Homelink Therapy Network

A Subsidiary of VGM HOMELINK

Thank you for your interest in joining Homelink Therapy Network, a new rehabilitation network for workers' compensation. We are looking forward to you being a member of our provider network. Please find enclosed a Homelink Therapy Network Participating Provider Agreement.

In order to facilitate prompt processing please complete the checklist of requested information and documents below.

REQUESTED INFORMATION AND DOCUMENTS	CHECKLIST ✓
All pages of the contract application	☐
Contact name, title, email address, phone and fax number for each clinic location	☐
If using Utilization/Benchmarking protocols enclose blinded samples as requested	☐
Complete attestation statement, signed by the attesting owner only	☐
A current signed and dated W-9	☐
A current Certificate of Liability Insurance Face Sheet	☐
A complete list of all therapists, degree, and individual NPI#'s	☐

Please send completed contract application to:

Mike Williams
Credentialing Coordinator
Homelink Therapy Network

FAX
844-247-3565

Email
mike.williams@homelinktherapynetwork.com

Mailing Address
Homelink Therapy Network
1111 W. San Marnan Drive
Waterloo, Iowa 50701

Thank you for your time and consideration!

Homelink Therapy Network
A Subsidiary of VGM HOMELINK

HOMELINK THERAPY NETWORK
PARTICIPATING PROVIDER AGREEMENT

This Agreement by and between Homelink Therapy Network, a division of VGM Homelink ("HTN") and _____, a physical therapy provider ("Participating Provider"). All sites under this Participating Provider's locations are listed as Attachment "B".

Whereas, HTN contracts with providers for the delivery of cost-effective Covered Services to Covered Individuals;

Whereas, HTN has entered and will enter into agreements with employers, insurance companies and medical service companies to arrange for the delivery of cost-effective health care services to the Covered Individuals;

Whereas, HTN wishes to engage the services of Participating Providers, subject to the terms and conditions of this Agreement; and

Whereas, Participating Provider is authorized to provide certain specialty medical and rehabilitation care services under the obligations of this Agreement,

Now, therefore, in consideration of the covenants and promises contained herein, and intending to be legally bound, the parties agree as follows:

1. Definitions

1.1 **Agreement** shall mean this Participating Provider Agreement, and all exhibits and attachments hereto:

1.2 **Clean Claim** shall mean a claim containing data to effectively process the claim, including at least: provider name, provider address, provider tax identification number, NPI, employer identification, date of injury, date of service, payor name, patient name, patient date of birth, appropriate CPT codes and amount charged. Further, the claims shall not be fraudulent and shall require no special treatment that prevents timely payments from being made on the claim under the terms of this Agreement.

Claims for medical services must be submitted to HTN within 90 days, or within 14 days prior to state claim submission deadline, whichever is deemed first, and may be deemed to be null and void and not be compensable by HTN if submitted after these timeframes.

1.3 **Covered Individuals** shall mean those persons authorized by HTN to use the Covered Services of Participating Providers in the Network. Covered Individuals will either be identified as those individuals who have been referred to Participating Provider where the responsible Payor is an exclusive Payor for HTN or where HTN has notified the Participating Provider that the individual is a Covered Individual.

1.4 **Covered Services** shall mean Medically Necessary services including, but not limited to, physical and occupational therapy, aquatic therapy, work conditioning, and functional capacity evaluations, which are generally and customarily provided to patients, and authorized by HTN. Supplies and equipment necessary to perform the service will be considered as bundled into the primary charge per that CPT code pursuant to the guidelines of CPT with regard to materials and supplies. DME provided separate from a therapeutic treatment may be billed according to appropriate codes will be considered a reimbursable charge with prior HTN authorization. Clinical Protocols for the HTN program are posted as Attachment C.

1.5 **Authorized Therapists** shall mean those therapists who are duly licensed and will comply with the treatment protocols as set forth in Attachment C. Participating Provider shall be responsible for the specified therapists enrolled with their group as a member of the HTN to educate themselves on the requisites of medical care to HTN clients and their insured. Authorized therapist shall be those professionals treating patients within the scope of physical therapy practice defined by the individual state's practice acts.

Participating Providers shall be responsible for the specified therapists enrolled with their group as a member of HTN to educate themselves on the requisites of medical care to HTN clients and their insureds.

1.6 **Medically Necessary** refers to a medical treatment which a Covered Individual requires, as determined by one or more Participating Providers; provided, however, that any services which are determined not to be medically necessary pursuant to the Payor's Utilization Review Plan shall not be deemed Medically Necessary for the purposes of this agreement. The service should be within applicable evidence based treatment guidelines, or in the absence, thereof, widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature.

1.7 **Network** shall mean HTN's health care provider network, which is a type of a preferred provider organization requiring Participating Providers to comply with the provisions of this Agreement.

1.8 **Non-Covered Services** shall mean those medical services for which benefits are not payable based on Utilization Review (when applicable), state law or non-compensability of a workers' compensation claim.

1.9 **HTN Fee Schedule** shall mean the fee schedule for the Covered Services attached hereto as Attachment "A".

1.10 **Payor** shall mean the insurance company, a self-insured employer, a workers' compensation insurance carrier / 'third party administrator or other managed care

workers' compensation organization that provides benefits to Covered Individuals for the Covered Services and which has agreed to associate with HTN to utilize HTN's services.

1.11 **Payor Agreement** is an agreement entered into by HTN with a Payor relating to the provision of Covered Services by Participating Providers to Covered Individuals.

1.12 **Utilization Review** shall mean a plan developed and administered by or at the direction of the Payor to monitor and review the delivery of medical services by Participating Providers to determine whether such services are provided in a cost-efficient and appropriate manner.

For claims related to workers' compensation injuries, review of Participating Provider bills to determine via prior authorization or respective review whether services and charges are appropriate, reasonable and related to a work-related injury, identifying defects including the following:

- Lack of medical appropriateness,
- Lack of supporting documentation,
- Unbundling and up-coding of services,
- Incorrect provider or diagnosis coding,
- Inflated level of service,
- Redundant services,
- Treatment of unrelated injury, or
- Delivery of services outside the individual Participating Provider's scope of practice.

1.13 **Authorized Visits** shall be the total number of visits, including evaluation, authorized by HTN for a Covered Individuals regardless of the number and types of rehabilitative services rendered for the Episode of Care. Based on each Covered Individual's diagnosis and chronicity of illness, treatment program and provider region, for each Episode of Care, HTN shall timely notify Participating Provider regarding the maximum number of Authorized Visits for Covered Services rendered by Participating Provider, subject to determinations of medical necessity.

The initial evaluation and first day of treatment are authorized. Based on the Participating Provider's clinical submission, HTN will review, either directly or through its Utilization Management/PAS Program, and respond to the Participating Provider within 2 business days of submission with the number of follow up visits allowed. If authorization is not provided by HTN after request in a timely manner (2 business days), then the next visit is considered authorized in order to not delay care to the covered individual. If the request for authorization by Participating Provider is not made prior to the service, then service will not be covered service if it occurs prior to the pre-authorization.

All medical care must be pre-authorized through HTN, and the Participating Provider must have a plan in place to acquire additional visits, when applicable, so that there is no disruption in the continuity of care. HTN will promptly respond to all requests for additional care so as to achieve the same goal.

1.14 **Bill Adjudication** shall mean the re-pricing of Participating Provider's medical bills to the Recommended Allowance.

1.15 **Plateau** shall mean the point in treatment where there is no documented progress in the Covered Person's condition for a minimum period of two (2) consecutive weeks.

1.16 **Date of Discharge** shall mean the earlier of the following dates: (i) the date on which the Covered Person voluntarily dismisses the Participating Provider as the provider of rehabilitation services; (ii) the date on which the Covered Individual has missed either two (2) consecutive weeks of treatment or thirty percent (30%) of treatments scheduled within one (1) month without written medical excuse; (iii) the date on which there is a Plateau documented by Participating Provider; or (iv) the date on which the Covered Individual achieves specific treatment goals as determined by Participating Provider or the treating physician.

1.17 **Day Rate** shall mean the amount of money paid by HTN to Participating Provider for Covered Services rendered by Participating Provider for a particular date of service regardless of the number and types of rehabilitative services rendered except that initial evaluations, same day pool therapy, functional capacity evaluations and work conditioning shall not be subject to Day Rate. Supplies and equipment used to deliver covered services shall be considered in the Day Rate.

1.18 **Recommended Allowance** shall mean the lesser of the Participating Provider's billed charges. The state-mandated fee schedule when applicable or other regulatory limitation, if any, or, if none, the eightieth (80^{th}) percentile of Usual, Customary and Reasonable (UCR) rate defined by Fair Health.

1.19 **Episode of Care** shall mean the period of time from the Covered Individual's date of initial evaluation until the Date of Discharge.

2. Participating Providers Services

2.1 **Licensed / Standard of Care.** Participating Provider shall furnish all necessary and appropriate Covered Services to Covered Individuals in accordance with the terms and conditions of this Agreement. Participating Provider shall perform such services for Covered Individuals in accordance with the rules and regulations of the licensing authorities to which they are subject and with at least the same care and in the same manner as Participating Provider customarily provides treatment and services for its patients who are not Covered Individuals. Nothing contained herein shall be interpreted to require HTN to refer any Covered Individual to Participating Provider for Covered Services.

During the term of this Agreement Participating Provider shall immediately notify HTN in writing of any professional disciplinary action taken against Participating Provider, including but not limited to the suspension or revocation of any licenses, certifications or accreditation applicable to Participating Provider.

2.2 **Responsibility.** It is hereby understood that Participating Provider is solely responsible for all decisions regarding the medical care of Covered Individuals as well as their treatment and the traditional relationship between Participating Provider and Covered

Individual. Participating Provider understands that the claims administration decisions made by HTN and determinations made in the connection with Utilization Review provisions of a Payor are solely for the purpose of determining whether services are covered under the terms of that Payor and to no extent to which benefit payments may be made there under. Accordingly, such determination shall in no way affect the responsibility of the Participating Provider to provide appropriate services to Covered Individuals.

2.3 **Non-Discrimination.** Participating Provider agrees not to differentiate or discriminate in the treatment of Covered Individuals because of race, color, national origin, religion, sex, marital status, sexual orientation, age, or health status. Further it is agreed Participating Provider shall render appropriate Covered Services to Covered Individuals in the same manner, in accordance with the same standards and within the same time availability as offered by Participating Provider to other patients.

2.4 **Changes.** Participating Provider agrees to notify HTN within 30 days of any material facility changes including but not limited to, any change in company name, address, or taxpayer identification number with respect to the entity rendering services pursuant to this Agreement.

2.5 **Referrals.** Participating Provider understands that HTN will use best efforts to have their clients conform to prospective referrals within the HTN group of Participating Providers. Participating Providers acknowledge that there may be instances whereby a Covered Individual may directly access rehabilitative services prior to notification to HTN. Upon notification by HTN clients, HTN may notify Participating Provider of the need to recognize such a circumstance, and will thereafter abide by the HTN Clinical Protocols and shall convert the billing to HTN. HTN will use best efforts to provide this notification and justification within a reasonable time period during the Episode of Care.

3. Billing and Compensation

3.1 Participating Provider agrees to submit a timely original ("Clean Claim") to HTN for each Covered Individual within the Network. Participating Provider agrees that such Clean Claim shall identify the Participating Provider's usual rates; however, all reimbursement for the Participating Provider by HTN shall be according to the HTN fee schedule. HTN shall reimburse the Participating Provider within fifteen (15) calendar days following the receipt of Clean Claim. Participating Provider agrees to accept the rates set forth in this Agreement as payment in full for Covered Services rendered to Covered Individuals.

3.2 Participating Provider agrees to adhere to the time basis rules for code selection as set forth in CPT as established and as updated by the American Medical Association. The standards shall apply to time measurement, unless there are code or code-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary. Time is the face-to-face time with the patient. A unit of time is attained when the mid-point is passed.

3.3 HTN will notify Participating Provider within 20 calendar days of receipt of a claim missing necessary adjudication information.

3.4 Participating Provider agrees not to submit a claim or otherwise directly or indirectly bill any patient, employer, Covered Individual or other Payor for Covered Services rendered to Covered Individuals. Participating Provider agrees to accept the rates set forth in the HTN Fee Schedule as payment in full for any and all referrals to Participating Provider regardless of source of referral as long as the Payor is one of HTN's Payor clients utilizing the Network.

3.5 Participating Provider agrees that, as between Participating Provider and HTN, HTN has the sole right to generate and submit to the appropriate Payor a HCFA 1500 or UB and to collect thereon directly from the Payor.

3.6 In the event the Participating Provider inadvertently billed or accepted payment from a Payor directly for Covered Services provided to a Covered Individual prospectively referred by HTN, the Participating Provider agrees to refund said Payor the full amount paid and accept the rates as set forth in the HTN Fee Schedule. It is also understood that Participating Provider shall not look to HTN or any Payor as the responsible party for payments of Participating Provider's fees, charges or expense of any kind whatsoever for the provision of Non-Covered Services to Covered Individuals.

3.7 In the event that a payment is paid directly to Participating Provider by Payor, or a duplicate payment is made to Participating Provider, HTN will notify Participating Provider that a refund that is due from Participating Provider, and HTN will not offset any monies due if the appropriate refund is made to HTN within forty-five (45) calendars days.

3.8 Participating Provider acknowledges that there is no compensation for missed appointments.

3.9 Participating Provider agrees to adhere to the Clinical Protocols which are posted as Attachment "C".

4. Term and Termination

4.1 **Term**. This Agreement is effective as of _____and shall be in effect for a period of two (2) years thereafter (the "Initial Term"). Unless HTN or Participating Provider shall give written notice to the other party at least ninety (90) days prior to the end of the Initial Term or any renewal term, this Agreement shall be automatically renewed for additional periods of one (1) year each.

4.2 **Termination without Cause**. This Agreement may be terminated by either HTN or Participating Provider without cause by giving a ninety (90) day prior written notice to the other party by certified mail, or at any time by mutual agreement of both parties.

4.3 **Termination for Cause**. This Agreement may be terminated by either HTN or Participating Provider upon thirty (30) days written notice to the other in the event the other party breaches this Agreement and fails to cure the breach within thirty (30) day notice period. Notice given under this Section shall specify the alleged breach.

4.4 **Immediate Termination**. Notwithstanding the foregoing provisions of this Section 4, this Agreement may be terminated immediately upon written notice by either HTN or Participating Provider to the other party upon the occurrence of any of the following events:

A) Any court or governmental agency determines that this Agreement violates any law or regulation;
B) The filing by or on the behalf of either HTN or Participating Provider of any voluntary or involuntary petition in bankruptcy, dissolution or liquidation;
C) The involuntary cancellation or termination of Participating Provider's general or professional liability insurance; or
D) The loss or suspension of any license or authorization of Participating Provider, which is required by Participating Provider to conduct its business or perform its obligations under this Agreement.

4.5 **Effect of Termination.** Upon termination or expiration of this Agreement, neither party shall have any further obligation hereunder except for: 1) HTN's obligations to reimburse Participating Provider for Covered Services for patients for the specific duration of the current Episode of Care; 2) obligations, promises or covenants contained in this Agreement for which performance was commenced before termination or expiration and for which performance may not be ended before completion herein or 3) obligations that were expressly made to extend beyond the term of this Agreement.

5. Assignment. This Agreement, being intended to secure the services of Participating Provider, shall not be assigned, delegated, subcontracted or transferred in any manner by Participating Provider to any other person or entity without the prior written consent of HTN which will not unreasonably be withheld. This Agreement will not be assigned by HTN without prior written notification by HTN to Participating Provider; at which time Participating Provider is permitted to decline further participation and terminate this Agreement. If not declined, then Participating Provider accepts "assignment" with payment for services continuing at HTN Networks' contracted rates, which may be less than the workers compensation fee schedule.

6. Participating Provider's Qualifications. Participating Provider represents and warrants to HTN that it has all the requisite licenses and certifications from (a) the state in which the Participating Provider at any time now and hereafter offers Covered Services and (b) all official and professional boards or bodies having authority over the area of medicine in which the Participating Provider is engaged.

7. Insurance. Participating Provider shall, at its own cost and expense, procure and maintain policies of comprehensive general and professional liability insurance as required in the state where the Participating Provider offers Covered Services, in minimum coverage amounts of at least $1 million per loss with an annual aggregate of $3 million, or if greater, in minimum coverage amounts required in the state where Participating Provider offers Covered Services, to insure Participating Provider and its employees against claims for damages arising by reason of personal injury or death resulting directly or indirectly from or in connection with the performance of any Covered Services by Participating Provider, its employees and agents. Participating Provider shall, except where a new policy is secured and no lapse in coverage occurs, provide HTN with written notification of any cancellation, termination, expiration or

alteration of any such policy(ies) within twenty-four (24) hours after Participating Provider receives notice of such change in policy(ies).

8. **Liability.** Participating Provider agrees to assume full responsibility for, and to indemnify and hold HTN harmless from and against, any liability imposed by law upon Participating Provider and its employees for claims for damages arising by reason of personal injury or death resulting directly or indirectly from or in connection with the performance of Covered Services by Participating Provider. Participating Provider shall not be responsible for any liability imposed by law upon HTN, and HTN shall not be responsible for any liability imposed by law upon Participating Provider. HTN and Participating Provider each agree to be responsible for its own liabilities to whatever degree determined.

9. **Quality Assurance and Utilization Review.** Participating Provider agrees to comply with HTN and/or Payor's requirements regarding quality assurance, utilization review, grievances, referrals of Covered Individuals, and maintenance of records.

9.1 Participating Provider shall maintain medical, financial, and administrative records concerning Covered Individuals. Participating Provider shall, upon reasonable notice and during regular business hours, allow any Payor to inspect such information as may be necessary for its compliance with state and federal laws (including HIPAA regulations at CFR 160-164), as well as for administrative purposes.

HTN and Participating Provider agree that medical records/medical notes of Covered individuals shall be treated as confidential to the extent necessary to ensure compliance with all applicable federal and state laws and regulations, including HIPAA regulations at 45 CFR 160-164.

9.2 Participating Provider acknowledges that HTN does not practice medicine and that clinical decisions regarding the treatment and discharge of Covered Individuals under Participating Provider's care, shall be made exclusively by Participating Provider, (notwithstanding the receipt of Participating Provider, whether in writing or otherwise, of any decision by HTN to withhold or deny payment for medical services rendered by Participating Provider to such Covered Individuals).

9.3 Participating Provider agrees to cooperate with HTN in maintaining and providing medical, financial, administrative and other records required for cost containment, quality assurance and peer review programs or otherwise required for the efficient and cost-effective operations of the Network. Participating Provider agrees to cooperate and participate with HTN in any internal peer review, credentialing process, utilization review or quality assurance procedures and external audits as may be established by HTN.

9.4 Participating Provider agrees to submit credentials and associated business information as reasonably requested by HTN. Participating Provider understands that prior to commencement of receiving referrals from HTN, Participating Providers' credentials will be primary source verified.

9.5 Participating Provider must contact HTN prior to performing any additional procedures on all Covered Individuals other than what was originally authorized or ordered. HTN

reserves the right to recommend denial of payment for any additional procedures that Participating Provider has not had pre-authorized.

10. **Confidentiality.** HTN and Participating Provider, during and subsequent to the termination of this Agreement, shall keep confidential all information related to or generated under this Agreement, including but not limited to all Covered Individual lists, all statistical data and reports, all fees, charges and financial information, and all quality assurance and utilization review information and shall utilize their best efforts to prevent and protect such information from unauthorized disclosure by their agents and employees. The restriction in the preceding sentence shall not apply to materials or information that is available to either HTN or Participating Provider from public sources or to HTN or Participating Provider from its own information systems. HTN acknowledges that Participating Provider is a provider of Covered Services and in this capacity has extensive knowledge of its internal operations and rehabilitation services in general, including statics related to utilization, outcomes, and quality assurance as well as fee schedules and financial information.

11. **Independent Contractors.** None of the provisions of this Agreement are intended to create or shall be deemed or construed to create any relationship between HTN and Participating Provider other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither HTN nor Participating Provider, nor any of their respective employees, agents or representatives shall be construed to be the agent, employee, representative, partner or joint venture of the other. Neither HTN nor Participating Provider has the express or implied right or authority to enter into contracts or to assume or create any obligations or responsibilities for the other party or make any warranties or representations on behalf of the other party.

12. **Authorization to Use Name.** HTN shall have the right to market the Network and to arrange to have Participating Provider's name, address, telephone numbers and other pertinent, publicly available information included in the Directory of Participating Providers. HTN may also use Participating Provider's name in marketing brochures and other marketing literature, without the prior consent of Participating Provider, in its discretion, for the purpose of identifying Participating Provider's contract with Network and otherwise to carry out the terms of this Agreement. Participating Provider may use the HTN name on marketing materials; however, express written authorization is required for the use of the HTN logo.

13. **Notices.** Delivery of any notice required to be given under this Agreement, or of any consent or waiver, shall be deemed to occur (A) on the date of delivery when delivered in person, (b) one (1) business day following deposit in overnight delivery to an overnight delivery service which guarantees next day delivery, or (c) three (3) business days following the deposit if mailed by U.S. certified mail, postage prepaid, when notice is given as follows:

If to Participating Provider: _____
_____
_____
Attn: _____

If to HTN: Homelink Therapy Network
1111 West San Marnan Drive
Waterloo, IA 50701
Attn: Robert Kroll PT, VP Business Development

14. **Entire Agreement.** This Agreement, including any attachments and exhibits hereto, constitutes the entire understanding of the parties with respect to the subject matter hereof, and supersedes all prior or contemporaneous negotiations, discussions, agreements or understandings between the parties, whether written or oral.

15. **Amendment.** This Agreement may be amended at any time during its term by written mutual consent of both parties or, in regard to reimbursement rates for Covered Services, upon ninety (90) days advance written notice from HTN to Participating Provider.

16. **Waiver.** The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach thereof or of any other breach or violation.

17. **Governing Law.** This Agreement shall be governed by and construed in all respects in accordance with the laws of the State of Iowa without regard to conflict principals.

18. **Location of Provider Facilities.** The obligations of Participating Provider under this Agreement shall apply to all Participating Provider's locations and facilities identified on the completed Facility Profile attached hereto, as updated from time to time by Participating Provider.

19. **Authorization.** This Agreement has been duly authorized, executed and delivered by HTN and Participating Provider and constitutes a legal, valid and binding obligation of HTN and of Participating Provider, enforceable against such parties in accordance with its terms.

20. **Severability.** In the event that any provision of this Agreement, or application of such provision to persons or circumstances is held to be invalid, illegal, or unenforceable under any applicable statute, rule of law, or administrative decree or order, then such provision or portion thereof shall be deemed omitted, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

21. **Participating Provider Staff/Associates.** Participating Provider agrees to notify appropriate staff members of this Agreement and of their responsibility to adhere to all terms and conditions of this Agreement. Furthermore, Participating Provider shall require each individual providing Services to comply with the obligations of Participating Provider under this Agreement.

22. **Dispute Resolution.** In the event a dispute arises relating to this Agreement, the parties shall meet and negotiate in good faith to attempt to resolve the dispute. If the dispute is not resolved within a reasonable period of time following written notice of a request for resolution, the party wishing to pursue the dispute shall submit a written notice of dispute to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"). The arbitrator(s) shall have no authority to award any punitive or exemplary damages, or to vary or ignore the terms of the Agreement, and shall be bound by controlling law. Each party shall bear the cost of any attorney in the event the arbitrator determines it is appropriate, interest and expenses may be awarded in favor of the prevailing party. Any arbitration proceeding under this Agreement shall be conducted in Black Hawk County, Iowa.

23. **Counterpart Signatures**. This Agreement may be executed in any number of counterparts, each of which including counterparts transmitted by facsimile or other electronic means, shall be deemed an original and all of which together shall constitute one and the same Agreement.

24. **Membership to VGM Advantage.** This Agreement will provide Participating Provider access to exclusive discounted products and /or services offered through VGM Advantage. It will be to the discretion of Participating Provider to utilize said discounted products and/or services. Participating Provider understands that VGM Advantage enters into contracts with certain venders to obtain discounted pricing for Participating Provider, and that such venders may pay a fee to VGM Advantage of up to three percent of the price of goods you purchase from the vendor. A copy of this executed contract shall be deemed an original for all purposes. Benefits afforded to Participating Provider can be found at www.vgmadvantage.com.

IN WITNESS WHEREOF, the undersigned have executed or caused this Agreement to be executed on the dates set forth below, to be effective as of the date set forth in Section 4.1.

	HOMELINK THERAPY NETWORK
Provider	
Signature	**Signature**
Name	**Name**
Title	**Title**
Date	**Date**

ATTACHMENT A

HOMELINK THERAPY NETWORK (HTN)

Workers Compensation Pricing Schedule

With the appropriate authorization, Provider agrees to bill their usual charges for services provided pursuant to this Agreement, and will accept as payment in full the following:

HTN will reimburse the lesser of (a) 78% of a mandated state fee schedule when applicable, (B) 78% of U&C (established by Fair Health at the 80th percentile referenced to specific geographic location) or (c) 78% of the billed charges, up to a maximum day rate as indicated below.

Initial evaluations (PT Evaluation CPT codes 97161, 97162, 97163) and OT Evaluation CPT codes (97165, 97166, 97167) are excluded from the daily maximum reimbursement and will be paid separately for that session in addition to the therapy provided. The reimbursement for the initial evaluation will be based on the lesser of (a) 78% of a mandated state fee schedule when applicable, (b) 78% of U&C (established by Fair Health at the 80th percentile referenced to specific geographic location) or (c) 78% of the billed charges.

The lesser of language is included as a default if the submitted charges do not exceed the specific per Day Rate where services are provided.

Rates are based on current payor contracts. There may be circumstances, such as potential for increased volume of referrals that necessitate an alternate reimbursement model for certain payors. Providers will be notified of any alternate reimbursement model upon completion of that contract.

Carve Out Codes

Functional Capacity Evaluations (97750) – will be reimbursed according to the lessor of (a) 78% of state fee schedule when applicable, (b) 78% of U&C (established by Fair Health at the 80th percentile referenced to a specific geographic location), or (c) 78% of billed charges. The Functional Reporting Criteria are posted as Attachment D. Work Conditioning, Initial two hours (97545) and each additional hour of work conditioning (97546) will be reimbursed at the lesser of (a) 78% of the mandated state fee schedule when applicable, (b) 78%of U&C (established by Fair Health at the 80th percentile referenced to the specific geographic location) or (c) 78% of the billed charges. FCE and Work Conditioning will not be subject to the maximum Day Rate.

All other procedures billed and not listed above will be reimbursed at the lesser of (a) 78% of a mandated state fee schedule when applicable, (b) 78% of U&C (established by Fair Health at the 80th percentile referenced to specific geographic location) or (c) 78% of the billed charges. These procedures must be preauthorized by HTN.

Where incidental or inclusive to provided services, medical supplies will not be allowed as a separate expense or reimbursement.

DME and medical supplies must receive prior approval through HTN. Reimbursement rates for DME or medical supplies dispensed and billed by your office will be negotiated on a case-by-case basis.

State	FEE/UCR	FEE % of Discount	UCR % of Discount	Provider Day Rate
MARYLAND	FEE	22%	NA	$95.00

Acknowledged By:

Name: _____ Title: _____

Provider Name: _____ Date: _____

Tax ID Number: _____

Group NPI Number: _____

ATTACHMENT B

PREFERRED PROVIDER APPLCATION

Provider Documentation Requirements *(Please provide the following documentation as required by the terms of your HTN agreement)*
○ Complete list of all therapists, degree, and individual NPI numbers ○ Complete attestation statement, signed by the attesting owner only ○ Current W-9 ○ Copy of insurance face sheet Please complete and return the entire application, including any attachments, by email or fax: **Email:** providerrelations@homelinktherapynetwork.com **Fax:** (844) 237-3565

Participating Provider Information	
Facility Name:	
Owner's Name:	Telephone Number:
Owner's Email Address:	
Owner's Professional Degree:	
Solo Practice: ☐ Yes No ☐	

Billing Address(es)		
Address:		Suite *(if applicable)*:
City:	State:	Zip Code:
County:		
Phone Number:	Fax Number:	
Contact Name /Title:		
Contact Email Address:		

Remit Address(es)		
Address:		*Suite (if applicable):*
City:	State:	Zip Code:
County:		
Phone Number:	Fax Number:	
Contact Name /Title:		
Contact Email Address:		

Office Locations

(Please photocopy this page and complete for each additional location. All changes must be communicated within 15 business days of change to providerrelations@homelinktherapynetwork.com)

Facility Name *(if different than main)*:		
Address:		Suite *(if applicable)*:
City:	State:	Zip Code:
County:		
Phone Number:	Fax Number:	
Contact Name /Title:		
Contact Email Address:		
TIN:	NPI:	
Medicare Number:	Medicaid Number:	
Office Hours (M-F):	Saturday:	Sunday:

Walk-In's Accepted ☐ Yes ☐ No	Handicap Access ☐ Yes ☐ No	Appointment Only ☐ Yes ☐ No	Open During Lunch ☐ Yes ☐ No

List Languages Spoken Other than English:

Please Check ✓ the Services that are Provided at the Above Location

☐ Physical Therapy	☐ Lymphedema Treatment
☐ Occupational Therapy	☐ Men's Health Rehabilitation
☐ Speech Therapy	☐ Post-Offer Employment Test
☐ Certified Hand Specialist	☐ Spine Rehabilitation
☐ Aquatic Therapy	☐ TMJ Rehabilitation
☐ Certified Manual Therapy (CMT)	☐ Vestibular
☐ Concussion Rehabilitation	☐ Women's Health Rehabilitation
☐ Ergonomic Consultation	☐ Work Conditioning/Hardening
☐ Functional Capacity Evaluation	

Education and Training Questionnaire	
1. Has any member of your professional staff been denied membership or renewal thereof or been subject to any disciplinary action in any medical organization by a local, state, or national/professional society?	☐ Yes ☐ No
2. Has the facility or any member of the professional staff been denied to participate in the Medicaid, Medicare or any other private or governmental reimbursement program?	☐ Yes ☐ No
3. Has any member of the professional staff had their licensure suspended, revoked, sanctioned, or otherwise restricted?	☐ Yes ☐ No
4. Has the facility or any member of the professional staff been denied professional liability insurance, or has such policy ever been restricted or canceled?	☐ Yes ☐ No
5. Has any member of the professional staff been convicted of a felony or under investigation of a felony offense or charged with a crime involving alcohol or controlled substances?	☐ Yes ☐ No
6. Have any professional liability lawsuits been filed against the facility or any member of the professional staff, or have any professional liability judgments or settlements been made against the facility or a member of the professional staff?	☐ Yes ☐ No
7. Has any member of the professional staff been treated for alcoholism, narcotics addiction, or mental illness, or is any member of the professional staff presently or have been dependent on alcohol or drugs?	☐ Yes ☐ No
8. Do any medical conditions exist among the members of the professional staff that might impair or negatively affect the ability to practice (e.g., diabetes, hepatitis, Parkinson's disease, a condition for which narcotic analgesics are used, impaired vision or hearing, alcoholism, drug dependence/mental illness, etc.)?	☐ Yes ☐ No
* ***If responded "YES" to any of the questions above, please provide a written description of the circumstances and resolutions.***	

Utilization / Outcomes Management
Utilization or Benchmarking Protocols Actively in Place: ☐ Yes ☐ No
Name and Description of Program Used:
How Frequently are Outcomes Measured:
Please enclose an ACTUAL BLINDED SAMPLE of a patient's outcomes report for 2 of the following 4 body parts (must be blinded sample, not a blank form): ☐ Back ☐ Shoulder ☐ Hand/Wrist ☐ Knee
Do you have a procedure in place to ensure all care is medically necessary *(please describe)*:

Malpractice Claims Information Form *(Please provide the following information for all malpractice suits and settlements within the past 5 years. If necessary, use additional paper and attach it to the application)*		
Patient Name:		
Age:	Sex: ☐ Male ☐ Female	Date of Incident:
Diagnosis:	Date Suit Filed:	
Date Suit Closed:	Amount of Judgement/Settlement:	
Primary Defendant:	Co-Defendant:	
Describe the specific allegation(s) of claim:		
Patient Name:		
Age:	Sex: ☐ Male ☐ Female	Date of Incident:
Diagnosis:	Date Suit Filed:	
Date Suit Closed:	Amount of Judgement/Settlement:	
Primary Defendant:	Co-Defendant:	
Describe the specific allegation(s) of claim:		

Patient Name:		
Age:	Sex: ☐ Male ☐ Female	Date of Incident:
Diagnosis:	Date Suit Filed:	
Date Suit Closed:	Amount of Judgement/Settlement:	
Primary Defendant:		Co-Defendant:
Describe the specific allegation(s) of claim:		

Attestation to be completed and signed by the owner or qualified representative of the physical therapy practice as the attesting provider:

I present this information as part of this credentialing process expecting that its confidentiality and privacy will be preserved, and that this information will be released or disclosed only as part of current and future credentialing, peer review, and quality assurance process. In order to evaluate my application for participation as a Network Provider, I hereby give permission for information to be solicited, provided, and acted upon regarding my qualifications, competence, and character.

Specifically included in this consent are the State Board of Professional Licensing, National Practitioner Databank, hospitals, professional sources and professional liability insurance carriers with whom I am or have been associated and any other agency or person who might provide pertinent information.

A photocopy of this permission will serve as the original. I understand that this information will be used in confidence and solely in conjunction with my application and that the information is not subject to re-disclosure other than under provisions of applicable state or federal law.

I hereby release from any liability and hold harmless any person or entity who is approached and furnishes information pursuant to this authorization and release. Additionally, I release from liability and hold harmless any person associated with HTN and its credentialing process.

I, _____ attest and certify the information contained in this statement is complete and accurate to the best of my knowledge.
Printed Name

_____ _____

Attesting Provider Signature ONLY Date

ATTACHMENT C

HOMELINK THERAPY NETWORK CLINICAL PROTOCOLS

- Participating Provider should have the ability to schedule a Covered Person within twenty-four to forty-eight hours from referral.

- Treatment visits should be scheduled appropriately and aggressively to promote early return to work. Home Exercise Programs should be developed at the initial visit and documentation of the patient's compliance recorded as part of their progress notes.

- The focus of the rehabilitation process must be functionally driven for a prompt return to work.

- The Initial Referral from HTN will be for the Initial Evaluation and the first day of therapeutic services. Based on clinical presentation including the physician's script and co-morbidities, HTN will provide promptly the authorization for additional visits.

- The clinic should track the number of visits authorized and prior to the completion of that number of authorized visits, should communicate to HTN the anticipated number of visits that may be needed through clear, concise documentation of such need.

- A discharge summary by fax or phone call should be sent to physician and the claims manager (case manager and/or adjustor) on record. All patient discharges should be reported to HTN within 24 hours of discharge.

- Participating Provider should fax or otherwise transmit to HTN within 24 hours, a copy of the Initial Evaluation summary report outlining findings, proposed treatment, expected results and anticipated disability time frame.

- The first follow up visit should begin within 72 hours of the initial evaluation. All subsequent visits should be in a timely and consistent fashion to promote prompt recovery.

- All progress notes will be required to be completed for each daily visit. The progress note should include the following:
    - Changes in the patient's subjective presentation
    - Changes in the patient's objective presentation
    - Daily assessment of the patient's condition (e.g. improvement, decline, no change)
    - Any changes in the treatment plan compared to previous documentation
    - Update on outcomes score and pain scale should be done every two weeks or 5 visits (whichever comes first)
    - Cancellations and no-show visits must be documented with the reason included

- All therapy visits will be required to be documented and billed in reports and on claims submissions as to the specific minutes associated with treatment.

- Supervision of therapy will follow the applicable state practice guidelines.

- All FCE's should be confirmed the night before the appointment and documentation of cancellations or no shows should be communicated with the physician and claims manager.

- HTN'S FCE Criteria is posted as Attachment D.

- HTN may request evaluation of job descriptions and completion of return to work restriction forms so that the injured Covered Person can be returned to productive activity. A re-evaluation charge for these testing and measurements will be authorized as a Covered Service if

requested by HTN or if the treating therapist identifies the intent of that service and receives pre-authorization from HTN.

- Participating Provider may be requested to provide status report on claimant(s) continuing to receive treatment outside evidence-based parameters. In such cases, HTN will initiate such request by faxing to Participating Provider a questionnaire to be completed by the treating therapist who provides insight of claimant's compliance and progress.

- Re-evaluations (97002, 97004) will be allowed only if a patient presents with the following:
    - A patient returns from an extended period of absence from physical therapy (greater than one month)
    - A patient presents with a significant change in condition
    - HTN requests an evaluation of job descriptions and completion of return to work restriction forms so the injured covered person can be returned to productive activity and the re-evaluation is pre-authorized

  Consistently performing re-evaluations without the patient meeting the above criteria may trigger a review of documentation to determine if one of the above criteria supported the billing of a re-evaluation.

- An Initial Evaluation will be allowed after a patient's return from a surgical procedure.

- A Work Conditioning Evaluation will be allowed (up to 10 units / 97750) on any patient not seen by a provider within your organization, prior to initiating work conditioning. Prior authorization is required.

- HTN will use best efforts to obtain prior to a patient scheduled for an FCE, the following:
    - Documentation from previous course of care from prior therapist and physician
    - A job description
    - Surgical and imaging reports if applicable.

- All Covered Services will be coordinated with the Covered Person's Payor through HTN.

- If questions arise as to the patient's clinical care or in the case of FCE's in which additional job function information might be needed to adequately assess the patient, HTN should be contacted. HTN will in turn contact the claims manager (case manager and/or adjustor) for this information.

- HTN will share the case manager or adjustor's contact information if it is on the patient file for direct therapist to case manager/adjustor discourse about clinical information. HTN will use best efforts to facilitate timely response to all clinical inquiries received by Participating Provider.

- The Participating Provider will follow a Cancellation / No Show policy. It is recommended that the provider attempt to re-schedule the patient within 2 days of the specific appointment scheduled, and if unsuccessful, HTN should be notified. Part of the re-scheduling process will be dialogue that the claimant may be reported as non-compliant and may be putting their TTD at risk by being so.

- The original bill for each Covered Person and the corresponding clinical documentation must be sent to HTN for each Covered Individual treated by Participating Provider.

- Participating Provider must complete and transmit to HTN all status reports requested by HTN within 48 hours of these status report requests.

ATTACHMENT D

HOMELINK THERAPY NETWORK

FUNCTIONAL CAPACITY EVALUATION

REPORT CRITERIA

A functional capacity evaluation (FCE) is a detailed examination and evaluation that objectively measures the client's current level of function primarily within the context of the demands of competitive employment. Measurements of function from an FCE may be compared to the physical demands of the job or other functional activities and are used to make return to work/activity decisions, disability determinations or to generate a rehabilitation plan. An FCE measures the ability of an individual to perform functional or work related tasks and predicts the potential to sustain these tasks over a defined time frame.

The report should include the following:

Statement of the purpose of the FCE or question(s) to be answered may include the following:

Purpose*

- Determination of work function/level as defined by the Dictionary of Occupational Titles (DOT)
- Return to work and job placement decisions and programs
- Disability evaluation
- Intervention and treatment planning
- Case management and case closure

Questions*

- Do the client's abilities match the physical demands of his/her regular job?
- Did the client appear to exhibit full physical effort?
- Do reported results appear functionally valid? (Was the functional level demonstrated by the client an accurate representation of his/her current abilities?)
- Do the client's reports of disability and pain appear to be reliable?
- If the client cannot return to their regular job, at what level of function are they performing?
- What is the client's current work function/level as defined by the DOT?

** Results in the report should satisfy the stated purpose(s) and/or answer the question(s) with documentation to support findings*

Statement of projected ability to sustain the demonstrated level for a specific time period (most commonly 8 hours) with documentation to support findings

Provide support for level of effort and reliability determination or justification for functional validity of results statement.

Examples:

- Comparison of reported/perceived level of activity to demonstrated
    - Multi-Dimensional Task Ability Profile (MTAP)
    - Spinal/Hand Function Sort
    - Oswestry, NDI, LEFS, DASH

- Distraction-based testing to compare subjective and objective findings
- Measurable changes in movement and/or function that correlates to pain reports
- Rapid Exchange Grip test
- Heart rate changes
- XRTS Hand Strength Assessment
- XRTS Lever Arm

Statement of client's predicted ability in the absence of less than full effort or invalid results with supporting documentation

Signed statement of client's acknowledgement/agreement to participate in the FCE

Client information and history:

- Name
- Date of birth
- Date of injury/illness
- Date of FCE
- Gender
- Physician
- Referral source
- Employer
- Job title
- Current work status
- Start and end time and/or total time for FCE
- Baseline heart rate and blood pressure with monitoring during the FCE and post FCE measurements
- Injury/illness history
- Treatment history
- Current medications
- Level and area(s) of reported pain

Musculoskeletal examination with comment on effect of any impairment on demonstrated functional ability

Results of Material Handling tasks

Results of Non-material Handling tasks

Provide references for tests and measures used to support findings

Policy of HTN:

- All FCE appointments will be pre-approved by HTN.
- All FCE's will be confirmed within 24 hours of the scheduled appointment time.
- There is no reimbursement for a cancellation or no show.
- The report must boldly state on the first page of the report as to the validity or non-validity of the evaluated injured worker.

- Prior to the first FCE performed for an HTN client by the Participating Provider, the provider will forward a blinded sample of a previously performed FCE to the Clinical Director (all contact information will be forwarded with the "HTN Welcome Packet") for approval of format and informational requirements. The Clinical Director will review and provide approval of format and content for use with HTN clients.
- Once the Participating Provider has had a clinical review of the FCE, all future FCE's may be forwarded directly to the referral source on record with a copy to HTN.