	Traction, mechanical	$12.00	NC	NC
97014	Electrical stimulation-unattended	$10.25	NC	NC
97024	Diathermy	$8.50	NC	NC
97026	Infrared	$8.50	NC	NC
97032	Electrical stimulation-manual	$10.25	NC	NC
97035	Ultrasound	$10.25	NC	NC
PROCEDURES:				
CPT Code	**Description**	**Commercial Fully & Self-Insured**	**Medicare**	**Medicaid**
97110	Therapeutic exercise	$20.00	NC	NC
97140	Manual therapy	$12.00	NC	NC
97530	Therapeutic activity	$20.00	NC	NC
97810	Acupuncture, initial 15 minutes	$25.13	$25.13*	$25.50
97811	Acupuncture, additional 15 minutes	$18.98	$18.98*	$18.93
97813	Acupuncture with electrical stimulation, initial 15 minutes	$26.85	$26.85*	$27.27
97814	Acupuncture with electrical stimulation, additional 15 minutes	$21.48	$21.48*	$21.46

* Valid only for members of Medicare Freedom plans that include an acupuncture benefit.
Please check each member's eligibility for coverage information.

RADIOLOGY:				
CPT Code	Description	Commercial Fully & Self-Insured	Medicare	Medicaid
71010	Chest; Single View, Frontal	$22.00	NC	NC
71015	Chest; Stereo, Frontal	$29.00	NC	NC
71020	Chest, Two Views, Frontal And Lateral;	$29.00	NC	NC
71021	Chest, Two Views, Frontal And Lateral; With Apical Lordotic	$36.00	NC	NC
71022	Chest, Two Views, Frontal And Lateral; With Oblique	$41.00	NC	NC
71030	Chest, Complete, Minimum Of Four Views;	$40.00	NC	NC
71035	Chest, Special Views (Eg, Lateral Decubitus, Bucky Studies)	$34.00	NC	NC
71100	Ribs, Unilateral; Two Views	$29.00	NC	NC
71101	Ribs, Unilateral;Including Posteroanterior Chest,Minimum 3Views	$36.00	NC	NC
71110	Ribs, Bilateral; Three Views	$37.00	NC	NC
71111	Ribs, Bilateral;Including Posteroanterior Chest,Minimum 4 Views	$50.00	NC	NC
71120	Sternum, Minimum Of Two Views	$28.00	NC	NC
71130	Sternoclavicular Joint Or Joints, Minimum Of Three Views	$35.00	NC	NC
72020	Spine, single view	$22.50	$22.50	$15.40
72040	Spine, cervical, a/p and lateral (includes APOM)	$32.00	$32.00	$23.48
72050	Spine, cervical, comprehensive, a/p and lateral, four views	$46.75	$46.75	$31.56
72052	Spine, cervical, complete, a/p and lateral, seven views	$57.75	$57.75	$39.89
72070	Spine, thoracic, a/p and lateral	$33.50	$33.50	$23.98
72072	Spine, thoracic, a/p and lateral plus swimmer's view	$36.75	$36.75	$24.49
72074	Spine, thoracic, complete with obliques, four views	$43.00	$43.00	$27.77
72080	Spine, thoracic, thoracolumbar, a/p and lateral	$34.25	$34.25	$21.46
72081	Spine (e.g. scoliosis), one view	$35.00	$35.00	$27.27
72082	Spine (e.g. scoliosis), two or three views	$36.25	$36.25	$44.18
72083	Spine (e.g. scoliosis), four or five views	$37.75	$37.75	$47.97
72100	Spine, lumbosacral, a/p and lateral	$34.25	$34.25	$24.74
72110	Spine lumbosacral, complete, oblique view	$47.50	$47.50	$34.59
72114	Spine, lumbosacral, complete, bending view	$59.50	$59.50	$44.18
72120	Spine, lumbosacral, bending only, four views	$42.25	$42.25	$28.53
72170	Pelvis; One Or Two Views	$25.00	$25.00	$22.47
72190	Pelvis; Complete, Minimum Of Three Views	$35.00	$35.00	$27.01
72200	Sacroiliac limited	$27.00	$27.00	$19.94
72202	Sacroiliac joints, three views	$31.25	$31.25	$23.23
72220	Sacrum and coccyx	$28.75	$28.75	$19.69
73000	Clavicle, Complete	$25.00	NC	NC
73010	Scapula, Complete	$25.00	NC	NC
73020	Shoulder, one view	$24.25	NC	NC
73030	Shoulder, complete, two views	$29.00	NC	NC
73050	Acromioclavicular joints, bilateral	$33.25	NC	NC
73060	Humerus, two views	$28.75	NC	NC
73070	Elbow, a/p and lateral	$26.00	NC	NC
73080	Elbow, complete, three views	$28.75	NC	NC

RADIOLOGY (CONT):				
CPT Code	Description	Commercial Fully & Self-Insured	Medicare	Medicaid
73090	Forearm, a/p and lateral	$26.25	NC	NC
73092	Upper Extremity, Infant, Minimum Of Two Views	$27.00	NC	NC
73100	Wrist, a/p and lateral	$25.25	NC	NC
73110	Wrist, complete, three views	$27.50	NC	NC
73120	Hand, two views	$25.25	NC	NC
73130	Hand, complete, three views	$27.50	NC	NC
73140	Fingers, two views	$21.50	NC	NC
73501	Hip, unilateral with pelvis, one view	$25.25	NC	NC
73502	Hip, unilateral with pelvis, two to three views	$30.50	NC	NC
73503	Hip, unilateral with pelvis, minimum of four views	$34.00	NC	NC
73521	Hip, bilateral with pelvis, two views	$30.25	NC	NC
73522	Hip, bilateral with pelvis, three to four views	$31.00	NC	NC
73523	Hip, bilateral with pelvis, minimum of five views	$32.00	NC	NC
73551	Femur, one view	$25.25	NC	NC
73552	Femur, two views	$28.75	NC	NC
73560	Knee, two views	$26.75	NC	NC
73562	Knee, three views	$29.50	NC	NC
73564	Knee, complete, including obliques	$33.00	NC	NC
73565	Knee, both, standing, anteroposterior	$25.75	NC	NC
73590	Tibia and Fibula, A/P and lateral	$26.75	NC	NC
73592	Tibia and Fibula, lower extremity, infant	$25.25	NC	NC
73600	Ankle, a/p and lateral	$25.25	NC	NC
73610	Ankle, complete, three views	$27.50	NC	NC
73620	Foot, a/p and lateral	$25.25	NC	NC
73630	Foot, complete, three views	$27.50	NC	NC
73650	Calcaneus, two views	$24.50	NC	NC
73660	Toes, two views	$21.50	NC	NC
76140	X-ray Consult	$25.00	NC	$25.00
ORTHOTIC PROCEDURES AND DURABLE MEDICAL EQUIPMENT (DME)				
CPT Code	Description	Commercial Fully & Self-Insured	Medicare	Medicaid
E0860	Home Traction Unit-Overdoor, Cervical	$30.00	N/A	N/A
E0890	Home Traction Unit-Att to Footboard, Pelvic	$59.25	N/A	N/A
E1805	Dynamic Adjustable Wrist Extension/Flex Device	$26.00	N/A	N/A
L0120	Cervical Collar--Flexible, Non-adjustable (Foam)	$14.00	N/A	N/A
L0628	Lumbar Flex Support	$30.00	N/A	N/A
L1810	Knee Orthosis--Elastic With Joints (Prefab)	$65.00	N/A	N/A
L1902	Ankle Foot Orthosis (Prefab)	$45.00	N/A	N/A
L1906	Ankle Foot Orthosis--Multiligamentus Ankle Support (Prefab)	$22.00	N/A	N/A
L3650	Shoulder Orthosis--Figure 8, Abduction Restrain (Prefab)	$47.40	N/A	N/A
L3660	Shoulder Orthosis--Figure 8, Abduction Restrain (Canvas Prefab)	$46.00	N/A	N/A
L3908	Wrist Hand Orthosis--Cock Up, Non-Molded (Prefab)	$16.00	N/A	N/A

This fee schedule is not a guarantee of coverage, final coverage will be determined by each member's benefit contract. This published schedule is not intended to fully detail all covered codes; additional services may be payable if covered under the member's benefit plan.

CIGNA

with administration by HealthPartners

Fee Schedule-Effective 1/1/2017

NEW PATIENT EXAMS:		
CPT Code	**Description**	**Fee**
99201	Problem focused history and examination --straightforward	$30.00
99202	Expanded history and examination – straightforward	$45.00
99203	Detailed history and examination – low complexity	$60.00
99204	Comprehensive history and examination – moderate complexity	$65.00
ESTABLISHED PATIENT EXAMS:		
CPT Code	**Description**	**Fee**
99211	Problem focused history and examination -- brief	$19.00
99212	Problem focused history and examination - straightforward	$30.00
99213	Expanded history and examination – low complexity	$45.00
99214	Detailed history and examination – moderate complexity	$50.00
CHIROPRACTIC MANIPULATIVE TREATMENT:		
CPT Code	**Description**	**Fee**
98940	Chiropractic manipulative treatment; spinal, one to two regions	$29.75
98941	Spinal, three to four regions	$34.00
98942	Spinal, five regions	$37.50
98943	Extraspinal – one or more regions	$21.50
MODALITIES:		
CPT Code	**Description**	**Fee**
97012	Traction, mechanical	$12.00
97014	Electrical stimulation-unattended	$10.25
97024	Diathermy	$8.50
97026	Infrared	$8.50
97032	Electrical stimulation-manual	$10.25
97035	Ultrasound	$10.25
PROCEDURES:		
CPT Code	**Description**	**Fee**
97110	Therapeutic exercise	$20.00
97140	Manual therapy	$12.00
97530	Therapeutic activity	$20.00
97810*****	Acupuncture, initial 15 minutes	$25.13
97811*****	Acupuncture, additional 15 minutes	$18.98
97813*****	Acupuncture with electrical stimulation	$26.85
97814*****	Acupuncture with electrical stimulation, additional 15 minutes	$21.48

* Acupuncture benefit may not be available for certain groups/members.

RADIOLOGY:		
CPT Code	**Description**	**Fee**
71010	Chest; Single View, Frontal	$22.00
71015	Chest; Stereo, Frontal	$29.00
71020	Chest, Two Views, Frontal And Lateral;	$29.00
71021	Chest, Two Views, Frontal And Lateral; With Apical Lordotic	$36.00
71022	Chest, Two Views, Frontal And Lateral; With Oblique	$41.00
71030	Chest, Complete, Minimum Of Four Views;	$40.00
71035	Chest, Special Views (Eg, Lateral Decubitus, Bucky Studies)	$34.00
71100	Ribs, Unilateral; Two Views	$29.00
71101	Ribs, Unilateral;Including Posteroanterior Chest,Minimum 3Views	$36.00
71110	Ribs, Bilateral; Three Views	$37.00
71111	Ribs, Bilateral;Including Posteroanterior Chest,Minimum 4 Views	$50.00
71120	Sternum, Minimum Of Two Views	$28.00
71130	Sternoclavicular Joint Or Joints, Minimum Of Three Views	$35.00
72020	Spine, single view	$22.50
72040	Spine, cervical, a/p and lateral (includes APOM)	$32.00
72050	Spine, cervical, comprehensive, a/p and lateral, four views	$46.75
72052	Spine, cervical, complete, a/p and lateral, seven views	$57.75
72070	Spine, thoracic, a/p and lateral	$33.50
72072	Spine, thoracic, a/p and lateral plus swimmer's view	$36.75
72074	Spine, thoracic, complete with obliques, four views	$43.00
72080	Spine, thoracic, thoracolumbar, a/p and lateral	$34.25
72081	Spine (e.g. scoliosis), one view	$35.00
72082	Spine (e.g. scoliosis), two or three views	$36.25
72083	Spine (e.g. scoliosis), four or five views	$37.75
72100	Spine, lumbosacral, a/p and lateral	$34.25
72110	Spine Lumbosacral, complete, oblique view	$47.50
72114	Spine, lumbosacral, complete, bending view	$59.50
72120	Spine, lumbosacral, bending only, four views	$42.25
72170	Pelvis; One Or Two Views	$25.00
72190	Pelvis; Complete, Minimum Of Three Views	$35.00
72200	Sacroiliac limited	$27.00
72202	Sacroiliac joints, three views	$31.25
72220	Sacrum and coccyx	$28.75
73000	Clavicle, Complete	$25.00
73010	Scapula, Complete	$25.00
73020	Shoulder, one view	$24.25
73030	Shoulder, complete, two views	$29.00
73050	Acromioclavicular joints, bilateral	$33.25
73060	Humerus, two views	$28.75
73070	Elbow, a/p and lateral	$26.00
73080	Elbow, complete, three views	$28.75
73090	Forearm, a/p and lateral	$26.25
73092	Upper Extremity, Infant, Minimum Of Two Views	$27.00
73100	Wrist, a/p and lateral	$25.25
73110	Wrist, complete, three views	$27.50
73120	Hand, two views	$25.25
73130	Hand, complete, three views	$27.50
73140	Fingers, two views	$21.50

RADIOLOGY (CONT):		
CPT Code	**Description**	**Fee**
73501	Hip, unilateral with pelvis, one view	$25.25
73502	Hip, unilateral with pelvis, two to three views	$30.50
73503	Hip, unilateral with pelvis, minimum of four views	$34.00
73521	Hip, bilateral with pelvis, two views	$30.25
73522	Hip, bilateral with pelvis, three to four views	$31.00
73523	Hip, bilateral with pelvis, minimum of five views	$32.00
73551	Femur, one view	$25.25
73552	Femur, two views	$28.75
73560	Knee, two views	$26.75
73562	Knee, three views	$29.50
73564	Knee, complete, including obliques	$33.00
73565	Knee, both, standing, anteroposterior	$25.75
73590	Tibia and Fibula, A/P and lateral	$26.75
73592	Tibia and Fibula, lower extremity, infant	$25.25
73600	Ankle, a/p and lateral	$25.25
73610	Ankle, complete, three views	$27.50
73620	Foot, a/p and lateral	$25.25
73630	Foot, complete, three views	$27.50
73650	Calcaneus, two views	$24.50
73660	Toes, two views	$21.50
76140	X-ray Consult	$25.00
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L3908	Wrist Hand Orthosis--Cock Up, Non-Molded (Prefab)	$16.00

This fee schedule is not a guarantee of coverage, final coverage will be determined by each member's benefit contract. This published schedule is not intended to fully detail all covered codes; additional services may be payable if covered under the member's benefit plan.

ADDENDUM TO AGREEMENT BETWEEN CHIROPRACTIC CARE OF MINNESOTA, INC. AND PROVIDER

This HealthPartners Workers Compensation Addendum (the "Addendum"), is an addendum to the Participating Provider Agreement (the "Agreement") between the the Contracted Provider ("Provider") and Chiropractic Care of Minnesota, Inc., a Minnesota non-profit corporation ("CCMI").

WHEREAS, CCMI desires to addend the Agreement for the purposes of arranging for the delivery of Covered Services to certain HealthPartners Worksite Health Members, and CCMI and Provider desire that Provider provide such Covered Services to such HealthPartners Worksite Health Members.

WHEREAS, CCMI and Provider mutually desire to amend certain terms of the Agreement pursuant to the terms set forth in this Addendum.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants, promises and undertakings hereinafter set forth, the parties hereto agree as follows:

HEALTHPARTNERS REQUIREMENTS

In addition to Provider's obligations under the Agreement, Provider agrees to abide by the following provisions:

ARTICLE I
DEFINITIONS

The following definitions shall apply to the capitalized terms in this Addendum and all amendments, exhibits and schedules hereto; provided, however, that in the event a definition below is inconsistent with the corresponding definition set forth in Minnesota Workers' Compensation Law, the latter shall control, but only to the extent necessary to resolve the inconsistency.

Section 1.1 Commissioner means Minnesota's Commissioner of Labor and Industry.

Section 1.2 Compensable Injury means a disease or injury sustained by an Employee which is eligible for compensation under Minnesota Workers' Compensation Law. An Employee's disease or injury is deemed to be a Compensable Injury when Provider receives an acknowledgment from the Employee's Insurer that the Workers' Compensation Claim in question is a work-related illness or injury as defined in Minnesota Workers' Compensation Law and that Insurer is financially liable for such claim.

Section 1.3 Covered Services means medical, surgical, chiropractic, dental or other health services medically necessary to treat a Compensable Injury.

Section 1.4 Employee means any employee who is entitled to treatment of an injury or disease under Minnesota Workers' Compensation Law and whose Employer has arranged for him or her to obtain Covered Services through a Workers' Compensation Product.

Section 1.5 Employer means an employer who has arranged for its eligible employees to obtain Covered Services through a Workers' Compensation Product.

Section 1.6 Health Care Provider means a physician, podiatrist, chiropractor, dentist, optometrist, osteopath, psychologist, psychiatric social worker, or any other person who furnishes a medical or health services to an Employee under Minnesota Workers' Compensation Law (but does not include a qualified rehabilitation consultant or approved vendor).

Section 1.7 Injured Worker means an Employee with a Compensable Injury.

Section 1.8 Insurer means a workers' compensation insurer, third-party administrator or self-funded employer which is responsible for administration and/or payment of workers' compensation benefits to Injured Workers under Minnesota Workers' Compensation Law and which has contracted with HealthPartners to provide managed care services and access to a network of providers to furnish Covered Services to Employees.

Section 1.9 Managed Care Plan means a health plan developed by HealthPartners and certified by the Commissioner to provide for the delivery and management of treatment to Injured Workers under Minnesota Workers' Compensation Law.

Section 1.10 Minnesota Workers' Compensation Law means Minnesota Statutes Chapter 176, as now in force or as may hereafter be amended supplemented or substituted, and all rules and regulations promulgated thereunder.

Section 1.11 Plan Summary means the documents issued by CCMI which describe: fee schedules, administrative procedures and other information regarding a Benefit Contract, any of which CCMI may change at any time and from time to time at its sole and absolute discretion; and benefits descriptions and Member eligibility requirements, which may be changed by the health plan company at any time and from time to time in its sole and absolute discretion.

Section 1.12 Participating Health Care Provider means a Health Care Provider which is a participating provider with CCMI and who has also agreed to provide Covered Services to Injured Workers under this Addendum. For purposes of this Addendum, employees or contractors of Participating Health Care Providers who meet CCMI's and HealthPartners' credentialing criteria and quality assurance standards are considered to be Participating Health Care Providers.

Section 1.13 Practice Guidelines means guidelines or uniform treatment standards establishing medical or dental protocols or parameters for use in treating Injured Workers, which are established and issued by HealthPartners, Provider in conjunction with HealthPartners, CCMI and/or the Commissioner pursuant to Minnesota Workers' Compensation Law.

Section 1.14 Primary Treating Health Care Provider means a physician, chiropractor, osteopath, podiatrist or dentist directing and coordinating the course of treatment for an Injured Worker, as more fully described herein and in Minnesota Workers' Compensation Law.

Section 1.15 Provider Manual means the manual and other materials compiled by the Managed Care Plan for Participating Health Care Providers regarding the administration of the Managed Care Plan and the provision of care to employees, as updated from time to time. The Provider Manual is hereby incorporated into this Addendum.

Section 1.16 Related Organization means:

(a) any entity now or hereafter formed: (i) which is controlled by HealthPartners; (ii) which controls HealthPartners; (iii) which is controlled by another entity that also controls HealthPartners; (iv) a majority of the Board of Directors of which consists of persons who are simultaneously directors of HealthPartners; (v) the directors of which constitute a majority of the directors of HealthPartners; or (vi) which is controlled by any entity described above; or

(b) any association, joint venture or contractual arrangement entered into by any entity described above, if such entity has a controlling, equity, or voting interest in the association, joint venture or contractual arrangement.

Hereinafter, the term "HealthPartners" shall include any or all Related Organizations.

Section 1.17 Workers' Compensation Claim means a claim by an Employee for compensation under Minnesota Workers' Compensation Law.

Section 1.18 Workers' Compensation Product means a managed care plan offered by HealthPartners which offers Covered Services to Employees in accordance with Minnesota Workers' Compensation Law.

ARTICLE II
HEALTH CARE SERVICES

Section 2.1 Provision of Services. Provider shall provide to Employees Covered Services as defined in this document in a high quality, cost effective manner designed to restore Employees to their fullest function and facilitate return to work as soon as medically appropriate, pursuant to Minnesota Workers' Compensation Law. In

connection with the provision of Covered Services to an Employee, Provider shall comply with the administrative and care requirements in the Provider Manual.

Section 2.2 Discrimination. Provider shall not discriminate in the provision of Covered Services under this Addendum on the basis of race, color, sex, religion, national origin, affectional orientation, the execution or failure to execute an advance directive, or on any other basis forbidden by law.

Section 2.3 Staff. Provider shall not make any changes in its present professional staff, administrative staff or organization which would render Provider incapable of providing Covered Services.

Section 2.4 Facilities and Equipment. Provider shall maintain its facilities and equipment in excellent working condition, in accordance with CCMI standards, as well as any applicable governmental standards. Provider shall not make any changes in its locations, facilities or equipment which would render Provider incapable of providing Covered Services.

Section 2.5 Management Responsibilities. The operation and maintenance of the offices, facilities and equipment of Provider, and the provision of all Covered Services, shall be solely and exclusively under the control and supervision of Provider. HealthPartners and CCMI shall have no right of control over the selection of support staff, supervision of personnel, or financial operation of Provider's practice. Nothing contained in this Addendum shall be construed as giving HealthPartners or CCMI any right to manage or conduct the practice of Provider as manager, proprietor, lessor or otherwise.

Section 2.6 Advertising and Promotion. Provider agrees to allow CCMI to list Provider's name, address and telephone number, as well as a description of its facilities and services, in HealthPartners' Participating Health Care Providers provider list and in other HealthPartners' brochures, publications and promotional materials.

ARTICLE III
CARE MANAGEMENT AND QUALITY COOPERATION

Section 3.1 Purposes Explained; Acknowledgment of Common Goals. The purpose of the parties' obligations described in this Addendum is to comply with and promote the goals of the Managed Care Plan and Minnesota Workers' Compensation Law. The parties hereby acknowledge that among their reasons for entering into this Addendum are the common goals of managing care in a manner that is timely, effective and convenient for Injured Workers, promoting communication among Employees, Employers, Insurers, Providers and the Managed Care Plan, facilitating early return to work and maximizing recovery. The parties hereby agree to pursue these goals in good faith in connection with their performance hereunder, and, in so doing, to comply with the terms of this Addendum and the Provider Manual.

Section 3.2 Practice Guidelines. Practice Guidelines developed by HealthPartners shall be consistent with uniform treatment standards developed by the Commissioner; provided, however, that Practice Guidelines developed by HealthPartners may, in furtherance of the purposes stated in Section 3.1 hereof, exceed standards developed by the Commissioner. Provider shall treat Employees in a manner consistent with applicable Practice Guidelines, except where such treatment is not in the best medical interest of a particular Employee. If Provider furnishes services in excess of the Practice Guidelines, Provider's reimbursement for such services may be reduced or eliminated by the Insurer. A HealthPartners Medical Director shall be available to consult with Provider and assist in Provider's development and implementation of Practice Guidelines.

Section 3.3 Case Management. A HealthPartners Medical Director and/or case managers shall be available as a resource for Provider in connection with Employee treatment and shall work with Provider to facilitate return to work place as soon as medically appropriate. Employee treatment oversight shall include, but need not be limited to, establishing Employee and Insurer expectations and implementing goals regarding return to work, light duty work schedules, early intervention of vocational rehabilitation and other treatment alternatives. As outlined in the Plan Summary, Provider shall cooperate with and participate in any case management services or plans provided or arranged by HealthPartners in connection with the treatment of an Injured Worker.

Section 3.4 Quality Management. Provider shall cooperate with HealthPartners in the implementation of quality assurance, quality improvement, risk management and utilization review programs, policies and procedures established from time to time by HealthPartners pursuant to its obligations as a Managed Care Plan. Such programs, policies and procedures shall include, but need not be limited to, precertification programs, referral policies, Practice Guidelines, peer review programs, benefit review procedures, concurrent review programs and case management. Provider shall furnish HealthPartners with sections of medical records or practice information as may be reasonably required by HealthPartners to implement said programs, policies and procedures, as more fully described in Article IV.

Section 3.5 Credentialing. Provider shall participate in and cooperate with credentialing plans established by CCMI. At any time during the term of this Addendum Provider's Participating Health Care Provider status or the Participating Health Care Provider status of any Health Care Provider employed by or affiliated with Provider may be terminated by CCMI if Provider or such Health Care Provider does not meet CCMI's credentialing standards.

Section 3.6 Licensure. Provider shall, and shall cause each of its Participating Health Care Providers to, maintain, without restriction all federal, state and local licenses, permits and certifications required for it or them to provide health services to Employees. Provider shall notify CCMI within five (5) business days of any suspension or termination of, or any qualification, limitation or restriction placed upon, Provider's or its Participating Health Care Providers' licenses, permits, certifications.

Section 3.7 Training. Provider shall participate in training as reasonably required by CCMI and HealthPartners.

ARTICLE IV
RECORDKEEPING, REPORTS AND CONFIDENTIALITY

Section 4.1 Reports. Provider shall furnish to HealthPartners, at no additional charge, all reports prescribed by the Commissioner or by the Managed Care Plan containing information about chiropractic services and supplies provided to Employees under the Workers' Compensation Product. If HealthPartners is requested by the Commissioner to provide data which are in Provider's control, Provider shall cooperate with HealthPartners in making such data available to the Commissioner.

Section 4.2 Specific Reports. Among the reports Provider is required to furnish under Section 4.1, above, are:

(a) Report of Work Ability. Within twenty four (24) hours of each encounter with an Employee, Provider shall transmit to HealthPartners and to the Employer a Report of Work Ability in substantially the form attached hereto as Attachment A, in accordance with the instructions contained on such form. HealthPartners may alter the form and transmittal instructions from time to time by furnishing Provider with a new or amended form.

Section 4.3 Availability of Records. Upon request by HealthPartners or the Commissioner, and in accordance with Minnesota Workers' Compensation Law, Provider shall make available to HealthPartners and/or the Commissioner, as the case may be, during regular business hours, all records related to services it provides to Employees under the Workers' Compensation Product. Provider shall maintain all such records for a period of five (5) years following the termination of this Addendum.

Section 4.4 Release of Medical Data. Medical data directly relating to a Workers' Compensation Claim shall be released by Provider only under the following conditions:

(a) Party to Claim. Provider shall release medical data relating to a Workers' Compensation Claim to an Employee, his or her Employer or his or her Insurer if they are party to the Workers' Compensation Claim itself; provided, however, that such disclosure shall be preceded by Employee's written consent if the information requested is protected under federal or state laws relating to the privacy of medical information.

(b) HealthPartners. To the extent permitted under applicable law, Provider shall release medical data relating to a Workers' Compensation Claim to HealthPartners upon request by HealthPartners pursuant to case management, quality assurance, quality improvement, risk management and utilization

review programs, policies and procedures established from time to time by HealthPartners.

(c) Government Requests. Provider shall release medical data relating to a Workers' Compensation Claim to state and federal agencies requesting such data in accordance with applicable law or pursuant to a duly issued court order.

(d) Other Requests. Provider shall not release any medical data or other information relating to a Workers' Compensation Claim under any other circumstances, except in accordance with applicable law.

Section 4.5 Other Information. At all times during the term of this Addendum and thereafter, Provider shall keep all information relating to the terms of this Addendum and the operations of CCMI and HealthPartners confidential, and shall not disclose such information without the prior written consent of HealthPartners and/or CCMI as appropriate, except pursuant to a duly issued court order.

Section 4.6 Costs Associated with Reporting and Recordkeeping. All reports, records and other data that Provider has been requested or required to furnish to the Managed Care Plan, Insurer, Employer, Employee, the Commissioner or any other party duly requesting such information under this Addendum shall be furnished in accordance with Minnesota Workers' Compensation Law.

ARTICLE V
REIMBURSEMENT FOR SERVICES

Section 5.1 Billing; Reimbursement for Covered Services.

(a) Billable Party. Provider shall bill the appropriate Insurer directly for Covered Services provided to an Employee. As outlined on the Plan Summary, Provider may bill Insurers only for Covered Services, and must submit bills to Insurers in the form and format prescribed in Minnesota Workers' Compensation law.

(b) Non-Recourse. Provider shall not bill, charge, collect a deposit from, or otherwise seek remuneration from or recourse against any Employee or person acting on the Employee's behalf for services provided under the Workers' Compensation Product. This provision applies to: (a) nonpayment by an Insurer; (b) breach of this Addendum; or (c) services provided that are not Covered Services. This provision does not apply to services provided after termination of this Addendum or to collection of fees by Provider for services that are not related to a Compensable Injury.

Section 5.2 Payment Fee Schedule. Except as otherwise provided in Section 5.3, below, Provider shall accept as full payment for providing Covered Services to

Employees, the fees established under Minnesota Statutes Section 176.136, Subdivisions 1.a and l.b, Minnesota Rules 5221, and any amendments thereto. As referenced on the Plan Summary, the current fee schedule shall be automatically updated in accordance with the Commissioner's annual publication of fees.

Section 5.3 Other Payments. When payment for services may be made in amounts other than those specified under Minnesota Statute 176.136, Subdivisions l.a and l.b., Minnesota Rules 5221, and any amendments thereto, Provider shall accept as payment in full for Covered Services from Insurers the permissible percentage, pursuant to Minnesota Workers' Compensation Law, of the lower of: (i) Provider's usual and customary charge; or (ii) the prevailing charge for similar treatment.

Section 5.4 Non-Covered Services. Provider shall not be reimbursed for any service that: (a) does not constitute a Covered Service as defined in this Addendum; (b) is deemed by HealthPartners or Insurer to be not medically necessary; (c) does not conform to Practice Guidelines; or (d) is deemed by the Commissioner to be excessive, inappropriate or not medically necessary. Except as otherwise provided in Section 5.6, below, Provider shall not attempt to collect payment for a non-Covered Service from any other source, including the Employee. However, if the claimed injury or illness is deemed to be Non-Covered because the claimed injury or illness is determined to be non-compensable under Workers' Compensation, then Provider may seek reimbursement from another payor if the Employee has health care or other applicable coverage from such payor, or from HealthPartners if the Employee has health care coverage underwritten or administered by HealthPartners, pursuant to the terms of such coverage.

Section 5.5 Insurer Liability. Each Insurer is solely responsible for payment of Covered Services provided to an Employee. HealthPartners and/or CCMI shall not be liable for payment under a Workers' Compensation Product.

Section 5.6 Coordination of Benefits; Subrogation. If an Employee receives services from Provider for an injury or disease that Insurer determines is not a Compensable Injury, Provider shall coordinate reimbursement for such services with Employee's (non-workers' compensation) health plan(s), other workers' compensation carriers or other payors (e.g., automobile insurance). Likewise, Provider shall in good faith cooperate with Insurer in connection with Insurer's subrogation activities.

ARTICLE VI
INSURANCE, INDEMNIFICATION AND DISPUTES

Section 6.1 Insurance. Provider shall maintain or cause to be maintained general and professional liability policies as may be necessary to protect Provider and its employees and agents against any and all claims for damages arising out of their action or inaction in connection with their performance under this Addendum; provided, however, that at a minimum Provider shall carry limits of no less than the following for each Participating

Health Care Provider employed by or associated with Provider at any time during the term of this Addendum:

	Per Occurrence	Annual Aggregate
Chiropractic Providers	$1,000,000	$3,000,000

Provider shall furnish CCMI with evidence of such insurance coverage upon request by HealthPartners and shall notify CCMI within ten (10) days of any change in carrier or coverage levels, any denial, limitation or termination of coverage or any claim against Provider's or any of its Participating Health Care Provider's policy or policies.

Section 6.2 Indemnification.

(a) Indemnification by Provider. Provider shall indemnify, defend and hold CCMI and HealthPartners harmless against any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by CCMI and HealthPartners that arise out of the acts or omissions (including, without limitation, malpractice, negligence or breach of this Addendum) of Provider or any of its Participating Health Care Providers, employees, agents or representatives in connection with its or their performance under this Addendum.

(b) Indemnification by CCMI and HealthPartners. CCMI and HealthPartners shall indemnify, defend and hold Provider and its Participating Health Care Providers harmless against any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by Provider or its Participating Health Care Providers that arise out of the acts or omissions (including, without limitation, negligence or breach of this Addendum) of HealthPartners or any of its employees, agents or representatives in connection with its or their performance under this Addendum.

Section 6.3 Disputes.

(a) Treatment /Coverage Disputes. Pursuant to Minnesota Workers' Compensation Law, HealthPartners has established a process for resolving disputes regarding the provision or non-provision of Covered Services to Employees and other disputes involving Employees or Providers relating to the treatment of Employees under Minnesota Workers' Compensation Law. Provider and its Participating Health Care Providers shall participate in and cooperate with this process.

(b) Contractual Disputes. Disputes between Provider or any of its Participating Health Care Providers and HealthPartners concerning this Addendum shall be handled as follows:

(i) Date of the Dispute. The date of a dispute shall be the date upon which written notice is given by a party to the other party stating the precise nature of the dispute.

(ii) Informal Resolution of Disputes. All disputes shall first be subject to resolution through informal methods. Within ten (10) business days after the date of the dispute, a representative from Provider or Participating Health Care Provider and a representative appointed by HealthPartners shall meet or shall otherwise establish contact and shall make a good faith effort to resolve the dispute.

(iii) Formal Resolution of Disputes. In the event the parties are unable to resolve the dispute within thirty (30) calendar days from the date of the dispute, or such other longer time period mutually agreed to by the parties, then the parties shall be entitled to pursue any remedies for such dispute available in law or equity and may, if the dispute relates to a default under or breach of a material term of this Addendum, terminate the Addendum as allowed pursuant to Section 7.2 (c) without providing any further opportunity to cure as set forth in Section 7.2 (c); provided, however, that disputes or complaints regarding the interpretation, implementation, alleged breach or enforcement of HealthPartners' credentialing plans shall be addressed and resolved in accordance with such plans.

ARTICLE VII
TERM AND TERMINATION

Section 7.1 Term; Renewal. This Addendum shall be effective as of the Agreement effective date between Provider and CCMI and shall continue for an initial term ending on the last day of the then current calendar year. Thereafter, this Addendum shall automatically renew for successive terms of one (1) calendar year, unless terminated pursuant to Section 7.2 of this Addendum.

Section 7.2 Termination. This Addendum may be terminated as follows:

(a) CCMI may terminate this Addendum without cause as of the end of any calendar month, upon at least one hundred twenty (120) days written notice to Doctor.

(b) Doctor may terminate this Addendum as of the end of any calendar month, upon at least one hundred twenty (120) days written notice to CCMI.

(c) By the non-defaulting or non-breaching party upon thirty (30) days' prior written notice to the defaulting or breaching party, where such notice includes a detailed description of the asserted default or breach, unless the default or

breach is cured by the defaulting or breaching party prior to the end of the thirty (30) day notice period;

(d) By CCMI upon revocation or suspension of Provider's or any of it's Health Care Providers' respective licenses or certification, or upon termination of Provider's Participating Health Care Provider status pursuant to CCMI's credentialing criteria, immediately upon Provider's receipt of CCMI's written notice of termination; or

(e) Upon the termination of the Agreement between CCMI and Provider.

Section 7.3 Effect of Termination.

(a) In General. Except as otherwise provided in Section 7.3(b), below, termination of this Addendum shall have no effect upon the rights and obligations of the parties arising in connection with services provided to Employees prior to the effective date of termination.

(b) Employee Access. Following termination of this Addendum, or in the event an Employer's contract with CCMI terminates during the term of this Addendum, Provider shall continue to provide Covered Services under the terms hereof to Employees for Compensable Injuries treated by Provider prior to the effective date of termination, until the Employee requests a change of provider. If said Employee requests a change of provider for continued treatment of a Compensable Injury, Provider shall cooperate with HealthPartners while HealthPartners makes alternate arrangements on behalf of said Employee for continued treatment of the Compensable Injury, pursuant to Minnesota Workers' Compensation Laws.

ARTICLE VIII
MISCELLANEOUS

Section 8.1 Compliance with Law. Each party shall, at all times during the term of this Addendum, be in material compliance with all applicable laws, including, without limitation, Minnesota Workers' Compensation Law. To the extent there is any conflict or inconsistency between the Agreement, this Addendum or the Provider Manual and the Minnesota Workers' Compensation Law, the Minnesota Workers' Compensation Law shall control.

Section 8.2 Relationship of Parties. The parties hereto are independent contractors, and nothing contained herein shall be construed or implied to create a partnership, joint venture or employment relationship between the parties or between a party and any of the other party's employees, agents or representatives.

Section 8.3 Notices. Notices and other communications required or permitted under this Addendum shall be deemed sufficiently given if transmitted in writing via personal

delivery, certified United States mail or facsimile to the following addresses (or to such other addresses as a party shall have duly notified the others), and shall be deemed given upon confirmed receipt.

If to HealthPartners: HealthPartners, Inc.
8100 34th Avenue South
P.O. Box 1309
Minneapolis, Minnesota 55440-1309
Attention: Director, Contracted Services

If to Provider, at the address set forth for Provider in the Agreement.

If to CCMI, at the address set forth for CCMI in the Agreement.

Section 8.4 Entire Agreement. This Addendum constitutes the entire agreement among the parties with respect to the subject matter herein. This Addendum supersedes and replaces any and all prior agreements and understandings among the parties with respect to such subject matter, whether oral or written.

Section 8.5 Amendments; Passive Amendment; Regulatory Amendment. This Addendum may not be modified or amended except in a writing signed by all parties; provided, however, that this Addendum may be unilaterally amended by CCMI by giving thirty (30) calendar days' written notice to Provider unless Provider makes a written objection to the proposed amendment within fifteen (15) calendar days of receiving notice from CCMI. This Addendum shall be deemed to be amended to the extent necessary to comply with changes in state or federal law or upon demand by a state or federal agency, such amendments to be effective as of the date so required.

Section 8.7 Assignment; Binding Effect. Except as specifically provided herein, neither this Addendum nor the rights and obligations hereunder may be assigned, in whole or in part, by operation of law or otherwise, without the prior written consent of the other parties; provided, however, that HealthPartners may assign this Addendum to any of its Related Organizations without Provider's consent. This Addendum shall be binding upon and inure to the benefit of the parties, their legal representatives and permitted successors and assigns.

Section 8.8 Severability. If any provision of this Addendum is determined to be invalid under any court or governmental agency of competent jurisdiction or under any statute, the remaining provisions of this Addendum shall not thereby be invalidated and shall remain in full force and effect to the extent possible to carry out the parties' intentions.

Section 8.9 Survival. Sections 4.3, 4.4 and 4.5, Article VII and this Section 8.9 shall survive the termination of this Addendum.

Section 8.10 Captions and Headings. Captions and headings in this Addendum are included for convenience of reference only and are not to be considered a part hereof, and shall not be deemed to modify, restrict or expand any of the terms or provisions of this Addendum.

Section 8.11 Non-Waiver. No failure or delay by any party in exercising any right or remedy under this Addendum shall waive any provision of this Addendum, nor shall any single or partial exercise by any party of any right or remedy hereunder preclude that party from otherwise asserting or further exercising such right or remedy or any other right or remedy contained herein or granted under law.

Section 8.12 Full Force and Effect. All other terms of the Agreement shall remain in full force and effect, except as specifically set forth herein.

Section 8.13 Execution and Counterparts. This Addendum and any amendments hereto may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

HealthPartners Worksite Health
Workers' Compensation Program FAQ

Provider Reimbursement

Q. What are the reimbursement rates for this Workers' Compensation Product?
A. Provider reimbursement is 100 percent of the fee schedule amounts established by the Minnesota Department of Labor and Industry (DOLI).

Fee schedule amounts are determined based on a calculation that was redefined in October of 2010 and includes the application of a conversion factor, Relative Value Unit (RVU) and other metrics as defined by the state.

For details related to the rate calculation, go to Subp. 1b, Section B.d. at **https://www.revisor.mn.gov/rules/?id=5221.4020**. To speak with the Minnesota Department of Labor and Industry, you may call (651) 284-5005 or 1-800-DIAL-DLI (1-800-342-5354).

Q. How often do these rates change and how will I know when that occurs?
A. Rates are adjusted by the state on October 1st of each year. When available, the state will post the updated rate information to the web sites listed above.

Q. Will the reimbursement rate always be 100 percent of the allowed rates?
A. As of now, all services eligible for reimbursement through HealthPartners' Workers' Compensation product will be paid at 100 percent of the allowed rate. In 2010, DOLI published notice of its intent to revise rules that would allow Managed Workers' Compensation Plans to execute provider contracts that pay less than 100 percent, however, final approval of those rule changes has not yet been obtained. If later approved, each payor that contracts with HealthPartners for Workers' Compensation administration would determine the reimbursement levels associated with their insured groups.

Patient Identification

Q. How will I identify patients who are eligible for coverage through the HealthPartners Workers' Compensation product?
A. In most cases, you will be able to identify eligibility through one of two methods:
- Your office will receive a phone call or fax from HealthPartners notifying you of the patient's eligibility.
- The patient may present a "HealthPartners Workers Compensation Managed Care Plan Employee Guide" at the time of care.
- If eligibility is determined after care has begun, a retro review can be conducted (see detail below).

Q. How many employees are eligible for Workers' Compensation benefits through this program?
A. Approximately 60,000 employees are eligible for benefits through HealthPartners Workers' Compensation Program.

Care Authorization

Q. Does care rendered through this Workers' Compensation product require authorization?
A. Yes, the HealthPartners Workers' Compensation Product is a managed program so authorization from HealthPartners is required for care. ChiroCare will **not** coordinate authorizations for the Workers' Compensation program.

HealthPartners Worksite Health
Workers' Compensation Program FAQ

Q. What is the care authorization process?
A. Care authorizations for this program will continue to be coordinated by HealthPartners, not ChiroCare. In many cases, patients will have obtained authorization from HealthPartners prior to their first visit. You will be able to identify these patients when HealthPartners contacts your office via phone or fax. If a patient presents in your office without coordination from HealthPartners, you must call the HealthPartners Worksite Health Case Management Line at (952) 883-5396 or (888) 779-3625 to initiate the authorization process and ensure coverage.

Q. Who conducts the clinical reviews?
A. HealthPartners conducts the reviews and utilizes a team of nurse case managers who specialize in workers' compensation to coordinate care associated with employee injuries.

Q. What documentation must be submitted to obtain authorization?
A. In most cases, providers will be asked to submit a Report of Work Ability form and SOAP notes to support the review.

Q. Where do I submit the required documentation?
A. All documentation required to support a review is to be submitted to HealthPartners:

HealthPartners: Workers Compensation Case Management
P.O. Box 1309
Mail Stop 21106A
Minneapolis, MN 55440
FAX: (888) 303-1079

When submitting any documentation, please be sure the employee is clearly identified on each page.

Q. What guidelines are applied by HealthPartners when processing an authorization request?
A. The Practice Guidelines developed by HealthPartners are consistent with the uniform treatment standards developed by Minnesota's Commissioner of Labor and Industry. Those guidelines are available at **www.dli.mn.gov**.

Q. What if I disagree with the case manager's clinical decision?
A. Through the HealthPartners Worker's Compensation Dispute Resolution Process, a clinical determination will be reviewed by a chiropractic peer. This process can be initiated through a phone call, fax, email or letter to HealthPartners' Case Management team and may be submitted by the provider, employee or other representative.

Q. Does HealthPartners coordinate retro reviews?
A. Yes, HealthPartners understands that in some cases, the provider may not initially be aware that the injury being treated is work-related. In these cases, providers are to contact HealthPartners' Case Management Team at (952) 883-5396 or (888) 779-3625 to initiate a retro review.

HealthPartners Worksite Health
Workers' Compensation Program FAQ

Claims

Q. What is the submission process for Workers' Compensation claims?

A. Claims are to be submitted to the applicable payor which may or may not be HealthPartners. Claims for this program are not to be submitted to ChiroCare. Payor information can be collected one of three ways:

1. from the HealthPartners Case Manager making the initial outreach to the provider.
2. from the Employee Guide, which will often be presented by the patient at the initial visit.
3. by calling HealthPartners Worksite Health's Care Line at (952) 883-5396 or (888) 779-3625.

Participation Overview

Q. As a new applicant to ChiroCare, how do I ensure I am included in the HealthPartners Workers' Compensation network?

A. As of November, 2010, ChiroCare's Participating Provider Agreement was adjusted to include a HealthPartners Workers' Compensation check box on the bottom of the front page. New applicants wishing to participate in the HealthPartners Workers' Compensation network simply check the box to indicate their preference.

Q. If I am already contracted with ChiroCare and have previously treated HealthPartners Workers' Compensation patients, am I automatically enrolled as a par provider for this new product?

A. No, ChiroCare and HealthPartners executed a new agreement for the Workers' Compensation product effective September 1, 2010. Any ChiroCare provider who has not elected to participate in the network for this specific product will not be considered par and/or eligible for Workers' Compensation referrals as of that date.

Q. Why does this product require an addendum to the standard ChiroCare Contract?

A. ChiroCare's standard Participating Provider Agreement is only applicable to medical insurance. Because this program is workers' compensation, a new product, different contractual language is required. Also, by separating the two documents, providers are able to contract with ChiroCare for the standard medical products but not the HealthPartners Workers' Compensation program.

Q. Am I required to participate in this Workers' Compensation network?

A. No, participation in the Workers' Compensation network is optional. As a contracted ChiroCare provider, you are being invited to participate but you are not required to do so.

Q. If I agree to participate in this Worker's Compensation network but later would like to terminate from it, can I do so without terminating my ChiroCare contract for health plan business?

A. Yes, as outlined in section 7.2 of the Addendum to Agreement Between Chiropractic Care of Minnesota, Inc and Provider (Addendum), providers currently contracted with ChiroCare may choose to terminate their participation with this program but continue their ChiroCare contract for health plan business.

HealthPartners Worksite Health
Workers' Compensation Program FAQ

Q. What happens if I do nothing?

A. ChiroCare Providers who want to participate in this Workers' Compensation program must agree to do so by signing and returning the Workers' Compensation Addendum or selecting the box on the front of the updated Participating Provider Agreement.

Providers who do not indicate a desire to participate by returning the signed addendum or selecting the check box will not be considered participating and/or eligible for referrals related to this program.

Q. What are the ramifications if I choose not to participate in this Workers' Compensation network?

A. Choosing to not participate in this Workers' Compensation network will not affect your contracted status with ChiroCare. You will continue to be a par provider for all ChiroCare health plan programs, i.e. UCare, Patient Choice and HealthPartners/CIGNA.

If you are currently treating any HealthPartners Workers' Compensation patients, effective 9/1/10 you will no longer be a par provider for that program and those patients will be directed to obtain care from another chiropractor who does participate in the Workers' Compensation network.

In some cases, non par providers may be able to obtain authorization for services but all eligible patients will first be referred to a Workers' Compensation contracted provider.

Q. If I choose to not participate in this Workers' Compensation network now, may I do so later?

A. Yes, ChiroCare providers who do not participate now may choose to do so at a later time.

Phone Resources

Q. Where do I call with questions related to this Workers' Compensation program?

A. Since ChiroCare is only providing a network for this program (not authorization or claims services), your calls should be directed as follows:

Provider Credentialing Provider program participation	ChiroCare Provider Services at (888) 638-7719
Patient Eligibility Patient Benefits	HealthPartners Case Management line at (952) 883-5396 or (888) 779-3625
Care Authorizations Clinical Reviews	HealthPartners Case Management line at (952) 883-5396 or (888) 779-3625
Claim Submissions	The applicable payor. If the payor is unknown, call HealthPartners Case Management line at (952) 883-5396 or (888) 779-3625 to obtain that information.
Claim Payment Status	The applicable payor. If the payor is unknown, call HealthPartners Case Management line at (952) 883-5396 or (888) 779-3625 to obtain that information.
Allowed Rates	The fee schedule is established by the Minnesota Department of Labor and Industry. They may be reached at (651) 284-5005 or 1-800-DIAL-DLI (1-800-342-5354).