LARACUENTE HEALTHCARE ASSOCIATES, PA

FAMILY PRACTICE

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Policies and Procedures Adopted on 1/27/2021.

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CHAPTER 1

Policy Development and Maintenance

POLICY 1.01 • Development and Administration of Policies and Procedures

POLICY 1.02 • Forms

POLICY DEVELOPMENT AND MAINTENANCE • POLICY 1.01

Development and Administration of Policies and Procedures

Laracuente HealthCare Associates will be referred throughout this manual as "the Practice".

It is the policy of the Practice for policies and procedures to follow a consistent process for development, approval, review, and implementation.

PROCEDURES

1. Written Format

    a. Use a standard policy and procedure format.

    b. State specific rather than generic guidelines. However, leave some room in a policy for individual management enhancements.

    c. Use simple terminology to make statements short and concise.

    d. Include no more than one idea in any single sentence.

2. Definitions

    a. Policy: A guide to the philosophy behind the Practice's objectives and procedures; a policy provides the framework from which consistent actions and decisions can be made.

    b. Procedures: Chronological steps or methods for implementing a policy.

3. Disclaimer

    Policies and procedures are not to be construed as a contract or agreement with any employee of the Practice.

4. Policy Categories (subject to change with future growth of the organization)

a. Personnel

b. Scheduling

c. Patient Administrative Services

d. Medical Records Transcription

e. Clinical Care

f. Medical Management

g. Information Systems

h. Financial Management

i. Materials Management

j. Facilities

k. Business Office

l. Disaster Planning

m. Exposure Control

n. Closing a Practice

o. Privacy

5. Policy Development

a. A cross-functional policy and procedure committee initiates and reviews policy development. The committee consists of staff and management from throughout the organization, and committee members are selected and recommended by the Administrator and are required to serve a minimum one-year term.

b. The policy and procedure team meets on a regular basis to review, and recommend for approval, the policies and procedures of the organization.

c. Management staff may be responsible for assisting in policy and procedure development and review. As appropriate, department heads review and sign off on draft policies and procedures.

d. All policies and procedures are presented to the committee for review and approval before being routed for final signature.

6. Final Policy Approvals

Final drafts are approved by the president and appropriate senior administrative employees:

a. Personnel: Director of Human Resources

b. Scheduling: Chief Operating Officer

c. Patient Administrative Services: Chief Operating Officer

d. Medical Records Transcription: Chief Operating Officer

e. Clinical Care: Chief Medical Officer

f. Medical Management: Chief Medical Officer

g. Information Systems: Director of Information Systems

h. Financial Management: Chief Financial Officer

i. Materials Management: Chief Operating Officer

j. Compliance Risk: Chief Operating Officer

k. Facilities: Chief Operating Officer

l. Business Office: Chief Financial Officer

m. Disaster Planning: Chief Operating Officer

n. Exposure Control: Chief Medical Officer

o. Closing a Practice: Chief Operating Officer

7. Implementation

Approved policies and procedures are distributed to all department managers. Managers are then responsible for distribution and implementation of all policies within their departments. All Practice employees must sign approved policies after reading them.

8. Policy Amendments

a. Policy amendments are presented to the policy and procedure committee for review.

b. Managers responsible for policy development acquire final approval(s) as outlined above.

9. Review of Policies

Each policy is reviewed every two years if it has not been revised within that time frame.

POLICY DEVELOPMENT AND MAINTENANCE • POLICY 1.02

Forms

It is the policy of the Practice to route all internal and external business forms, regardless of format, through the Administrative Forms Committee for review and approval. All medical record forms are routed through the Medical Staff Forms Committee for review and approval. Every form is maintained in a manual in paper and electronic formats to allow for consistency and quality throughout the organization.

PROCEDURES

a) Two committees review all current internal and external forms in use throughout the Practice. The Administrative Forms Committee reviews all administrative forms and templates. The Medical Staff Forms Committee reviews medical record forms and templates. These committees review each form and template for:

    a. Legality;

    b. Content;

    c. Need;

    d. Legibility;

    e. Repetition;

    f. Accuracy;

    g. Consistency; and

    h. Efficiency.

2) The committees create all new forms and templates, and forms and templates introduced through an acquisition or new system implementation, according to research resulting from consulting appropriate departments. Prior to approval, each committee routes the forms and templates to the appropriate departments for input and final review.

3) All approved forms and templates are maintained in a manual developed by the Practice administration. Each approved form and template is assigned a number indicating one of these categories:

    a. Personnel

    b. Scheduling

    c. Patient Administrative Services

    d. Medical Records Transcription

    e. Clinical Care

    f. Medical Management

    g. Information Systems

    h. Financial Management

    i. Materials Management

    j. Facilities

    k. Business Office

    l. Disaster Planning

    m. Exposure Control

    n. Closing a Practice

    o. Other categories as assigned by the committees

A copy of the manual and specific reorder and usage instructions are provided to each Practice site. All new forms and templates are released to each site's manager.

CHAPTER 2

Personnel

Alert: *Nothing in this Chapter 2 or any other policy is intended to or shall create any right to employment by any person for any particular period of time. To the maximum extent permitted by law, all employees serve the Practice "at will," and any person's employment may be terminated by the Practice in its discretion, with or without cause.*

As with other topics addressed in this volume, it is very important for individual practices to consult the specific laws of their respective jurisdictions in addressing personnel and other human resource issues, as such requirements can and do vary from state to state.

POLICY 2.01 • Shifts

POLICY 2.02 • Working Hours

POLICY 2.03 • On-Call Program

POLICY 2.04 • Flexible Hours

POLICY 2.05 • Employee Classifications

POLICY 2.06 • Per Diem Employees

POLICY 2.07 • Nepotism

POLICY 2.08 • Salary Determination

POLICY 2.09 • Wage and Salary Administration

POLICY 2.10 • Timekeeping

POLICY 2.11 • Direct Deposit

POLICY 2.12 • Equal Employment Opportunity

POLICY 2.13 • Employment Processing

POLICY 2.14 • Selection Steps

POLICY 2.15 • Background Check

POLICY 2.16 • Orientation and Training

POLICY 2.17 • Competency Assessment

POLICY 2.18 • Confidentiality Agreement

POLICY 2.19 • Name Tags for Employees

POLICY 2.20 • Dress Code

POLICY 2.21 • Uniforms

POLICY 2.22 • Insurance Benefits

POLICY 2.23 • Workers' Compensation Claims Management

POLICY 2.24 • Smoking

POLICY 2.25 • Smoke-Free Workplace

POLICY 2.26 • Seminar Reimbursement

POLICY 2.27 • Tuition Reimbursement

POLICY 2.28 • Meetings and Training

POLICY 2.29 • Absenteeism and Tardiness

POLICY 2.30 • Leaves of Absence

POLICY 2.31 • Family and Medical Leaves of Absence

POLICY 2.32 • Provider Time Off

POLICY 2.33 • Paid Time Off

POLICY 2.34 • Paid Holidays

POLICY 2.35 • Adverse Weather Conditions

POLICY 2.36 • Bereavement Leave

POLICY 2.37 • Jury Duty

POLICY 2.38 • Voting Leave

POLICY 2.39 • Alcohol Consumption on the Premises

POLICY 2.40 • Drug and Alcohol Use

POLICY 2.41 • Tuberculosis Test

POLICY 2.42 • HIV Infection Screening

POLICY 2.43 • Drug Screening

POLICY 2.44 • Use of Practice Property

POLICY 2.45 • Practice Property Ownership

POLICY 2.46 • Personal Phone Calls

POLICY 2.47 • Disciplinary Guidelines

POLICY 2.48 • Employee Conduct

POLICY 2.49 • Harassment and Discrimination

POLICY 2.50 • Workplace Violence Prevention

POLICY 2.51 • Safety and Health Rules

POLICY 2.52 • Grievance

PERSONNEL • POLICY 2.01

Shifts

It is the policy of the Practice to schedule extended hour shifts to provide service as needed by patients. Non-exempt employees may be required to work 10- or 12-hour shifts. Extended shifts are scheduled in accordance with all state and federal employment guidelines.

PROCEDURES

1. The Practice complies with current overtime guidelines, as defined by the U.S. Department of Labor's Wage and Hour Division[1]:

   (a) "Covered nonexempt employees must receive overtime pay for hours worked over 40 per workweek (any fixed and regularly recurring period of 168 hours—seven consecutive 24 hour periods) at a rate not less than one and one-half times the regular rate of pay. There is no limit on the number of hours employees 16 years or older may work in any workweek. The Fair Labor Standards Act (FLSA) does not require overtime pay for work on weekends, holidays, or regular days of rest, unless overtime is worked on such days."

   (b) The Practice complies with any applicable state laws, recognizing that if an employee is subject to both the state and federal overtime law, the employee is entitled to overtime according to the higher standard (i.e., the standard that will provide the higher rate of pay).

2. Lunch and break times are scheduled by the office coordinator/supervisor, but in no case will the combination of break time exceed that normally entitled by other employees given the equivalent time worked.

3. Vacation, holiday, illness, and injury are paid on the basis of regular time scheduled.

4. Premium pay for a holiday is paid in accordance with those hours actually worked on the holiday.

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[1] U.S. Department of Labor, Wage and Hour Division. *Fact Sheet #23: Overtime Pay Requirements of the FLSA*. Available at: http://www.dol.gov/whd/regs/compliance/whdfs23.pdf. Accessed February 6, 2015.

PERSONNEL • POLICY 2.02

Working Hours

It is the policy of the Practice to establish working hours as required by workload, staffing requirements, and patient needs.

PROCEDURES

1. Office hours are normally 8 a.m. to 5 p.m., Monday through Friday, and 8 a.m. to 12 noon on Saturday. Although employees may have flexible or staggered working hours, the Practice maintains staff coverage during all office hours.

2. All employees are required to observe a lunch break or meal break of not less than 30 minutes and not more than one hour during each eight hour period. This lunch break shall be in addition to the hours of work used to determine the length of the workday.

3. There is no scheduled time or place for restroom breaks. Employees are encouraged to use the restroom whenever time allows and office flow is not disrupted.

4. Work beyond the regularly scheduled work shift is not encouraged. Overtime is permitted only upon approval from a supervisor. Documentation must be provided for the hours accrued, and the reason for them, to the Administrator or designee.

    a. Occasionally, it may be necessary to work overtime.

    b. Employees are expected to stay when required and non-exempt employees will be compensated for overtime at the rate of one and one-half (1½) times the regular hourly rate, if the time worked is more than 40 hours per workweek (the fixed and regularly recurring period of 168 hours — seven consecutive 24-hour periods, as defined by the Practice).

5. If an employee remains home on a workday due to illness, injury, or other justifiable reason, he or she must notify his or her supervisor according to the contact protocol established by the supervisor. The employee is expected to call personally. If for physical reasons, he or she is unable to do so, a member of the immediate family should call.

6. Excessive tardiness or absenteeism is considered a lack of dedication, and duly noted in an employee's personnel file. Any tardiness, regardless of the amount, may be subject to corrective action.

PERSONNEL • POLICY 2.03

On-Call Program

It is the policy of the Practice to assign on-call responsibilities in circumstances when patient care is required outside of normal office hours. To fulfill its responsibilities to patients, under certain specified conditions, the Practice requests employees to be on call and subject to immediate recall to duty to perform the type and scope of duties for which they were hired.

The Practice complies with all applicable federal and state laws regarding compensation for on-call employees.

PROCEDURES

1. Establishment of an on-call program

   a. If a department director or supervisor wishes to establish or formalize an on-call program, a written recommendation must be submitted to and approved by the Administrator or designee, the human resources manager, and then by the president. Recommendations are to include the following information:

      1) Reason for requesting on-call coverage;

      2) The number of employees to be utilized and number of shifts to be covered; and

      3) The projected cost, including overtime.

2. Coordinating on-call resources

   a. The Administrator or designee oversees the on-call program. Upon receiving an On-Call Staffing Request Form (see below) from a supervisor or department director, the Administrator or designee schedules the on-call employee as appropriate.

ON-CALL STAFFING REQUEST FORM

Name: _____

Department: _____

Phone/Fax #: _____

Position to be filled: _____

Dates to be covered: _____

Please list and fully explain any contingencies or possible expansion of the coverage date.

_____

_____

_____

Reason for coverage:

_____

_____

_____

_____

Department Director_____ Date _____

PERSONNEL • POLICY 2.04

Flexible Hours

It is the policy of the Practice to implement flexible hours for an employee when it supports the efficiency of Practice operations. The normal workday for a full-time, non-exempt employee is eight hours, not including the nonpaid meal period. Various factors, such as workloads, operational efficiency, staffing needs, and work schedules, may require variations in the employee's starting and ending times.

PROCEDURES

1. An employee's supervisor considers the needs of the organization when scheduling any variations to the employee's workweek.

2. The supervisor issues the starting and ending times of each employee's standard workday and workweek.

3. Punctual and consistent attendance is a condition of employment.

4. If an employee's standard workweek consists of a 10-hour, four-day workweek, holiday pay is calculated at the normal eight-hour workday rate, if the holiday falls on one of the employee's workdays.

PERSONNEL • POLICY 2.05

Employee Classifications

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law.*

It is the policy of the Practice to classify each employee in one of the following position types: regular, temporary, or per diem. These position types may be filled on a full-time or part-time basis. In addition, each employee is classified with one of the following employee statuses: orientation, regular, or promotional-orientation.

Regardless of classification, the Practice provides employment on an "at will" basis. Although the Practice does offer an orientation period, all employees remain "at will" even after the completion of the orientation period. The Practice reserves the right to discharge regular, temporary, or per diem employees at any time or for any reason.

PROCEDURES

The following defines each employee's status and position type:

1. An employee in a full-time position works at least 36 hours per week.

2. An employee in a part-time position works less than 36 hours per week.

3. Temporary positions are created to meet special Practice needs. A temporary position can be either full-time or part-time. No benefits are granted.

4. An employee in a per diem position works as needed and does not have an established work schedule.

5. Regular employee status is awarded to an employee who has successfully completed a six-month orientation period and earned all rights and benefits afforded to regular employees. Even after the completion of the orientation period, employment remains "at will."

6. Orientation status is given when a new employee is first hired or when a former employee is rehired.

7. Promotional-orientation status is given to a regular status employee who has been promoted to a higher-level position.

PERSONNEL • POLICY 2.06

Per Diem Employees

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law. The content of this policy should altered based on the needs of your Practice. Some or all of the material included in this policy may be incorporated in the agreement with the per-diem employee(s).*

It is the policy of the Practice to maintain per diem employees to provide flexibility in cases of fluctuating workload, to provide a consistent quality of service, and to control costs.

PROCEDURES

1. A per diem employee is defined as follows:

    a. Available to work a rotation of shifts (i.e., day/evening, straight evening, or straight weekends).

    b. Available for eight shifts per four-week period, including two weekend shifts.

    c. Available to work Thanksgiving, the day after Thanksgiving, Christmas, or New Year's Eve or New Year's Day, and available to work either Memorial Day, Independence Day, or Labor Day.

    d. Provides the manager with specific dates and times available to work two weeks in advance of available time and agrees to work those times when called or scheduled.

    e. Not guaranteed a minimum number of hours of work per week and works at the discretion of management.

    f. Subject to call-in, if not scheduled, until the start of the designated date and shifts.

2. A per diem employee may be ineligible to maintain this status if he or she:

    a. Fails to respond to call-in during times and dates specified to the manager as being available, for a total of three times in a 12-month period.

    b. Is not available for a period of 90 days.

3. A per diem employee satisfies the available-for-work commitment by meeting one of the following conditions regarding designated shifts:

    a. The employee is available for the designated shift and not called in or scheduled.

    b. The employee is available for multiple, designated shifts and called in or scheduled on one of the shifts in the 24-hour period.

    c. The employee is available for a designated shift, but called in or scheduled for another shift within a 24-hour period.

    d. The employee is available for a designated shift (called-in or scheduled), reported for work but work cancelled upon arrival or during the first two hours of reporting.

4. In the event that the practice cancels work upon arrival or during the first two hours of reporting, the per diem employee receives two hours of call-in pay.

5. The per diem employee is required to cancel availability a minimum of 24 hours before the designated shift.

6. Supervisors communicate refusal to work or concerns regarding quality of work and training needs to the human resources department.

7. Per diem employees maintain one time sheet for the pay period and designate the location of the hours worked in the comments section. Each record of hours worked at a Practice site must be signed by a supervisor.

8. Time sheets must be turned in to the supervisor by 8 a.m. on the Monday following the end of the pay period.

9. Mileage is paid for the distance between two Practice sites or Practice centers if the per diem employee works in more than one Practice site during any one day. (Mileage forms and travel expense reports must be submitted to the supervisor.) The supervisor submitting the per diem employee's time sheet forwards it to the central human resources department, indicating which cost center is charged for hours worked.

10. All paychecks for per diem employees are mailed to the employee's home address on Thursday evening prior to the regular Friday pay date.

11. A per diem employee is required to follow all other policies and procedures of the Practice.

12. A per diem employee is eligible for wage increases in accordance with established policies and procedures with effective date consideration given for the amount of time actually worked during the evaluation period.

13. A per diem employee is not entitled to the following employee benefit plans or policies, except as provided by law: health insurance, dental insurance, life insurance, long-term disability insurance, bereavement leave, personal paid days off, extended illness bank, parking discounts, tuition reimbursement, employee assistance program, child care referral service, and service awards program.

PERSONNEL • POLICY 2.07

Nepotism

It is the policy of the Practice that family members of employees may be considered for employment if the circumstances of employment do not create an actual or apparent conflict of interest. Employees cannot be supervised (either directly or within the same reporting structure) by a family member.

For the purposes of this policy, the term "family member" includes parents, stepparents, spouses, children, stepchildren, siblings, step-siblings, grandparents, grandchildren, aunts, uncles, nieces, nephews, first cousins, children's spouses, in-laws, or any individual for whom the employee is the primary child care provider.

PROCEDURES

1. A supervisor may not participate in decisions about hiring, evaluation, termination, salary, promotion, monetary awards, or other personal interest for a family member employed by the Practice as defined in this policy.

    a. This prohibition applies even when the supervisor is not in the direct line of authority over that employee.

    b. This prohibition does not apply to a decision that is made about a work unit consisting of several employees.

2. Supervisors who become related to an employee they directly supervise must notify their immediate superior within 10 working days after the supervisor and employee become related. At that time, the administrator or designee will make a decision regarding the future supervision of the employee who is now being supervised by a family member.

3. The Practice may authorize the appointment of a person to a position that would otherwise violate this nepotism policy if the Practice determines that enforcement of the policy will be impracticable and cause an undue hardship to the Practice. Factors that the Practice may consider in making such an exception include the difficulty in recruiting applicants for the positions affected by the nepotism policy.

PERSONNEL • POLICY 2.08

Salary Determination

It is the policy of the Practice to provide a salary structure for exempt and non-exempt positions. This policy enables the Practice to attract qualified, competent staff while at the same time maintaining appropriate internal salary equity.

PROCEDURES

1. Basis for salary determination

    a. Starting salaries for new employees take into account the following factors:

        1) The established salary range for the position;

        2) The qualifications of the candidate in comparison to both the requirements of the position and to the qualifications of any incumbents in the same or comparable positions within the Practice;

        3) The salary of any incumbents in the same or comparable positions within the Practice;

        4) Marketplace conditions; and

        5) Budgetary considerations.

    b. The following factors are used to establish a fair and equitable salary for all employees:

        1) Salary range for the position;

        2) Training and experience required for the position;

        3) Attitude, cooperation, loyalty, and dedication;

4) Attendance;

5) Initiative;

6) Quality and quantity of work; and

7) Ability to follow instructions.

c. Salary scales are based on the technical training, experience, and responsibility of the position held. The prevailing salary scale in the community or area constitutes the basis for salaries.

2. Definitions of terms

a. Management/exempt/supervisory: Positions classified as exempt are part of the management salary structure. An exempt individual is a professional whose primary duty consists of the performance of work that requires an advanced type of knowledge or skill. These positions are graded using a salary range with a minimum, midpoint, and maximum. Employees hired into these positions are exempt from the overtime compensation provisions of federal and state wage and hour regulations.

b. Non-exempt/hourly: Positions classified as non-exempt are governed by wage and hour regulations. These positions are graded using a scale, established by the director of human resources and approved annually by the Administrator.

3. Determination of starting salary

Management determines a candidate's starting salary based on the candidate's education, experience, and qualifications, and how these correlate to the position requirements, as well as how these criteria compare to the qualifications of incumbents.

4. Procedures for exempt employees

a. Starting salary

The Administrator and human resources director determine the starting salary for candidates below the level of Administrator by considering the appropriate salary range up to and including the midpoint of the range. The human resources director reviews and approves any salary recommendation that is above the midpoint of the range.

b. Salary increases

Salaries of exempt employees are generally reviewed at the end of a six-month probationary period and on an anniversary date on an annual basis thereafter.

1) Orientation period review

Unless otherwise approved, the six-month orientation increase is as much as one-half the determined percentage merit increase for the year in which the individual completes the orientation period.

2) Annual review

a) This is a merit system and the amount of the annual increase will be determined by a number of factors, which include:

- Budgetary considerations;
- Employee's job performance; and
- Length of time employee has been in position.

b) An anniversary date will be established for the review of salary increases.

5. Procedures for non-exempt employees

a. Starting salary

Starting salary is based on a candidate's verified work experience, education, and qualifications. Non-exempt candidates will be hired at a salary step commensurate with appropriate experience. Candidates are normally given one year of credit for each year of verified relevant experience.

b. Salary increases

Non-exempt employees are eligible for salary increases on an annual basis. Increases for non-exempt employees are generally a combination of an annual general wage adjustment and a step increase on the employee's anniversary date.

c. General wage increase

A general wage increase represents movement in the non-exempt structure that results in an increase in the employee's current step rate. This adjustment is not related to job performance, but is a reflection of marketplace factors. All hourly employees are eligible to receive this increase regardless of their step in the range.

d. Step increase

A step increase represents an increase that is based upon satisfactory or better performance in the employee's position. If the employee does not receive a satisfactory score on the evaluation, he or she will not receive the step increase for

the current year. Usually, an employee progresses through the wage scale for the position based upon performance until he or she reaches the maximum salary of the range. At this point, he or she is no longer eligible for step increases. However, he or she may receive general wage adjustments.

6. Salary adjustments

a. Appropriate salary adjustments will be determined and implemented when an employee is either promoted to a position of greater responsibility or demoted to a position that is assigned to a lower grade.

1) Annual step increase

a) Promotion—If an employee is promoted, the eligibility date of the step increase changes to one year following the effective date of the promotion.

b) Demotion—If the employee takes a voluntary demotion that results in a pay decrease, the eligibility date of the step increase remains the same.

2) Base rate frozen employees

a) An employee whose salary is at or above the maximum level in his or her new position as a result of job or departmental restructuring may have their base salary rate frozen. This means that the employee will remain at his or her current hourly step rate and will no longer be eligible for step increases. However, he or she is eligible to receive general wage increases or special marketplace adjustments until the wage scale catches up.

b) When an employee is temporarily promoted to supervisory position to cover a vacancy or leave of absence, his or her hourly rate is not adjusted. Rather, he or she is eligible to receive charge pay determined by market rates.

7. Salary surveys

a) The Practice periodically assesses the competitiveness of its wage rates. The assessment is the responsibility of the human resources department, which conducts salary surveys in accordance with statutory guidelines.

8. Exceptions to policy

a) It shall be the responsibility of the human resources director to ensure compliance with this policy. Any exception to this policy requires joint approval of the human resources director and the Administrator.

PERSONNEL • POLICY 2.09

Wage and Salary Administration

It is the policy of the Practice to maintain wage and salary administration in compliance with all governmental regulatory agencies. The Practice will follow consistent procedures for job evaluation, wage and salary adjustments, special pay practices, and the implementation of the wage and salary program.

PROCEDURES

1. Salary schedule

Wage and salary administration is accomplished in a manner that achieves a consistent, basic compensation practice throughout the Practice, without regard to *marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law*. (See related policy 2.08 on Salary Determination.)

2. Pay offers

   a. Managers and supervisors making pay offers to employees upon initial employment or reinstatement with the Practice must comply with the following:

      1) Offers are based on the specific training, experience, and ability of the applicant in relation to the value of the position as determined by the pay grade.

      2) A reinstated employee who was paid at entry level and reinstated into the same classification is placed at the same rate of pay if the pay range has not been adjusted. If the pay range has been adjusted, the rate is the new entry-level rate. If reinstated to a different classification, the individual is treated as a new hire. The pay and performance review dates are based on the reinstatement date.

      3) A reemployed employee (took leave without pay or was laid off) is placed into the last pay rate held before the leave without pay or layoff occurred. If reemployed to

a different classification, the individual is treated as a new hire. The pay and performance review dates do not change. Unless the employee returns from a leave without pay for more than 14 days within one pay period, the review dates are moved ahead for each day following.

4) An employee who was laid off due to lack of work, and who is later reemployed in the same position, is reemployed at the same rate paid at the time of layoff. A laid-off employee who is reemployed in a different position is treated as a new hire for purposes of determining the starting rate.

3. Merit increases

a. Merit increases are only granted to those employees whose performance warrants an increase. A signed performance review form must accompany all requests for merit increases. Performance reviews may be conducted as frequently as necessary. A performance review must be completed after six months of employment, as well as at least once a year for each employee.

b. Temporary employees are defined as employees who are hired to perform a specific job, which is expected to continue for a period of six months or less. For this reason, merit increases are not typically granted to temporary employees.

c. Should an employee in temporary status be transferred to regular status in the same classification, eligibility for merit review is based on the original date of hire.

d. An employee returning from leave with pay receives an increase upon his or her return if the merit review date occurred while on paid leave and the employee's work performance was satisfactory before the paid leave occurred.

4. Promotional increases

a. The Practice encourages promotions and career advancements by generally recognizing that an increase in responsibility is accompanied by a pay increase. A promotion is defined as the transfer of an employee to a position with increased duties
and responsibilities and a pay grade higher than the previously held position.

b. Promotional increases are granted on the effective date the employee is required to perform the duties and responsibilities of the new position and are planned to coincide with the start of a payroll period.

c. Eligibility for future merit increases is based on the effective date of the promotional increase.

5. Lateral transfers

    a. When an employee transfers from one classification to another classification with the same pay grade, there is no salary adjustment. Eligibility date for the next merit increase does not change.

    b. The department receiving the employee is responsible for coordinating the time sheets between the receiving and departing departments. The department the employee is leaving sends the status change form to the receiving department.

6. Payroll

    a. Payroll periods cover a two-week time frame beginning on the 1st and 15th of each month. This is a 336-hour time frame with each workweek consisting of as many as 168 hours.

    b. The official record used to determine an employee's pay is the time sheet. Each day an employee is scheduled, he or she records pertinent information on the time sheet. At the end of each payroll period, the appropriate supervisor verifies each employee's record of time.

    c. Employees are paid on the Friday following the end of each payroll period. Several options are available for receiving paychecks:

        1) The most preferred method is direct deposit. By completing an authorization form with the human resources department, employees can have their paychecks automatically deposited into their bank accounts.

        2) Managers or their designees may pick up their employees' paychecks or records and distribute them to their employees.

    d. Certain payroll deductions or withholdings are made from an employee's paycheck. By law, those deductions are:

        1) Federal income tax;

        2) Social Security payroll taxes (FICA);

        3) State tax;

        4) City/county occupational tax; and

        5) All garnished payments required by a court.

    e. Employees may request the following withholdings (if applicable) from their paycheck when authorized in writing and signed by the employee:

1) Health insurance;

2) Dental insurance;

3) Life insurance;

4) Parking fee;

5) Uniform fee; and

6) Retirement.

7. Overtime

   a. Overtime is one and one-half (1½) times the base pay rate for covered non-exempt employees for hours worked over 40 per workweek (the fixed and regularly recurring period of 168 hours — seven consecutive 24-hour periods, as established by the Practice). Non-exempt (hourly) employees subject to federal and state overtime regulations are eligible for overtime, regardless of their employment status (i.e., full-time, part-time, or temporary). Exempt (salaried) employees are not eligible for overtime.

   b. Not included in overtime calculations are vacation, sick, holiday, and any other leave with pay or leave without pay. Working hours only are included.

   c. Non-exempt employees may work overtime only upon the request and authorization of the immediate supervisor. The immediate supervisor must approve overtime hours and document the reason for the overtime, and they are paid at the premium rate required by state and federal law.

   d. Hours worked include only time actually spent on the job. They do not include vacation, sickness, or holiday hours. For purposes of calculating overtime pay, unpaid sick leave, personal leave, and any other time away from work are not considered hours worked.

8. Holiday premium

   a. Non-exempt (hourly) employees working on a recognized holiday receive premium pay (1½ times the hours worked).

   b. Recognized holidays are:

      1) New Year’s Day;

      2) Memorial Day;

3) Independence Day;

4) Labor Day;

5) Thanksgiving Day; and

6) Christmas Day.

c. Holiday hours eligible for premium pay are those hours worked between 12:01 a.m. and midnight on the holiday.

d. A recognized holiday occurring on a Saturday is observed on the previous Friday. A recognized holiday occurring on a Sunday is observed on the following Monday.

9. Severance pay

a. An employee is eligible for severance pay only if the separation is the result of a layoff due to reduction of the workforce.

b. Employees who have completed the introductory period and have less than five years of service are paid two weeks of severance pay. The amount is based on scheduled hours before the layoff.

c. Employees with five or more years of service are paid four weeks of severance pay. The amount is based on scheduled hours before the layoff.

PERSONNEL • POLICY 2.10

Timekeeping

It is the policy of the Practice to require all non-exempt employees (those subject to the minimum wage and overtime provisions of the Fair Labor Standards Act) to record work hours by means of a paper or electronic timekeeping system that indicates daily hours worked.

PROCEDURES

1. Employees will report to work no earlier than five minutes before their work schedule begins and leave no later than five minutes after it ends.

2. Employees are responsible for accurately recording their time. If an employee discovers any inaccuracies, he or she will contact his or her supervisor immediately to complete a correction form.

3. The employee must record his or her own time, never the time of another employee or vice versa.

4. The time sheet is a legal document. Falsification of time sheets or other timekeeping documents is grounds for disciplinary action, up to and including termination of employment.

5. Time sheets and other timekeeping devices are the property of the Practice. Employees may not destroy them.

PERSONNEL • POLICY 2.11

Direct Deposit

It is the policy of the Practice to provide direct deposit of an enrolled employee's paycheck into his or her bank account.

PROCEDURES

1. To enroll in direct deposit, an employee needs to complete an Authorization Agreement for Direct Deposit Form (see below).

2. Employees may elect to use direct deposit anytime during their employment.

3. It takes two pay periods to activate the automatic process; in the meantime, an employee will receive his or her paycheck according to the normal schedule of the Practice. (See related policy 2.09 on Wage and Salary Administration.)

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Practice name _____

I (we) hereby authorize [Name of Practice] to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated below; and I authorize the bank named below to credit and/or debit the same to such account.

Bank name: _____

Please check only one for type of account below:

Checking _____

Savings _____

City: _____ State: _____ ZIP: _____

Transit #: _____ Account #: _____

This authority is to remain in full force and effect until [Name of Practice] has received written notification from me or the Administrator or designee of its termination in such time and in such manner as to afford the payroll company and the bank a reasonable opportunity to act on it.

Employee name: _____

Social Security #: _____

Date: _____ Signature: _____

Please attach a voided check to this form below.

PERSONNEL • POLICY 2.12

Equal Employment Opportunity

It is the policy of the Practice to provide equal employment opportunities to all employees and potential employees through a positive and continuing program that prohibits discrimination in employment because of marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law. Potential and current employees are eligible for employment provided they meet the qualifications and can perform the essential functions of the position for which they are applying, with or without accommodation.

This policy applies to but is not limited to all activities involving communications, recruitment, job placement and promotions, training and educational programs, layoffs and terminations, compensation, employee benefits, and working conditions.

PROCEDURES

1. The human resources director implements this policy throughout the Practice.

2. The human resources department ensures compliance with this policy.

3. Department directors and supervisors ensure compliance with this policy with regard to any employment decisions within their jurisdiction.

PERSONNEL • POLICY 2.13

Employment Processing

It is the policy of the Practice to follow a defined methodology of processing candidates for employment. The Practice relies on the accuracy of information contained in the employment application, as well as the accuracy of other data presented throughout the hiring process and subsequent employment, to ensure an appropriate fit for both the candidate and the employer.

PROCEDURES

1. Any misrepresentations, falsifications, or material omissions in any of the employment information submitted may result in the exclusion of the candidate from further consideration for employment or, if the candidate has been hired, termination of employment.

2. For hiring and/or employment considerations, the Practice may obtain a consumer credit report concerning credit worthiness, credit standing, and credit capacity; a compliance report concerning any violations of local, state, or federal law; and a screening test for drugs.

3. If the Practice discovers any violations that require an adverse hiring decision or employment action based in whole or in part on a consumer credit, compliance, or drug screen report, a copy of the report and a summary of individual rights is provided to the candidate or employee, as well as any other documents required by law.

PERSONNEL • POLICY 2.14

Selection Steps

It is the policy of the Practice to establish and follow fair, consistent, and nondiscriminatory employee practices in compliance with all applicable federal and state regulations, including the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, and the Americans with Disabilities Act. The human resources department recruits, screens, and refers qualified applicants to be considered for employment. The Administrator or designee selects the final candidate.

PROCEDURES

1. Recruitment

   a. Position vacancies are filled in accordance with the Practice's budget for the applicable department or site.

   b. To initiate the recruitment process, a supervisor who recognizes a personnel need completes and submits a Personnel Requisition Form (see below).

   c. Through the application of the Practice's job posting system, every effort is made to identify qualified candidates from within the Practice. In addition, recruitment advertising is generally conducted simultaneously in an effort to recruit a wide selection of qualified candidates for positions.

   d. In an effort to fill vacancies, the Practice may utilize a variety of recruitment sources, including:

      • Online job postings;
      • Recruiters;
      •Newspaper advertising;
      • Employee referrals;
      • Professional journals;

- Employment agencies;
- Campus recruitment;
- Career days; and
- Other recruitment sources.

e. The human resources department coordinates all recruitment activity and related postings. In addition to determining the efficacy and selecting the media used, the human resources department plans and places all recruitment postings. If a search firm or employee agency is used, approval of the human resources director and the Administrator or designee is required in advance.

f. No posting will appear that in any way discriminates against any individual with regard to marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law.

2. Employment application

a. All applicants for positions will complete an employment application. The human resources department reviews applications to determine qualifications of selected individuals before interviews are scheduled.

b. Applications are carefully reviewed for appropriate items (see sample forms below), including:

- Professional licensure;
- Work status;
- Experience; and
- Education.

3. Initial employment interview

a. The human resources department conducts preliminary screening of all qualified applicants. This screening process includes:

- An application review;
- A discussion of qualifications and experience; and
- A discussion of the job description and Practice benefits and salary.

b. All candidates interviewed are recorded on a Recruitment Record Form (see below), which is maintained by the human resources department.

4. Departmental interview

The human resources department coordinates all interviews with the appropriate supervisor.

a. The human resources department forwards an application and interview evaluation form for each referred candidate.

b. Departmental interviews focus on assessing specialized qualifications and skills in terms of the specific, essential duties of the position. The departmental interviewer fully discusses the job description with the applicant.

c. At the completion of the interview, the supervisor forwards all completed interviewer evaluation forms to human resources. These forms must include job-related reasons why candidates were or were not acceptable.

d. When the department has identified a final candidate, the departmental interviewer confers with the human resources department to:

1) Discuss the applicant's acceptability;

2) Determine the additional follow-up required (i.e., references, licensure, education verification); and

3) Establish a starting salary and the start date of employment.

5. Background checks

Before making an offer of employment, the human resources department thoroughly checks the employment and educational references, background, and drug use of all candidates. This aids in determining an applicant's ability to meet the requirements of the position for which he or she is applying. (See the Applicant Reference Check form below and related policies 2.43 on Drug Screening and 2.15 on Background Checks.)

a. All candidates complete an Applicant Information Release form (see below) to authorize reference checks and background investigations.

b. The human resources director or designee performs references with a minimum of two persons, including one former employer. Verification of employment, education, and credentials are obtained from applicable sources.

c. Unsatisfactory references may preclude the employment of a job candidate.

d. If a candidate does not permit contact with his or her present employer before the job offer is made, the candidate is advised that upon acceptance of an offer, the present employer is contacted and such offer is contingent upon a satisfactory reference from this employer.

e. Any misrepresentation, falsification, or willful omission of information on the employment application or any other employment documents renders such records void and is grounds for disciplinary action, refusal of employment, or discharge from employment, without regard to when the falsification of records is discovered.

f. All information obtained during the reference check is privileged and confidential and is not shared or discussed with anyone.

g. Educational requirements are verified for each position according to the Educational Requirements Guideline (see below).

6. Approval

The Administrator or designee approves all candidates.

7. Offer of employment

a. Although the department makes the selection of a final candidate, it is understood that the human resources department makes all offers of employment.

b. The human resources department ensures that the starting salary complies with the Practice's compensation program and does not conflict with salaries for comparable positions within the Practice.

c. An offer-of-employment letter is prepared for all new employees confirming the start date, title, hours, and other conditions of employment.

8. Notification

a. The human resources department is responsible for notifying all candidates of the final decision of employment.

b. The human resources department director completes and submits the approved requisition.

c. The human resources department coordinates all recruitment activities, which include: arranging initial interviews, determining starting salary, initiating offer, and completing references of selected candidates.

PERSONNEL REQUISITION FORM

Request for: _____ New position _____ Existing position

Title of position to be filled: _____ Date of position to be filled: _____

Location of position: _____ Job code: _____

Name of employee being replaced: _____

Job title: _____

Work schedule: _____

Salary range: _____ Description established: ____ Yes ____ No

Justification for creating or filling position: _____

_____

(attach pages, as necessary)

_____

Supervisor Signature Date

_____

Administrator or Designee Signature Date

To Be Completed by the Human Resources Department

Date request received: _____

Job description approved: _____

Employment ads placed: (location and date)

_____

_____

_____

RECRUITMENT RECORD

Name of candidate: _____ Date interviewed: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

To Be Completed by the Human Resources Department

Name of person filling position: _____

Starting date: _____

Date scheduled for orientation: _____

Date letter sent: _____

Comments: _____

_____

APPLICANT INFORMATION RELEASE

This authorization and consent for release of personal information acknowledges that the Practice and its agent may now, or at any time I am employed by the Practice, conduct investigations, whether the records are of a public, private, or confidential nature.

I hereby certify that the information contained in this application form is true, correct, and complete. I understand that if any information proves to be incorrect or incomplete, grounds for the canceling of any and all offers of employment will exist and may be used at the discretion of the Practice. I understand that investigative inquiries on my background, in accordance with the Fair Credit Reporting Act and all state and federal laws, will be made on me, including information as to my personal character, abilities, work habits, mode of living, residency, general reputation, performance, experience, and other qualities pertinent to my qualifications for employment, including reasons for termination of past employment.

I understand that my prospective employer may make inquiries including, but not limited to, my consumer credit history, education, professional licensing, and criminal history and driving history. Furthermore, I understand that my prospective employer and the Practice may request information from various federal, state, and other agencies that maintain records concerning my past driving history, credit history, criminal history, military history, and civil and other experiences.

I understand that according to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my prospective employer from a Consumer Reporting Agency. Upon written request, I will be informed whether an investigative consumer report was requested and will be given full information as to the nature and the scope of the investigation, as well as the name of the reporting agency or sources of information.

I authorize without reservation, any party (including, but not limited to, employers, law enforcement agencies, state institutions, and private information bureaus or repositories) contacted by the prospective employers from any and all liability for damages arising from the investigation and disclosure of the requested information. I further release and discharge all liability from all companies, agencies, officials, officers, employees, and other persons who, in good faith, provide to the prospective employer the abovementioned information as requested, in order to successfully complete a background investigation for my application of employment. I will allow a photocopy of this authorization to be valid as the original.

Print full name: _____

Social Security #: _____ Date of birth*: _____

Current address: _____

City/State/ZIP: _____

Driver's license #: _____

Prospective employer: _____

Applicant's signature: _____ Date: _____

** Date of birth is being requested only for the purpose of identification in obtaining accurate retrieval of records and will not be used for discriminatory purposes.*

APPLICANT REFERENCE CHECK

Name of applicant: _____

Person contacted: _____

Position or title: _____

Company: _____

City: _____ State: _____ Phone #: _____

I would like to verify some of the information given to us by (Mr., Ms.) _____, who is applying for a position with our company.

1. What were the dates of his or her employment with you?

From 19___ or 20___ to 19___ or 20___

2. What was the nature of his or her job?

_____

3. What did you think of his or her work?

_____

4. How would you describe his or her performance in comparison with other employees?

_____

5. What job progress did he or she make? _____

6. What were his or her earnings? _____

7. Why did he or she leave your company? _____

8. Would you rehire this employee? Yes___ No___ (Why not?)

_____

_____

9. What are his or her strong points? _____

_____

10. What are his or her limitations? _____

_____

11. How did he or she get along with other people? _____

_____

12. Please comment on his or her:

(a) Attendance _____

(b) Dependability _____

(c) Ability to take on responsibility _____

(d) Potential for advancement _____

_____

(e) Degree of supervision needed _____

_____

_____

(f) Overall attitude _____

_____

13. Did he or she have any personal difficulties that interfered with his or her work?

_____

14. Is there anything else about this applicant that we should know?

_____

_____

Date: _____ Checked by: _____

EDUCATIONAL REQUIREMENTS GUIDELINE

The Educational Requirements Guideline is used to assess educational requirements for the position and serves as a guide for assessing the education of the candidates.

FORMAL EDUCATION	EQUIVALENT TO
1. Elementary	Ability to read, write, add, subtract, use simple tools
2. 4 years high school	Vocational or business skills, such as typing, dictation, mechanics, drafting
3. 18 or fewer months of university, community college, business school	More advanced knowledge of vocational or business field (e.g., bookkeeping, licensed practical nursing)
4. 18 months to 3 years of specialty or technical training	Associate degree (2-year) or special training programs, such as laboratory technician
5. College degree	Advanced training (4-year degree) in field of study, such as business, accounting, nursing
6. Master's degree	Advanced professional training in a well-defined field of study, such as business or accounting
7. Doctoral degree	Extensive, advanced study, including the conduct of significant, original research

List any officially recognized certificates, licenses, and other required qualifications necessary for the position.

PERSONNEL • POLICY 2.15

Background Check

It is the policy of the Practice to actively recruit and hire qualified applicants regardless of marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law.

When considering an applicant for employment, making a decision whether to offer employment, deciding whether to continue employment (if an individual is hired), and making other employment-related decisions directly affecting an employee or candidate for a position in the Practice, the Practice will conduct a background check. The Practice may obtain and use a consumer report or an investigative consumer report from an external consumer reporting agency for employment purposes.

PROCEDURES

1. A consumer reporting agency is a person or business that regularly assembles or evaluates consumer credit information or other information on consumers. Applicants or employees are considered a "consumer" under the Fair Credit Reporting Act.

2. A consumer report may include information about character, general reputation, personal characteristics, or mode of living, which is used or collected for employment purposes. An investigative consumer report also involves personal interviews with sources such as employers and educators.

3. The Practice informs applicants or employees that all consumers have a right to request disclosures of the full information as to the nature and scope of any investigative consumer report that a company obtains. Consumers also have other rights under the Fair Credit Reporting Act.[2]

4. The Office of Inspector General's List of Excluded Individuals/Entities (LEIE)[3] is searched for all candidates to assure that candidates have not been debarred from federal, state, or other similar healthcare programs. Job offers are not extended to any debarred candidates.

[2] Federal Trade Commission. Fair Credit Reporting Act. Available at: http://www.consumer.ftc.gov/sites/default/files/articles/pdf/pdf-0111-fair-credit-reporting-act.pdf Accessed February 6, 2015.

[3] U.S. Department of Health and Human Services Office of Inspector General. List of Excluded Individuals/Entities (LEIE). Available at: https://oig.hhs.gov/exclusions/exclusions_list.asp. Accessed February 6, 2015.

ACKNOWLEDGMENT AND AUTHORIZATION

I hereby authorize and acknowledge that the Practice may obtain investigative consumer reports and a Cumulative Sanction Report from the Office of Inspector General about me from any consumer reporting agency or federal reporting agency and may consider information in consumer reports and investigative consumer reports when making decisions regarding any aspect of my application for employment and/or continued employment with the company including periodic re-screening of current employees.

I understand that according to the Federal Fair Credit Reporting Act, I am entitled to know whether employment was denied based upon the information obtained and to receive, upon written request, a disclosure of the background report. I also understand that I may request a copy of the report from the reporting agency.

In addition, I release and discharge the company and its agent and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs expenses, or any other charge or complaint filed with any agency arising from retrieving and reporting this information.

Signature: _____

Full legal name (please print): _____ Date: _____

Witness signature: _____

Witness name printed: _____ Date: _____

PERSONNEL • POLICY 2.16

Orientation and Training

It is the policy of the Practice to provide an orientation session to help all new employees learn more about the Practice and what is expected of them as members of the organization. Orientation to the Practice's standard policies and procedures ensures consistency among staff. Consistent understanding and adherence to policies and procedures decreases uncertainty, errors, and duplication of effort. All other training of new employees takes place within their particular work area.

PROCEDURES

1. Orientation session

    a. When hired, a new employee is scheduled for an orientation session. The session includes a review of the following orientation agenda:

        Orientation Agenda

        1) Practice mission

        2) Organizational policies and procedures

        3) Personnel benefits

        4) Position requirements

        5) Department familiarization

        6) Training schedule for skill requirements

    b. Each new employee completes the Orientation Checklist (see below). The checklist is used to ensure completion of the orientation process. When completed, the employee turns in the checklist to the human resources department.

c. A new employee must sign W-2 (Wage and Tax Statement) and I-9 (Employment Eligibility Verification) forms in compliance with government regulations.

d. The employee's supervisor or representative supplies the new employee with a copy of the Practice Policy and Procedure Manual, which should be read thoroughly.

e. When hired, each employee receives a written job description.

f. Specific training on the practice management, electronic health record, and telephone systems, as well as other tools and resources, as required by the position, is provided.

ORIENTATION CHECKLIST

Name: _____ Date of hire: _____

Department: _____ Job title: _____

DATE COMPLETED	TOPICS
	History of Practice
	Mission of Practice
	Review of employee handbook and sign off (If applicable, list specific policies)
	Procedure training for department or role to which employee is assigned
	Job description and sign off
	Telephone training
	Practice management system training
	Electronic health records system training
	New hire personnel information form
	Health insurance
	Consolidated Omnibus Budget Reconciliation Act (COBRA)
	Dental insurance
	Life insurance
	Disability insurance
	Flexible spending account
	Leave
	Expense reimbursement forms

	Equipment
	Paydays/direct deposit
	Tax forms
	I-9 documentation
	Other

I hereby acknowledge that the above listed topics have been explained to me. I understand that the policies and procedures of the Practice are not to be construed as a contract or agreement. I understand and agree that the Practice may change or modify this information and other policies and procedures relating to employment matters from time to time as it considers necessary in its sole discretion, either in individual or Practice-wide situations, without notice to me. I understand that the policies and topics listed above may change and that I will be notified in writing of those changes as they occur.

Employee's signature: _____ Date: _____

This Section to Be Completed by the Human Resources Department

Application date: _____

DATE COMPLETED	APPLICATION	DATE	APPLICATION	DATE
	References		Flex benefit form	
	New hire form		Life insurance form	
	Federal tax form (W4)		COBRA letter	
	State tax form		I-9 documentation	
	Job description (signed)		Direct deposit (cancelled check)	
	Receipt-of-handbook acknowledgment		Other	

PERSONNEL • POLICY 2.17

Competency Assessment

It is the policy of the Practice that every employee is assessed for competence in his or her assigned tasks and responsibilities.

PROCEDURES

1. To evaluate an employee's knowledge of assigned tasks and responsibilities, he or she takes a competency assessment every two years.

2. The employee's supervisor initially creates and then updates the competency assessment.

3. If the employee does not meet the competency requirement determined by the department, additional training is provided immediately. After training, a follow-up competency assessment is administered. If there is no change, the supervisor incorporates the issue into the employee's performance evaluation process.

4. A sample of a competency assessment for an employee responsible for registration and scheduling is provided herein.

COMPETENCY ASSESSMENT
REGISTRATION AND SCHEDULING

Sample Only

TASK	LEVEL (E, S, OR N)
System sign-on	
Accessing registration menu	
New patient registration	
Identification of guarantor, patient, and dependents	
Editing and updating an account	
Financial clearance (insurance coverage and benefits eligibility)	
Executing commands	
Greeting a caller	
Matching patients' needs to appropriate provider	
Searching for an appointment	
Viewing and moving in the schedule	
Scheduling an appointment	
Canceling and rescheduling an appointment	
Arriving a patient	
Recommendations/Comments:	

Key: E = Excellent; S = Satisfactory; N = Needs additional training

PERSONNEL • POLICY 2.18

Confidentiality Agreement

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law.*

It is the policy of the Practice that all employees review, sign, and adhere to a confidentiality statement.

PROCEDURES

When hired, each new employee receives a confidentiality statement to read, sign, and have witnessed. Because all employees have access to confidential Practice information and trade secrets, in whole or in part, all employees are required to sign a Confidentiality Agreement Acknowledgment of Confidentiality Statement (see below).

This signed statement is kept on file in the employee's personnel file.

CONFIDENTIALITY AGREEMENT
ACKNOWLEDGMENT OF CONFIDENTIALITY STATEMENT

I have received a copy of, read, understand, and agree to uphold the written policy on matters of confidential information and trade secrets. I also understand that in my daily job duties, I have access to confidential Practice operations, and any violation of confidentiality, in whole or in part, could result in disciplinary action, up to and including termination and/or legal action.

Confidential information is defined as any information found in a patient's medical record, personal information, and work-related information (including salary information). All information relating to a patient's care, treatment, or condition constitutes confidential information that is considered protected health information (PHI), and subject to all applicable federal and state laws. This confidentiality policy also encompasses any trade secret and scientific and technical information developed by the Practice or its personnel.

Employees never discuss PHI with any non-employee of the Practice, friends, or family members. Confidential matters involving patients are not discussed in areas where they might be overheard by other patients or other non-employees of the Practice. Employees should take appropriate steps at all times to ensure that conversations regarding PHI are not overheard by others. All salary information is confidential and may not be shared with others in the Practice or with patients. Only authorized individuals may relay salary information to employees or non-employees. Any unauthorized disclosure of confidential information by employees could render the Practice liable for damages. Any employee who violates the confidentiality of the Practice or discloses confidential medical or employee-related information is subject to disciplinary action up to and including termination.

Signed this _____ day of _____

Employee: _____

Witnessed by Practice representative: _____

Date: _____

PERSONNEL • POLICY 2.19

Name Tags for Employees

It is the policy of the Practice that all employees wear name tags while on duty. The Practice believes that patients, family members, caregivers, visitors, and others have a right to know the name and position of the person with whom they are working or who is providing services to them. This is an important part of the personalized service the Practice provides and promotes a positive relationship. The Practice provides a name tag for each employee that must be worn during business hours. The Practice pays for the employee's first name tag.

PROCEDURES

1. The Practice orders a name tag for every new employee following their hire date (full or part-time).

2. The name tag contains the first name and job position.

3. The name tag is usually delivered in about two weeks. A human resources representative brings it to the new employee when it arrives.

4. No additional authorization is required for this part of the employment process. Supervisors know these charges appear against their department budget. They are notified when the charge is incurred. No authorization is necessary.

5. An employee who loses a name tag must request a replacement name tag from his or her supervisor.

6. The supervisor notifies the human resources department to order a name tag for an employee. Any employee who loses his or her name tag is charged $5.00 for the first replacement. The employee is charged $10.00 for each additional replacement. The employee can pay the replacement cost will be deducted from the employee's next paycheck.

7. Charges for replaced name tags are placed against the department budget and the credit for employee reimbursement is credited to the department budget.

8. If an employee changes positions in the Practice and requires a new name tag, the Practice pays for the new name tag and the new department budget is charged as necessary.

9. When a supervisor approves the internal transfer of an employee, no additional authorization is necessary to order a new name tag.

PERSONNEL • POLICY 2.20

Dress Code

It is the policy of the Practice to require every employee to dress professionally and appropriately for his or her position. Each employee represents the Practice to its patients, vendors, and visitors. Because of our responsibility to inspire confidence in our professionalism and high quality of care, employees are expected to wear appropriate dress as defined herein. Each employee is expected to reflect the organization's high standards through professional dress, grooming, conduct, language, and decorum.

PROCEDURES

1. Standards for dress, grooming, and personal cleanliness contribute to the morale of all staff members and affect the business image of the Practice. During business hours, employees are expected to present a clean and neat appearance and dress according to the requirements of their positions.

2. Employees who arrive for work inappropriately dressed are sent home to remedy the situation and directed to return to work in appropriate attire immediately. Under such circumstances, employees are not paid for the time away from work.

3. Anything that is exaggerated or overdone, whether it is jewelry, make-up, hairstyle, perfume, or clothing, is inappropriate. The Practice reserves the right to determine if jewelry, make-up, hairstyle, perfume, or clothing is appropriate. Employees should consult their supervisors if they have questions about what constitutes appropriate attire.

4. Employees are required to maintain a clean, odor-free personal hygiene. Strong-smelling perfume, aftershave, scented lotions, and cologne are not permitted.

5. Employees are required to maintain fingernails clean, well-manicured, and moderate in length. Nail color will be in keeping with the professional image of the Practice.

6. Employees are required to keep hair (including facial hair) clean, neatly trimmed, and contained so that it does not come in contact with patients. Hairstyle and hair color should support the Practice's professional image. Hair colored green, blue, pink, red, etc., is not acceptable.

7. If an employee desires to wear jewelry, it must be small and simple. It cannot obstruct his or her work, and should be visible on the ear only (that means no facial jewelry such as nose, eyebrow, lip, etc., piercings).

8. Tattoos and other body art must be covered at all times while on duty.

9. Shoes should be closed-toes, and functionally appropriate.

10. Appropriate dress standards

    a. All clothing should be clean, pressed, and in good repair with the proper fit. Clothing should fully cover the mid-back, lower-back, and stomach. Undergarments should not be visible. Bare legs, if applicable, must be neat and presentable.

    b. Guidelines for appropriate attire are provided herein; however, these lists are not inclusive. Good judgment must always be considered.

        - Scrubs (note that an appropriate long-sleeved shirt may be worn underneath the scrubs for warmth; however, hooded sweatshirts are not permitted)
        - Uniforms issued by the Practice
        - Business suits or pants suits
        - Pants or skirts (appropriate length to knee, no mini-skirts)
        - Shirts/blouses and sweaters
        - Clean, closed-toe shoes

11. Inappropriate dress standards

    a. Inappropriate dress for all personnel is as follows:

        - Soiled, tattered, torn, frayed, or ripped clothing
        - Shorts of any kind
        - See-through garments, or those with plunging or revealing necklines
        - Garments exposing midriff or undergarments
        - Tube-tops, tank tops, or tight, form-fitting shirts
        - Spaghetti straps, and low-cut or off-the-shoulder shirts or dresses

- Sweatshirts
- Stirrups, leggings, or exercise attire
- Tight or transparent clothing (including tight-fitting T-shirts)
- Any clothing with slogans, advertising, or questionable or suggestive logos or emblems
- Any clothing that promotes alcohol or tobacco
- Belly shirts
- Baseball caps or hats
- Low-rise jeans

12. All employees are subject to the dress code policy. Non-compliance is grounds for disciplinary action.

PERSONNEL • POLICY 2.21

Uniforms

It is the policy of the Practice that all employees wear uniforms to present a professional appearance to patients. As such, all employees are entitled to a uniform allowance by the Practice.

PROCEDURES

1. The human resources department authorizes a credit, as established by the Practice, at a uniform company when an employee is hired.

2. On each annual anniversary date of hire, the employee is entitled to the credit, as established by the Practice, at the company if he or she needs a new uniform. To receive the credit, the employee sends a written request to the human resources department (e-mail is acceptable) stating the need for a new uniform.

3. The human resources department calls the uniform company to place the credit, as established by the Practice, on the employee's personal account.

4. If an employee purchases uniforms two weeks prior to the first day of employment at the Practice, the new employee may submit the original receipt to accounting for reimbursement, up to the credit established by the Practice, within two weeks following his or her first day of work.

5. All Practice employees are entitled to this benefit.

6. The initial and annual credits are one-time credits to the employee. The uniform company does not maintain account balances. Employees may not go back throughout the year to use what they did not originally spend on uniforms.

7. There is no dollar figure available until human resources contacts the uniform company to place the employee's name on an account.

8. The company bills the accounting department at the Practice for the actual dollar amount of uniforms purchased on the Practice account.

9. No supervisor approval is necessary.

PERSONNEL • POLICY 2.22

Insurance Benefits

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law. In addition, the particular terms of a given practice's insurance coverage may necessitate appropriate modifications.*

It is the policy of the Practice to provide healthcare benefits to all full-time employees who have successfully completed three months of employment.

PROCEDURES

1. Group health insurance plan

    a. The Practice pays [all or __%] of the cost of coverage for each full-time employee. A full-time employee may add other family members to the group health insurance plan, but the employee must pay the additional amount of premium incurred.

    b. If an employee is married and covered by his or her spouse's coverage, the employee may formally waive the single health insurance coverage.

2. Workers' compensation

    a. The Practice is insured under the Workers' Compensation Act. Workers' compensation insurance provides compensation for lost time, medical expenses, and loss of life or dismemberment from injury or illness arising out of or in the course of regular work duties.

    b. To protect an employee's and the Practice's interest in case of work-connected injury or illness and so a report can be made to the malpractice insurance carrier, the employee must immediately report such an incident to his or her supervisor, the human resources department, and the Administrator.

3. Life/disability insurance

    a. After three months of employment, the Practice provides life and disability insurance to every full-time employee who works at least [x] hours per week. The Practice pays [all or __%] of the cost of such coverage.

    b. The amount of insurance and benefit periods are based on the specific Practice insurance policy in force during employment. The benefits are explained to the employee during orientation and at annual policy change periods.

4. Consolidated Omnibus Budget Reconciliation Act (COBRA)

    a. In accordance with federal law, an employee is entitled to continue health insurance coverage for a period of [x] months after termination of employment, or [x] months if the employee is disabled. (The number of months depends on the size of the organization and is subject to state law.) To maintain the coverage, the employee pays the monthly premium. Specific arrangements must be made in writing with each terminated employee. Moreover, the COBRA law is subject to periodic federal modifications. Please consult the Administrator if there are questions.

5. Changes in Insurance Coverage

    a. The form and scope of all the insurance benefits referenced in this policy are subject to change from time to time. While such changes may be made at the employer's discretion, employees will be periodically updated of pertinent developments.

PERSONNEL • POLICY 2.23

Workers' Compensation Claims Management

It is the policy of the Practice to require employees to immediately report workplace injuries. Fear and uncertainty are primary reasons for injured employees to delay reporting injuries. This may be due to concern over medical bills, lost income, and even the loss of employment. The following procedure is used to alleviate these fears and ensure that Workers' Compensation claims are handled in a fair and expeditious manner.

PROCEDURES

1. All employees are provided an explanation of the Workers' Compensation system and the benefits it provides.
2. An employee who experiences a work-related injury or illness must report the injury or illness to his or her supervisor, the human resources department, and the Administrator.
3. If the injured employee needs immediate attention, he or she is driven or sent to the nearest appropriate hospital or medical practice.
4. If the injury is not an emergency, an appointment is made with an appropriate medical provider as soon as possible.
5. An accident investigation is conducted following all work-related injuries. The supervisor or safety coordinator interviews the injured employee and all witnesses.
6. The safety coordinator reports the claim by phone to [name and phone number of Workers' Compensation carrier] within 24 hours of the accident.
7. If the incident involves an employee death or a catastrophe, the Occupational Safety and Health Administration (OSHA) must be notified in accordance with federal guidelines.
8. The safety coordinator uses information from the accident investigation to identify changes that may help prevent future incidents.

9. For lost time claims, a supervisor contacts the injured employee at least once a week to answer questions, keeps the injured employee informed of organizational activities, and discusses return to work options.
10. The safety coordinator contacts the medical provider and/or case manager after each appointment to keep current on the employee's work status and medical progress, and to ensure that appointments are being kept.
11. Modified duty procedures are as follows:
    a. The employee's supervisor evaluates medical restrictions and determines if the employee can return to his or her regular job duties.
    b. If the employee is unable to return to normal job duties, the supervisor determines if the employee's position can be temporarily modified to accommodate the restrictions.
    c. If the job cannot be modified, the safety coordinator evaluates other tasks or positions the employee may be able to perform until the medical restrictions are lifted.
    d. If the employee is unable to return safely to a modified position, the medical restrictions are reevaluated after each appointment with a medical provider to ensure the employee returns to work as soon as possible.
12. An entry is made on the OSHA log for all cases involving medical treatment.
13. Accurate records are kept for all Workers' Compensation claims. This file documents all communications regarding the claims and all records from the medical providers and [name of Workers' Compensation carrier]. The documentation is maintained permanently by human resources.

PERSONNEL • POLICY 2.24

Smoking

Notice: *This policy is designed for practices that wish to retain the right to smoke at the workplace.*

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law. Some states may limit an employer's ability to regulate employee behavior in this context, particularly if such limitations affects employee's after-hours behavior.*

It is the policy of the Practice to maintain a healthy and safe environment for its patients, employees, providers, and visitors while respecting individual choice. This policy is intended to eliminate the potential for exposure to secondhand smoke.

The smoking or inhaling, exhaling, burning, or carrying of any lighted cigar, cigarette, electronic cigarette, personal vaporizer, pipe, or the use of any nicotine delivery system; or any tobacco product, including chewing tobacco, by patients, employees, providers, and visitors is banned from the Practice, except as designated in this policy.

PROCEDURES

1. Smoking is permitted only in the area specifically designated and posted as a smoking area in the rear of the parking lot, so marked with a sign "Designated Smoking Area." Practice employees may not smoke along the walkway leading to or from the designated smoking area, nor may employees smoke in the parking lot or outside of the building except in the designated area. Employees may smoke in their personal vehicles, but the smoke and tobacco products must be completely contained within the vehicle.

2. Smokers and users of any form of tobacco products must dispose of the remains in the proper containers.

3. Adequate signage must be posted to ensure that patients, employees, providers, and visitors are informed of the smoke-free status of the Practice (with the exception cited herein). “No Smoking” signs should be clearly posted at all entrances, stairwells, bathrooms, and as appropriate in the Practice.

4. The Practice informs all applicants for employment at the Practice of the smoking policy prior to an applicant accepting an offer of employment. The policy is reviewed at new employee orientation.

5. With the exception of the designated area, employees smoking or using tobacco products in the Practice or its facility and grounds are in violation of this policy and subject to corrective action.

6. If a patient or visitor is seen smoking or using a tobacco product at the Practice, a supervisor is alerted. The supervisor informs the patient that the Practice maintains a smoke-free workplace, with the exception of the designated smoking area. The patient is asked to stop smoking or using the tobacco product immediately.

7. Smoking cessation counseling and support is provided by the Practice upon request.

PERSONNEL • POLICY 2.25

Smoke-Free Workplace

Notice: *This policy is designed for practices that wish maintain a smoke-free workplace.*

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law.*

It is the policy of the Practice to maintain a healthy and safe environment for its patients, employees, providers, and visitors. The smoking or inhaling, exhaling, burning, or carrying of any lighted cigar, cigarette, electronic cigarette, personal vaporizer, pipe, or the use of any nicotine delivery system; or any tobacco product, including chewing tobacco, by patients, employees, providers, and visitors is banned from the Practice. All areas of the workplace are smoke-free without exception.

PROCEDURES

1. Adequate signage must be posted to ensure that patients, employees, providers, and visitors are informed of the smoke-free status of the Practice. "No Smoking" signs should be clearly posted at all entrances, stairwells, bathrooms, and as appropriate in the Practice.

2. Smoking is not permitted anywhere in the workplace, including all indoor facilities, company vehicles, private enclosed offices, conference and meeting rooms, cafeterias, lunchrooms, staff lounges, and the entire grounds of the Practice, including the parking lot.
3. The Practice informs all applicants for employment at the Practice of the smoke-free workplace policy prior to an applicant accepting an offer of employment. The policy is reviewed at new employee orientation. This policy is included in the personnel policies provided in writing to the new employee; these policies must be acknowledged with the employee's signature.
4. Employees smoking or using tobacco products in the Practice or its facility and grounds are in violation of this policy and subject to corrective action.
5. If a patient or visitor is seen smoking (in any form) or using a tobacco product at the Practice, a supervisor is alerted. The supervisor informs the patient that the Practice maintains a smoke-free workplace. The patient is asked to stop smoking or using the tobacco product immediately.
6. A referral for smoking cessation counseling and support for employees is provided by the Practice upon request.

PERSONNEL • POLICY 2.26

Seminar Reimbursement

It is the policy of the Practice to reimburse 100 percent of the costs and related fees for approved seminars and workshops. Approved courses include degree and non-degree courses if they relate to an employee's current or future job within the Practice. Approval depends on budget availability, employee eligibility, and whether or not the courses apply to the employee's current or future position, as determined in advance by the Administrator.

To obtain reimbursement, the employee must be employed with the Practice at the time of the request and complete a Seminar Request Form (see below).

Types of courses not eligible for reimbursement include, but are not limited to:

- Courses taken for auditing purposes with no grade;
- Courses that have no application to the employee's current or future position and;
- Courses that are recreational or related to a hobby.

PROCEDURES

1. Seminar Request Form

   Any employee seeking seminar reimbursement should

   a. Submit a Seminar Request Form to his or her supervisor for approval prior to seminar enrollment;

   b. Attach to the request form appropriate documentation of the course content and its applicability to the employee's current or future position; and

   c. Obtain approval from the Administrator or designee.

2. Eligibility

   Employees are eligible for seminar reimbursement by satisfying the following requirements. If any requirements are not met, eligibility is at the discretion of the Administrator.

   a. Have regular, full-time employee status for at least one year;

   b. Complete and submit a seminar request form and obtain approval;

   c. Complete the course or courses of study;

   d. Have received a satisfactory job performance evaluation for the preceding 12 months; and

   e. Have received no disciplinary actions (verbal or written) in the preceding 12 months.

3. Scope of Assistance

   Seminar reimbursement can be sought for the following items subject to the limitations discussed above:

   a. Application fees;

   b. Registration fees;

   c. Tuition;

   d. Books; and

   e. Travel, meals, and lodging.

SEMINAR REQUEST FORM

Employee name: _____

Department: _____

Seminar title and sponsor: _____

Seminar date and location: _____

Supervisor: _____

Reason for attendance: _____

_____

Name of person requesting attendance: _____

List goals for the seminar. What will the attendee learn and how will the employee(s) and/or the Practice benefit?

_____

_____

_____

ANTICIPATED COSTS	TO BE PAID BY EMPLOYEE	TO BE PAID BY PRACTICE
Registration	_____	_____
Travel	_____	_____
Lodging	_____	_____
Meals	_____	_____
Other (specify)	_____	_____
Total of columns	$_____	$_____

TOTAL COST (sum of both columns) $_____

SIGNATURES AND APPROVALS

Employee: _____

Request approved: _____ Date:_____ Request denied: _____ Date: _____

Supervisor signature: _____

Administrator signature: _____

PERSONNEL • POLICY 2.27

Tuition Reimbursement

It is the policy of the Practice to reimburse tuition to employees for formal educational opportunities related to job improvement, job advancement, and/or career change within the Practice. The necessary forms must be completed prior to the start of class; appropriate guidelines and procedures must be followed, eligibility requirements must be met, and the course must be satisfactorily completed ("C" equivalent or better).

PROCEDURES

1. Employee eligibility

    a. All full-time personnel who have completed six months of continuous service at the Practice prior to the start of class are eligible to participate in this program.

    b. Qualified part-time employees (persons routinely scheduled for 32 or more hours of work per two-week period) may participate on a prorated basis, provided they have been employed at the Practice for at least five years.

    c. Applicants must perform satisfactorily in their jobs.

    d. Employees who change their status to non-eligible before the completion of courses are not eligible for reimbursement.

2. Reimbursement

    a. Reimbursement to full-time personnel is for 100 percent of tuition costs. This includes out-of-state rates if an individual is taking courses at a state institution and has not yet met residency requirements.

    b. Qualified part-time personnel are reimbursed on a sliding scale based upon their years of service.

c. Reimbursement is provided to cover tuition costs and any required laboratory fees. No books or other material costs are eligible for reimbursement.

d. A maximum of six college/university credits is reimbursed per term. As many as nine credits can be reimbursed with authorization of the Administrator.

e. A maximum of $3,000 is reimbursed to an eligible employee during any calendar year.

3. Approved courses

a. Courses taken for which reimbursement is sought must be from an accredited school or from an institution recognized for its expertise in the field of study.

b. Correspondence school courses are eligible for reimbursement if the program is accredited, if successful completion of each course is documented, and if the institution is recognized for its expertise in the field of study.

c. Non-credit courses are eligible for reimbursement if the purpose is job improvement, job advancement, or job change, and a grade equivalent of a "C" or better is earned.

d. Approved classes are taken during off-duty hours and are arranged to not conflict with normal work requirements.

4. Tuition aid

a. The employee must receive approval for tuition aid prior to the class starting date.

b. Prepayment of tuition fees may be requested only in cases when documented hardships would result in the employee's inability to pay for the course in advance.

c. The tuition aid application is approved or disapproved by the human resources department and the Administrator based on the following approval process:

1) The employee completes the tuition aid application and career plan if appropriate.

2) The supervisor approves or disapproves application.

3) After the supervisor approves the application, it is sent to the Administrator for final approval.

4) At the completion of the course, the employee submits the approved copy of the tuition aid application, along with the official grade report and proof of payment, to the human resources department.

5) The supervisor requests the accounting department to process the employee's reimbursement as soon as all documentation is submitted.

6) Payment is made through the payroll department. All payments are treated as earned income and withholding of taxes occurs.

5. Separation

a. In the event that an employee separates from the Practice, the Practice will not reimburse the employee for the currently enrolled classes.

b. The Practice may decide to require a commitment of 12 months of employment following tuition payment. If this commitment is not upheld, the Practice may withhold the employee's final paycheck(s) and severance pay.

PERSONNEL • POLICY 2.28

Meetings and Training

It is the policy of the Practice to require employees to occasionally attend work-related meetings. Meetings for supervisors are also held on a regular basis to establish lines of communication between departments, problem solve, and gain a global perspective of the Practice, the market, and economics related to the healthcare industry.

PROCEDURES

1. Occasionally, it is necessary for certain personnel to attend educational seminars that are conducted away from the Practice to learn new skills, gain additional knowledge necessary to remain proficient on the job, or maintain certification or licensure.

2. The Administrator or designee reviews each request and grants approval or non-approval as deemed appropriate.

3. The Administrator or designee may approve payment of an employee's registration and tuition fees, travel, lodging, and meal expenses, in addition to the regular pay for time the employee would have otherwise worked.

4. The Practice only pays wages for a 40-hour or less workweek (excluding weekends).

5. When travel away from the job site is required, reimbursable expenses are based on the lesser of actual expenses or the least expensive and most practical modes of travel, including coach airfare booked at a minimum of 21 days in advance of the initiation of the travel.

    a. Reimbursement for transportation, meals, and lodging is based on receipts of actual paid expenses.

    b. However, in no case will payment exceed a per diem, which the Administrator or designee sets and updates from time to time.

6. Every licensed or certified employee is required to maintain active registration, licensing, and/or certification.

    a. It is the employee's responsibility to ensure this active registration is maintained.

    b. The Practice pays for these recertification/relicensing expenses for current employees in good standing. CPR training for clinical staff is one example of this certification requirement.

    c. Such educational or certification seminars and training must be requested on the Seminar Request Form (see related policy 2.26 on Seminar Reimbursement).

PERSONNEL • POLICY 2.29

Absenteeism and Tardiness

It is the policy of the Practice to require every employee to work as scheduled and to arrive at his or her assigned work area at the proper time. Progressive disciplinary action is applied in instances when absenteeism or tardiness is considered to be excessive or patterned.

DEFINITIONS

1. Unscheduled Absence: Failure of an employee to report for work during a shift when the employee is scheduled to work. This includes both paid and unpaid hours.

2. Tardiness: An employee who clocks in after the scheduled start time or reports to the assigned work area after the scheduled start time is considered tardy. Although the employee is not docked if he or she clocks in within six minutes after the start of his or her shift, he or she is considered tardy.

3. Short-Time Absence: A type of absence in which an employee leaves the work area after the beginning of the scheduled shift. The employee is expected to continue working until the end of his or her scheduled shift. Although the employee is not docked for clocking out six minutes prior to the end of his or her shift, stopping work early without authorization is considered a violation of this policy.

4. Occurrence**:** An instance of unscheduled absence of one or more consecutive workdays.

5. Pattern of Absence**:** Unscheduled absences that occur in a pattern, such as the beginning or end of a workweek, weekends, the day before or after a legal holiday or scheduled day off, and any other observable pattern.

PROCEDURES

1. Each employee is expected to report absences directly to his or her supervisor. If the supervisor is unavailable, the employee should notify the Administrator or the human resources department.

2. The employee has the responsibility for knowing where, when, and whom to call and must personally report his or her absences. Failure to properly report an absence may result in disciplinary action and/or ineligibility for personal leave payment.

3. Absences of more than one day are to be reported on a daily basis. The daily notification requirement may be waived in cases of hospitalization or extended illness beyond one week if approved by the supervisor. However, to keep his or her supervisor informed, the employee must contact the supervisor at least once every two weeks.

4. Employees accrue points for absenteeism, tardiness, and short-time absences.

5. Progressive disciplinary action is taken based on the accrual of points over the course of a rolling 12-month period. Points are assigned as follows:

Occurrence	Point(s)
Incidence of unscheduled absence	3
Tardiness (up to 15 minutes late)	1
Tardiness (15 minutes or more)	2
Short-time absence (leaving up to 15 minutes early)	1
Short-time absence (leaving more than 15 minutes early)	2

6. In any 12-month period, disciplinary action is taken according to the accompanying scale. The maximum attendance rating is the highest performance evaluation rating a supervisor may give to an employee who falls into a particular category (see following scale).

Points	Disciplinary Action
0–5	None
6–11	Documented counseling
12–17	Written warning
18–23	Suspension
24 or more	Probation or termination

7. Generally, patterned absenteeism is reviewed on an employee-by-employee basis and is subject to appropriate disciplinary action regardless of the numerical standards defined above.

8. An employee's supervisor will attempt to determine the reason(s) for unscheduled absence or lateness. If mitigating circumstances (i.e., proven emergency, personal problem, death in

family) exist, an exception to this policy may be considered after consultation with the human resources department. If the reasons for the unscheduled absence are due to the employee's serious health condition or that of a defined family member, the provisions of the leave of absence policy apply. Any absence that is covered by either the federal Family and Medical Leave Act (FMLA) of 1993 or any applicable state law is not assigned points under this policy as long as it was scheduled in advance.

9. Employee attendance records

    a. Each payroll period, the supervisor records each employee's scheduled and unscheduled time used on an employee attendance record.

    b. An employee attendance record is maintained for every employee on a calendar year basis; however, attendance is monitored on a rolling 12-month period.

    c. Employee attendance records are maintained in a separate binder or electronic file within the department. It is considered and becomes a permanent part of the employee's personnel file. Individual attendance records are reviewed with an employee as necessary and whenever a formal performance appraisal occurs.

PERSONNEL • POLICY 2.30

Leaves of Absence

Alert: *This policy should not be used in conjunction with policy 2.33 on Paid Time Off. Rather, it is an alternative.*

It is the policy of the Practice to grant appropriate time off for sickness, vacation, and other leaves of absence.

PROCEDURES

1. Sick leave

   The Practice compensates eligible employees during absences for illness or injury up to an established limit as follows:

   a. All full-time employees are eligible for sick leave.

   b. During the first six months of employment, new employees are not eligible to use sick leave benefits. However, sick time starts accruing from the first day of employment.

   c. Sick leave is granted only for the actual illness of the employee or immediate family (spouse or child).

   d. Employees earn four hours sick leave per month of continuous service.

   e. Employees may accumulate sick time, but it may not exceed 90 days. Unused sick time over 90 days may be cashed in at the value of the employee's salary at the time of expenditure.

   f. Notification of absence due to illness or injury must be made no later than 7 a.m. on the day of the absence, according to the protocols established by the supervisor.

g. Part-time employees are granted sick leave on a prorated basis.

h. Verification of illness from an employee's physician may be requested.

2. Vacation leave

It is the policy of the Practice to grant annual vacation leave with pay to eligible employees in accordance with the following guidelines:

a. All full-time and regular part-time employees are eligible for vacation leave during the calendar year after the first 12 months of employment.

b. Eligible employees may borrow one week of vacation after six months of employment; but if the employee terminates employment before the year ends, he or she is required to pay back the Practice for that vacation time at his or her current pay. Part-time employees are entitled to vacation leave on a prorated basis.

c. Temporary and probationary employees are not eligible to earn vacation leave.

d. The Practice attempts to grant all employees' requests for vacation leave. However, for the Practice to provide adequate levels of staffing, employees should cooperate with their supervisor when scheduling vacation leave.

e. When a conflict over vacation scheduling between a supervisor and an employee occurs, resolution is the Administrator's or designee's responsibility. When vacation-scheduling conflicts occur within a department, priority is based on the order of documented requests received by the Administrator or designee. Requests for vacation leave must be submitted in writing and dated, on paper or electronically.

f. The following vacation leave guidelines, based on the number of years of continuous, full-time employment, are used in granting vacation:

Years of Service	Vacation Days per Annum
≥1 to <5 years	10 working days
≥5 to 15 years	15 working days
≥15 years	20 working days

1) Paid vacation time is earned on an annual basis at the end of the employee's first year of employment. Therefore, the employee receives no paid vacation leave until he or she has completed one year of service. The exception to this is stated in Section 3.

2) Vacation leave must be taken in the year in which it is earned. The Administrator approves any exceptions to this provision in writing. Employees are not paid for unused vacation leave remaining at the end of the vacation year.

3) If a holiday falls during the vacation period, the employee may take an additional day of vacation leave during the scheduled vacation period or at another time during the anniversary year.

4) Upon separation from employment for reasons other than cause or resignation without due notice, an employee receives vacation pay for unused vacation up to a maximum of five days accrued during the year in which termination occurs.

5) All employees, regardless of status, must schedule their vacation periods sufficiently in advance to ensure continuity of office staff coverage. Vacation periods longer than one week are approved at the discretion of the Administrator or designee and approved only for non-peak periods. Extended vacations are kept to a minimum.

3. Other leaves of absence procedures

The Practice grants eligible employees leaves of absence for personal, educational, medical, maternity, and adoption reasons within the following guidelines, which are consistent with the Family and Medical Leave Act (see related policy 2.31 on Family and Medical Leaves of Absence):

a. Unpaid leaves of absences may be granted to full- and regular part-time employees who have completed at least one continuous year of service.

b. The Practice makes every effort to grant a leave of absence request when it is properly justified and in the best interest of the employee and the Practice.

c. Earned paid leave (e.g., vacation) must be taken first; the remaining portion of the leave is unpaid.

d. A leave of absence may be granted for a period not to exceed 12 weeks for family or medical emergencies. An extension of a leave of absence may be granted only in extenuating circumstances.

e. Employees in non-pay status while on an approved leave of absence are not eligible to be paid for holidays, accrued vacation, or sick leave benefits.

f. An employee returning from a family or medical leave will be placed in his or her former job or a job comparable to the position held and at the rate of pay received when the leave commenced. Employees taking personal leave are not guaranteed a position after the specific period. The Practice will attempt to hold the position open during the leave of absence, but retains the right to fill it if necessary to ensure the smooth functioning of the Practice.

g. If an employee fails to return to work at the conclusion of an approved leave of absence, the leave is cancelled and employment is terminated. The effective date of termination is the last day worked.

h. Any medical group benefits that the employee received before the leave of absence commenced do not continue during the period of absence. Employees may make arrangements to pay for their own medical insurance during an approved leave.

4. Military leave

a. An employee does not need to meet the six-month introductory period to request in writing a leave of absence for military reasons.

b. An inductee, enlistee, reservist, or National Guard member is eligible for reemployment rights if he or she has received an honorable discharge and has applied for reemployment within 90 calendar days as stated in the Vietnam Era Veterans Readjustment Act of 1974.

c. A reservist or National Guard member who voluntarily or involuntarily reports for an initial period of active duty training for not less than three consecutive months has 31 days in which to apply for reemployment upon returning from training.

d. A reservist or National Guard member who performs weekly or weekend training duty has the option to use vacation days before receiving a leave without pay.

e. Military leaves are automatic if the employee is available for work, until it is necessary to report for military duty.

PERSONNEL • POLICY 2.31

Family and Medical Leaves of Absence

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law. The Family Medical Leave Act applies to all public agencies, including state, local, and federal employers; local education agencies (schools); and private-sector employers who employ 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including joint employers and successors of covered employers.*

It is the policy of the Practice to provide leave to employees who are eligible for a leave of absence as specified by the Family and Medical Leave Act (FMLA), if they have completed 12 months of service and if they have worked 1,250 hours during the previous 12-month period. Leave may be taken for the following reasons:

1. The birth, adoption, or foster care of a child;

2. To care for the employee's spouse, son, or daughter, or parent who has a serious health condition;

3. For a "qualifying urgent situation" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation; or

4. For a serious health condition of the employee, rendering the employee unable to perform the functions of his or her job.

Leave due to the birth or adoption of a child must be taken within 12 months of the birth or placement. "Son" and "daughter" includes biological children, stepchildren, legal wards, adopted, or foster children who are younger than 18 years of age, and children of any age when the child is incapable of self-care because of a mental or physical disability.

PROCEDURES

1. Definition of leave[4]

   Eligible employees may take up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons, or for any "qualifying urgent situation" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The FMLA also allows eligible employees to take up to 26 workweeks of job-protected leave in a "single 12-month period" to care for a covered service member with a serious injury or illness.

2. Job restoration

   a. An employee's position or an equivalent position with equivalent pay, benefits, and other terms and conditions are available if the leave is 12 weeks or less. The amount of leave that provides this job guarantee is calculated by determining how much leave an employee has taken in the 12 months preceding the requested leave.

   b. If both spouses are employees of the Practice, there is a 12-week limitation on job restoration rights per year per couple when leave is taken for the birth or adoption of a child or to care for a sick parent.

   c. If the leave exceeds 12 weeks, an employee's position is not guaranteed to be held open. If the manager determines that the position must be filled, the human resources department attempts to place the employee when he or she returns. Employees who do not return to work at the end of their authorized leave may be terminated.

   d. An employee who is away from work on a leave of absence necessitated by his or her own serious health condition is required to provide a medical release from his or her physician in order to return to work. This release should be given to the supervisor who will forward the release to the human resources department. Failure to provide a medical release to return to work will result in the delay or denial of job restoration.

   e. Certain "key" employees may be denied reinstatement from a leave under this policy to prevent substantial and grievous economic injury to the Practice's operations. The Practice will notify such employees of their status as a "key" employee and the conditions under which job restoration may not be made available.

[4] U.S. Department of Labor Wage and Hour Division. *Fact Sheet #28: The Family and Medical Leave Act.* Available at: http://www.dol.gov/whd/regs/compliance/whdfs28.pdf. Accessed February 6, 2015.

3. Use of paid leave

    a. The Practice requires employees to use all accrued paid time off as part of the 12-week FMLA leave. Periods of time during which short- and long-term disability benefits are received are also considered part of an employee's FMLA entitlement. Therefore, the maximum amount of FMLA leave, either paid or unpaid, that an employee may take in any 12-month period is 12 weeks.

4. Medical Condition Form

    a. When an employee requests leave because of his or her or a family member's serious health condition, including pregnancy, he or she must submit to a completed Medical Certification Form (see below) regarding the medical condition to the human resources department. Failure to provide such certification upon request may result in the delay or denial of the leave. At its own expense, the Practice may require the employee to receive a second or third opinion from another healthcare provider certifying the medical condition of the employee or the employee's family member. The Practice reserves the right to require periodic recertification of the medical condition for which the leave is taken.

    b. In the case of an adoption, the employee must provide the human resources department with records of the adoption.

    c. In the case of a deployment, the employee must provide the human resources department with documentation of orders from the military.

5. Employee notification

    a. Employees who anticipate taking a family or medical leave are expected to notify their supervisor of the need at least 30 days in advance of the leave or as soon as is practical. In cases when the need for the leave is foreseeable, an employee's failure to provide 30 days notice prior to taking the leave may result in denial or delay of the leave. If the need for the leave is not foreseeable, notice must be given as soon as is practical.

    b. During a leave of absence, an employee should keep in contact with the supervisor of his or her department regarding the present situation and any changes that might occur. When returning from a leave, an employee must notify the supervisor of his or her intent to return to work at least two weeks before the leave ends.

6. Intermittent leave

    a. An employee may take an intermittent or reduced basis leave because of a serious health condition. The 12-week maximum is calculated based on the actual time off for an intermittent or reduced leave. For example, an employee who takes six hours

of unpaid leave during each of 20 weeks for a particular form of medical treatment is regarded as using 120 hours (three weeks) of the 12 weeks of FMLA leave to which he or she is entitled.

b. The employee must advise the Administrator of the reasons why the intermittent or reduced schedule leave is necessary and of the treatment schedule (if applicable) in addition to providing the other notice required for leave under this policy. As with other leaves, intermittent or reduced schedule leave must be supported by medical certification.

c. The Practice may require an employee taking intermittent or reduced schedule leave to transfer temporarily to an alternative available position for which the employee is qualified, or the Practice may modify an employee's existing job, as long as the temporary position has equivalent pay and benefits and better accommodates the employee's recurring periods of leave.

7. Insurance benefits during leave

a. An employee on a paid leave will continue to receive insurance benefits.

b. During a leave, the employee remains responsible for his or her portion of the insurance premium.

c. Failure to pay premiums in a timely manner may result in a lapse of coverage.

d. Any health insurance premiums paid by the employer during the leave may be recaptured from an employee who fails to return to work at the conclusion of the leave, unless the employee is unable to return to work because of his or her own serious health condition or because of the serious health condition of a family member or other circumstances beyond his or her control.

MEDICAL CERTIFICATION FORM
(FAMILY AND MEDICAL LEAVE ACT) PAGE 1

1. Employee's name: _____

2. Patient's name (if different from the employee): _____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please circle the applicable category.

(1) (2) (3) (4) (5) (6) or none of the above

4. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

_____

5. State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different):

_____

6. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item 5)?

_____

If yes, give the probable duration: _____

7. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____

8. If additional treatments are required for the condition, provide an estimate of the probable number of such treatments:

_____

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment, if known, and the time required for recovery, if any:

_____

9. If any of these treatments will be provided by another provider of health services (e.g., a physical therapist), please state the nature of the treatments:

_____

MEDICAL CERTIFICATION FORM
(FAMILY AND MEDICAL LEAVE ACT) PAGE 2

10. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (i.e., prescription drugs, physical therapy requiring special equipment, etc.):

_____

11. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

_____

12. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions): _____? If yes, please list the essential functions the employee is unable to perform:

_____

13. If neither 11 nor 12 applies, is it necessary for the employee to be absent from work for treatment?

_____

14. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

_____

15. If the answer to 14 is no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

_____

16. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____

_____

(Signature of healthcare provider) (Date) (Name of Practice)

_____

(Address) (Telephone #)

To be completed by the employee needing family leave to care for a family member:

Attach a statement describing the care you will provide and an estimate of the dates during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____

(Employee signature) (Date)

CERTIFICATION OF HEALTHCARE PROVIDER (FAMILY AND MEDICAL LEAVE ACT OF 1993) PAGE 1

DEFINITIONS

Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave. A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital care

   Inpatient care (i.e., an overnight stay) in hospital, hospice, or residential medical care facility, including any period of incapacity[5] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence plus treatment

   A period of incapacity[5] of more than three consecutive calendar days (including a subsequent treatment or period of incapacity[5] relating to the same condition) that also involves:

   a. Treatment[6] two or more times by a healthcare provider or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider; or

   b. Treatment by a healthcare provider on at least one occasion, which results in a regimen of continuing treatment[7] under the supervision of the healthcare provider.

3. Pregnancy

   Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic conditions requiring treatments

   A chronic condition, which:

   a. Requires periodic visits for treatment by a physician or non-physician provider;

   b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and

   c. May cause episodic rather than a continuing period of incapacity[5] (e.g., asthma, diabetes, epilepsy,

[5] *"Incapacity," for purposes of FMLA, is defined as inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.*

[6] *Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.*

[7] *A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include taking over-the-counter medications, such as aspirin, antihistamines, or salves, bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a healthcare provider.*

etc.).

CERTIFICATION OF HEALTHCARE PROVIDER (FAMILY AND MEDICAL LEAVE ACT OF 1993) PAGE 2

5. Permanent/long-term conditions requiring supervision

   A period of incapacity[5], permanent or long-term, due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple treatments (non-chronic conditions)

   Any period of absence to receive multiple treatments (including any period of recovery from the treatments) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[1] of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

PERSONNEL • POLICY 2.32

Provider Time Off

It is the policy of the Practice to maintain continuity of provider availability and patients' ease of access to providers. To ensure that patients' medical needs are met, physicians and advanced practice providers are required to submit a formal request for time away from patient care a minimum of six weeks prior to the requested date(s), unless in an emergency.

PROCEDURES

1. Each provider will submit the Provider Time Off Request Form (see below) to the Administrator, who submits the request to the Executive Committee or Board for approval. Each request is acted upon within one week from date of receipt.

2. Providers will be informed, in writing, of the requirement to request time off no later than six weeks prior to the requested date(s).

PROVIDER TIME OFF REQUEST FORM

Name:_____ _____

Reason for request: (please circle one)

1. Vacation

   Beginning date: _____ through: _____

2. Meeting or study course

   Name of meeting or course: _____

   Location: _____

   Beginning date: _____ through: _____

   (Per diem will be paid based on above dates.)

3. Practice business

   Time off, airfare, and per diem are only granted for this request with the specific approval of the board of directors. Attach a cover letter explaining the purpose and relation to the Practice's business, as well as the location and dates of the event.

   Upon return, complete the travel expense form and submit to the accounting department for reimbursement.

4. _____ Other

   Please describe: _____

Requesting provider's signature: _____ Date: _____

The following to be completed by Administrator:

Balance remaining before this request:

Vacation: _____

Meeting time: _____

Balance remaining after approval:

Vacation: _____

Meeting time: _____

Date received: _____

Appointment desk notified (Y / N)

Number of patients who had to be rescheduled: _____

Comments about handling their care: _____

Board member approval signature: _____ Date: _____

PERSONNEL • POLICY 2.33

Paid Time Off

Alert: *This policy should not be used in conjunction with policy 2.30, Leaves of Absence. Rather, it is an alternative.*

It is the policy of the Practice to combine vacation and sick leave into a single program called paid time off (PTO).

PROCEDURES

1. This policy treats all paid days off the same. Each full-time employee accrues time in his or her PTO bank at the rate of 5.23 hours per pay period beginning on the first day of employment. (Amount is pro-rated for part-time employees.) PTO accrues during the 90-day probation period, but is not vested and cannot be taken until the 91st day of employment. If the employee terminates employment during the first 90 days, no PTO time is paid.

PTO Accrual Rate

Years of Service*	Total PTO Days
0–2	17
3–5	19
6–10	24
11–15	29
16+	34

** For purposes of interpretation, the third year of service begins the day following the second year anniversary. This interpretation should be applied to each of the above ranges for years of service.*

2. The Practice recognizes the importance of time off for its employees, and it accommodates requests as often as possible. However, because the Practice provides medical care, it must be available to its patients and, if applicable, referring physicians. Therefore, some restrictions in PTO may be necessary to meet their needs. Every employee must discuss requested time off with his or her immediate supervisor prior to placing a formal request for time off.

3. To request time off

    a. To request PTO, the employee must submit a documented request to the supervisor of his or her department (and to the Provider if the employee is a member of the clinical staff) for written approval noting that the form is available to complete and submit electronically.

    b. Considerations that may affect whether time off is granted include (but are not limited to) provider and patient schedules and adequate staff coverage to handle department workload.

4. With the exception of unforeseen emergencies and illnesses, PTO may not be taken without written approval. It is the employee's responsibility to secure this approval. Days taken without approval may result in disciplinary action, including possible termination.

5. If an illness or emergency prevents the employee from coming to work the next day, and the employee needs/wants to take PTO, the employee should call his or her supervisor as soon as possible, in accordance with the protocols established by the supervisor.

6. The policy does not allow time off without pay if PTO hours are available. This policy applies to both full-time and part-time employees. PTO may be used in one-hour increments.

7. Carry-over days

    A maximum of five days of accrued PTO time may be carried over from one year to the next. All other PTO time must be taken by the end of the year. PTO time not taken or carried over is converted to additional extended-sick leave (ESL) days (a maximum of four) or lost. ESL is time applied to a disability-qualifying period.

8. Part-time employees

    A part-time employee who works 20 to 36 hours per week accrues PTO time credit based on the actual hours worked.

    Example:
    A full-time employee accrues 5.23 PTO hours per 80-hour pay period. An employee working a 40-hour pay period (20 hours per week) accrues 2.6 hours per pay period (20/40 = 50% of 5.23). An employee working 30 hours per week (or a 60-hour pay period) accrues 3.9 PTO hours per pay period (30/40 = 75% of 5.23).

9. Extended PTO requests

   Vacations are an important source of recreation, and the Practice encourages employees to use the time allowed, which is a valuable benefit.

   a. A PTO request for three consecutive days or more is considered "extended time off." A request for three or more consecutive days should be submitted and approved in writing by the immediate supervisor at least one month prior to the requested time off.

   b. It is the intent of the Practice to approve these requests to accommodate the employee. However, these requests are also subject to the needs of the Practice and the department concerned.

   c. If more than one employee in a department requests identical time-off dates, it may be necessary to deny a request. One or more individuals may need to reschedule.

   d. Each employee should plan ahead and keep in mind the peak workload times in his or her area, as well as the peak (or most desired) dates for time off.

   e. When a holiday falls within an extended time off period, the holiday is not charged as PTO.

   f. Remember: Approval for time-off is granted at the discretion of the supervisor. Plan ahead whenever possible and secure approval as soon as possible.

10. An employee who terminates his or her employment.

    An employee may request approval to use unearned PTO time. However, if the employee terminates his or her employment, the amount owed to the Practice for time taken but not yet earned is deducted from the employee's final paycheck.

11. Additional paid time off

    a. Holidays. The Practice recognizes six paid holidays for its employees:

       1) New Year's Day

       2) Memorial Day

       3) Independence Day

       4) Labor Day

       5) Thanksgiving Day

6) Christmas Day

- If any of these holidays falls on a Saturday or a Sunday, the Friday or Monday immediately preceding or following the holiday is designated as the paid holiday.
- An employee receives pay for a holiday if he or she is on a paid status (approved PTO leave or extended sick leave on the day before and/or the day after the holiday in question).
- The employee is also paid for the holiday if he or she is on an approved unpaid leave on the holiday or if he or she is receiving workers' compensation benefits during the holiday.
- An employee who takes unapproved time off on the day before or the day after a holiday will not be paid for the holiday.

b. Holiday policy for employees with flexible hours

1) An employee who has a regular schedule of four 10-hour days is paid at his or her regular rate for all hours actually worked. The employee is paid for eight hours for holidays, as are all other employees who work five eight-hour days per week.

2) No overtime is paid for weeks that contain holiday pay.

Example: *If you work four 10-hour days Monday through Thursday, and Friday is a holiday, you are paid for the eight holiday hours, but do not receive any overtime pay. (Holiday pay is pay for hours not actually worked.)*

c. Holiday policy for part-time employees

1) Part-time employees receive pro-rated holiday pay.

2) The Practice values its part-time employees and their contributions. Part of that appreciation is expressed in giving to them the same number of paid holidays as full-time staff members receive. Therefore, part-time employees receive holiday pay for the number of hours regularly worked, whether or not the holidays are regularly scheduled workdays.

Example: *A part-time employee who works a regular schedule of four hours per day is paid for four hours. Or, if the employee works a regular schedule of 20 hours per week (half-time), he or she receives one-half the holiday pay, or 4 hours.*

12. Summary of paid time off provided by the Practice

Years of Service	Total PTO Days	Paid Holidays	Total
0–2	15	7	22
3–5	20	7	27
6–10	25	7	32
11–15	30	7	37
16+	35	7	42

13. Adverse weather

    If management decides to close the office because of adverse weather conditions, the entire office staff scheduled to work that day is paid for the adverse weather day. If the office is open but an employee elects to stay home because of inclement weather, he or she must call in and use PTO to be paid for those hours.

14. Explanations

    a. **Sick Leave.** There is no separate sick leave policy because both vacation and sick leave are combined into one PTO policy. Part-time employees who work an average of 20 to 35 hours per week accrue PTO time for vacation and sick leave as stated in the policy.

    b. **PTO Policy Abuse.** The Practice wants employees to use their PTO. However, employees who are repeatedly absent or take PTO without appropriate notice to and approval by the supervisor create great difficulties for the rest of the staff who have to cover their work assignments. Examples of abuse of PTO are: (a) excessive absences; (b) predictable and regular absences on certain days; and (c) a consistent lack of notice. Such abuse of PTO is grounds for dismissal or warning.

PERSONNEL • POLICY 2.34

Paid Holidays

It is the policy of the Practice to recognize six paid holidays for all employees during each calendar year.

PROCEDURES

The holidays that the Practice recognizes as paid holidays are as follows:

1. New Year's Day
2. Memorial Day
3. Independence Day
4. Labor Day
5. Thanksgiving Day
6. Christmas Day

When employees are required to work any of these holidays, they are paid one and one-half (1½) times the base rate. Recognized holidays occurring on a Saturday are observed on the previous Friday. Recognized holidays occurring on a Sunday are observed on the following Monday.

PERSONNEL • POLICY 2.35

Adverse Weather Conditions

It is the policy of the Practice to close sites when the Administrator or designated person determines that excessive snowfall or other adverse weather conditions make it hazardous or impossible for employees to work.

PROCEDURES

1. Notify the Administrator or designee of adverse weather or hazardous conditions and await instructions.

2. If the Practice decides to close the office because of adverse weather conditions, the entire office staff scheduled to work that day is paid for the adverse weather day. If the office is open but an employee elects to stay home because of inclement weather, he or she must call in and use paid time off (PTO) to be paid for those hours.

3. The Administrator or designee notifies the answering service in the event of closure, posts the notification of the closure on the Practice's portal and Website, and instructs the automated reminder system vendor to contact all patients scheduled for the day to inform them of the closure.

PERSONNEL • POLICY 2.36

Bereavement Leave

It is the policy of the Practice to provide bereavement leave with pay to employees who have satisfactorily completed their introductory period. Bereavement leave with pay is granted in the event of a death of an immediate family member, which includes a parent (legal guardian), spouse, child, sister, brother, and grandparent.

PROCEDURES

1. An employee may be granted leave with pay for up to two assigned workdays. The amount of time paid depends on the amount of travel required, as determined by the employee's supervisor. The employee must acquire approval from his or her supervisor.

2. The amount of time normally paid is based on the scheduled hours for which the employee is absent.

3. The Administrator may grant leave without pay if no leave time is available.

4. Bereavement leave is granted during periods of time off with pay, such as vacations, holidays, personal paid days off time, and other such periods of time off with pay. The amount of time paid is equal to the amount of benefit time approved, plus the bereavement benefit time.

5. Bereavement leave is not granted during periods of time off without pay, such as personal leave without pay, layoffs, medical leave without pay, and other periods of time off without pay.

PERSONNEL • POLICY 2.37

Jury Duty

It is the policy of the Practice to encourage employees to fulfill their civic responsibilities by reporting to jury duty when required. Time off may be granted to employees requested by the Court to serve as a juror or witness.

PROCEDURES

1. Serving as a jury member is a civic duty and a privilege. If an employee is summoned to serve as a jury member, the Practice continues to pay his or her salary during the jury selection process (one day) and the first two days of jury service (three days total) if he or she is selected to serve as a juror. A copy of the notification requesting him or her to appear for jury duty (or as a witness) must be submitted to human resources as soon as it is received. It is filed for documentation of the paid absence.

2. If an employee is selected to serve on a jury, some jurisdictions begin paying a stipend immediately, and some begin paying the per diem on the fourth day of jury service (fourth day of cumulative jury selection/service time). Regardless of the day you receive it, an employee is expected to deliver the stipend per diem check, signed over to the Practice to the human resources department. The Practice continues paying the employee's full salary during these three days.

3. The Practice does not pay the difference between an employee's regular salary and the amount received for jury duty after the third day of selection and service as a juror. The employee keeps the per diem paid by the court for those days of service beginning on the fourth day, and the paycheck is reduced by those days or hours of missed work. The Practice reserves the right to request satisfactory evidence of time spent as a juror.

4. An employee is expected to report to work when doing so does not conflict with his or her court obligations. It is the employee's responsibility to keep his or her supervisor informed about the amount of time required for jury duty.

5. The time spent on jury duty is not considered in the calculation of overtime or premium pay.

PERSONNEL • POLICY 2.38

Voting Leave

It is the policy of the Practice to encourage each employee to fulfill his or her civic responsibility by voting. Any employee registered to vote in a general election may take time off to vote.

PROCEDURES

1. An employee is granted two hours between the time the polls open and the time the polls close on the day of the election, unless he or she is not scheduled to work for three or more hours when the polls are open.

2. The employee must ask his or her supervisor for time off to vote prior to the day of election.

3. The supervisor requires advance notice of time off to vote so he or she can schedule the time off at the beginning or end of a shift, whichever causes the least disruption to the normal work schedule.

PERSONNEL • POLICY 2.39

Alcohol Consumption on the Premises

It is the policy of the Practice to prohibit alcohol consumption on the Practice's premises and during working hours.

PROCEDURES

1. Employees are prohibited from consuming alcohol during working hours or on the premises.

2. On special occasions (i.e., holiday parties and other special functions), the Administrator may authorize a limited amount of alcohol consumption on site upon approval of the board of directors. If alcohol is served, the Practice must make arrangements to provide transportation to attendees. No employee may drive away from the occasion inebriated.

PERSONNEL • POLICY 2.40

Drug and Alcohol Use

Alert: *As with other policies addressing personal matters, please refer to your state's specific laws to address drug and alcohol testing considerations, as well as any drug screening policy (see policy 2.43).*

It is the policy of the Practice to provide a drug-free, healthy, and safe workplace. To achieve this goal, every Practice employee is required to report to work in an appropriate mental and physical condition in order to perform his or her job in a safe and satisfactory manner.

PROCEDURES

1. An employee may be asked to take a drug or alcohol test at any time to determine the presence of drugs, narcotics, or alcohol if there is reasonable suspicion that he or she is under the influence of a controlled substance or if the employee exhibits unusual or impaired behavior (specific physical, behavioral, or performance indications) that indicates he or she is under the influence of a controlled substance.

2. An employee may be asked to take a drug test after a workplace accident.

3. Any employee who tests positive for unlawful drugs or controlled substances is subject to discipline up to and including termination of employment.

4. It is a violation of this policy to refuse to take a drug test. An employee who refuses to submit to a test may be subject to immediate termination.

5. No employee may use, possess, distribute, sell, or be under the apparent influence of alcohol or illegal drugs while on the Practice premises or while conducting business-related activities off the premises.

6. Prescribed drugs are excluded from this policy when used according to the combination and quantity prescribed, unless job performance is affected. An employee who must use an over-the-counter or prescribed drug that causes adverse side effects or may affect his or her ability to perform work in a safe and productive manner must notify his or her supervisor prior to

starting work. After proper inquiry, the supervisor determines if the employee can remain at work and/or if work restrictions are imposed.

7. Compliance with this policy is a condition of employment for all employees of the Practice. Any employee who is convicted under a criminal drug statute or pleads guilty or *nolo contendere* to such charges must notify the Practice within five days of such conviction or plea. Failure to do so results in disciplinary action, up to and including termination for a first offense.

8. Employees who are convicted or plead guilty or nolo contendere to such drug-related violations are subject to termination and/or mandatory attendance and successful completion of a drug abuse assistance or similar program as a condition of continued employment.

9. Any employee with questions or concerns about the drug and alcohol policy should bring them to the attention of his or her supervisor or the director of human resources.

PERSONNEL • POLICY 2.41

Tuberculosis Test

It is the policy of the Practice that each employee has an appropriate screening test for tuberculosis. This is accomplished by a purified protein derivative (PPD) skin test.

PROCEDURES

1. The Practice makes PPD tests available to every employee (new and current) at no cost to the employee.

2. New employees are required to have a PPD test within 90 days prior to the start of their employment. If one has been done in the past 90 days, the employee must supply written evidence that it has been done and provide documented results. The cost of the test will be reimbursed by the Practice with appropriate documentation of a receipt. This applies only to new employees.

3. Each employee should be aware that if he or she has a positive reaction, he or she is required to go to his or her physician for a chest X-ray. The Practice assumes no liability for the cost or results of this test.

4. An annual test is required for all employees. The Practice will not pay for the test to be taken outside of the Practice.

5. Any employee receiving a PPD test at the Practice must sign a Tuberculosis Test Form (see below).

TUBERCULOSIS TEST FORM

I hereby request that I be given a PPD test through the Practice in order to meet the state public health requirements of a screening test for tuberculosis. I understand that the Practice assumes no liability for this test and that if I have a positive reaction, I will consult my primary care physician.

Date: _____

_____
(Employee's signature)

_____
(Employee's printed name)

Date of birth: _____

Department: _____

Date test given: _____ Date test read: _____

Read by: _____

Results: _____ Negative _____ Positive Arm: _____ Left _____ Right

Lot #: _____

PERSONNEL • POLICY 2.42

HIV Infection Screening

Alert: *As with other policies addressing personnel matters, please refer to your state's specific laws to address HIV infection screening considerations.*

It is the policy of the Practice to make human immunodeficiency virus (HIV) infection testing available at no cost to employees at their cost. Physicians and advanced practice providers (APPs) who have tested positive for HIV must comply with directives, as ordered by the medical director.

PROCEDURES

1. Testing is voluntary and anonymous. Practice employees who wish to be tested are provided a confidential test for which they are financially responsible, unless the test is required because of a needle stick or other exposure to bloodborne pathogens.

2. Work activities of providers who have tested positive for HIV are defined by the medical director in consultation with the board of directors. Providers who are infected with HIV and continue to work may not be permitted to do certain invasive procedures, but may be permitted to work for the Practice doing appropriate medical activities. Any procedures that create a risk of transmission of HIV to others, including surgical procedures, are limited. Further, the providers' patients may be required to sign an informed consent noting they understand the provider is HIV positive. The state public health department is notified if required by law.

3. The Practice endeavors to assure that any available disability policy will apply to providers who are HIV positive. Please consult the Administrator if there are questions.

4. The Practice will use its best efforts to provide HIV-positive providers the Practice's standard malpractice coverage as long as they report their HIV-positive status to the medical director within 30 days of positive, documented confirmation of the diagnosis and comply with recommendations regarding the type of medical services they provide. The Practice will use its best efforts to provide that HIV-positive providers without knowledge of their status will be protected by the Practice's malpractice insurance policy.

5. As a condition of employment, all physicians and APPs undergoes a physical examination, a substance abuse screening, and an HIV test. Providers being recruited are made aware of the HIV policy.

6. Alternatives to communicating with the media and patients about an HIV-positive provider whose status might become public knowledge are developed and reviewed annually for appropriateness. What is done to manage a specific problem is determined when the problem occurs.

7. Most employees do not function in high-risk capacities, so no special HIV employee policies are necessary. If an employee knows he or she is HIV positive, the employee is expected to disclose this fact. Job reassignment without loss of income is made if necessary.

PERSONNEL • POLICY 2.43

Drug Screening

Alert: *See policy 2.40 for cross-reference purposes.*

It is the policy of the Practice to help protect worker safety and health and prevent the business from the negative effects of substance abuse in the workplace. Every candidate for employment, including employees and providers, participates in a drug screen prior to being employed.

To assure compliance with all government regulations, the Practice reserves the right to randomly test for drug use on an unannounced basis or when there is reasonable suspicion that the employee is under the influence, or the employee exhibits unusual or impaired behavior.

PROCEDURES

1. The candidate or employee must sign a Drug and Alcohol Test Consent Form (see below) prior to the final hiring decision. Refusal to submit to the test is grounds for rejection of the application.

2. The candidate or employee will go to the designated facility and provide the required samples for screening. In the instance of onsite testing, the employee will submit to the testing under controlled circumstances by a reputable testing agency.

3. The screening center provides the results of the test to the Practice within 48 hours.

4. All results are shared with the employee and become a part of his or her personnel record.

5. Individuals who are candidates for employment and receive a positive result on the test are not offered employment.

6. Every employee who receives a positive result on the test is subject to disciplinary action, up to and including termination of employment.

7. If the employee refuses to submit to a test, he or she may be subject to immediate termination.

DRUG AND ALCOHOL TEST CONSENT FORM

As an employee or candidate for employment of the Practice ("the Company"), I understand that the use of drugs, alcohol, and other controlled substances in the workplace creates a safety concern for all employees. In the interest of creating a safe working environment, I hereby give my consent for the Company to conduct the drug and alcohol tests it considers necessary.

I authorize the Company to take the necessary specimens from me to test for drugs, alcohol, and other controlled substances, and I authorize laboratory or medical personnel retained by the Company for these tests to release the results to the Practice. I release the laboratory or medical personnel conducting the drug test, the Company, and the Company's employees, directors, officers, and successors from any liabilities, claims, and causes of action, known or unknown, contingent or fixed, that may result from these tests, and I agree not to file any lawsuits or other actions to assert a claim.

_____

Name (printed)

_____

Signature

_____

Date

_____

PERSONNEL • POLICY 2.44

Use of Practice Property

It is the policy of the Practice to deny use of its property to employees without proper authorization.

PROCEDURES

1. Employees are not permitted to use office or medical supplies for their personal use without first obtaining permission from the Administrator or designee.

2. Employees may not use medical office equipment or instruments for personal reasons either for themselves or their families unless otherwise authorized to do so by the Administrator or designee. (See related policy 8.12 on Staff Computers, E-mail, and Internet Use for more information about the limitations of Internet usage.)

3. No equipment, documents, records, or other property of any kind belonging to the Practice may be removed from the premises by an employee who has not first obtained permission from the Administrator or designee.

4. Stationery or forms on which the Practice name appears may not be used for personal purposes at any time.

5. Personal use of any medications provided in the office, including sample drugs, is strictly forbidden.

6. The Receipt of Company Property and Deduction Authorization form (see below) must be completed and signed by the employee in receipt of the Practice property and the Administrator or designee.

RECEIPT OF COMPANY PROPERTY AND DEDUCTION AUTHORIZATION

I have received the following items for work-related purposes:

Date	Value	Description
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____

I understand that the Practice property described above is my responsibility and if not returned, the value of all property will be deducted from my final paycheck(s).

I hereby authorize the Practice to deduct from my final paycheck(s) the value of any unreturned Practice property.

Employee signature: _____

Printed name of employee: _____

Administrator: _____

Date: _____

PERSONNEL • POLICY 2.45

Practice Property Ownership

It is the policy of the Practice to maintain ownership of its property at all times.

PROCEDURES

1. All documents, photographs, and other materials generated in the course of a Practice's or employee's work, which are paid for by the Practice, remain the property of the Practice at all times.

2. To request the buy-back of any item expensed to the Practice, a formal request form is completed and presented to the accounting department. The Practice is reimbursed for such item within two weeks of the written request.

3. If a provider or other employee leaves the Practice, these materials become part of the Practice's and/or department's records and are retained in an appropriate place.

4. All equipment purchased by the Practice also remains the property of the Practice. If a provider or employee wishes to take such a piece of equipment when he or she leaves, he or she can only do so after receiving approval from the board of directors, and after negotiating a price for the purchase of the equipment.

5. A departing provider can take any item purchased from the Practice as a salary reduction, or he or she can pay the Practice.

PERSONNEL • POLICY 2.46

Personal Phone Calls

It is the policy of the Practice to manage and minimize all employees' personal use of the telephone. Urgent and emergency local calls may be made at the employee's discretion.

PROCEDURES

1. It is important to keep the Practice's telephone lines free for business use. Although occasional use of the Practice's telephones for a personal emergency may be necessary, routine personal calls are not allowed.

2. If personal calls are necessary, the Practice telephone should only be used during breaks, lunch, and before or after the employee's shift.

3. Employees are not authorized to make personal long-distance telephone calls on company phones.

4. The use of personal cell phones is restricted for personal emergencies only. If necessary, a cell phone should only be used during breaks, lunch, and before or after the employee's shift. This includes texting.

5. When making a personal call, be constantly alert. If all the lines should become busy, terminate the call immediately.

6. The receptionist transfers to voice mail or takes the name and number of parties calling employees on personal business so the employee may return the call at a convenient time.

PERSONNEL • POLICY 2.47

Disciplinary Guidelines

It is the policy of the Practice to follow established disciplinary guidelines and work rules to ensure a positive working environment for all who work for the Practice.

No set of guidelines can cover all employment situations. Reasons listed in this policy are not exclusive. As noted at the outset of this Chapter 2, all employees serve the Practice as "at will" employees and the Practice retains job discretion to discipline or discharge an employee at any time, with or without cause, to the maximum extent permitted by law.

PROCEDURES

1. Absenteeism

    a. Each employee is hired because his or her services are needed to provide or support quality patient care. Regular and timely attendance is necessary to ensure this goal.

    b. Absenteeism and tardiness:

        1) Decreases the functioning of the department;

        2) Generates additional costs; and

        3) Has special ramifications on weekends, holidays, and peak vacation times when staffing may be proportionally lower.

    c. An employee with excessive absences and/or tardiness is subject to disciplinary action.

    d. The Notice of Disciplinary Action form (see below) is used for all documentation.

2. Definition of terms

    a. Scheduled Absence: This is time off that has been approved and scheduled in advance by a supervisor based upon the Practice's ability to provide adequate staff coverage. Included in this category are holidays, vacations, low-volume days, bereavement leave, jury duty, voting time, educational leave, prearranged medical disability leave, and other approved leaves of absence. This also includes time off required by disciplinary action.

    b. Authorized Absence: This absence results from a personal illness or other unplanned event, family illness, or problems requiring an employee to be absent from work. An employee must give notice of an authorized absence a minimum of two hours prior to work and in accordance with departmental procedures, which may vary from department to department.

    c. Nonscheduled Absence: Any absence that occurs on an assigned workday and is not a scheduled absence.

    d. Unauthorized Absence: Failure to report for work when assigned without giving adequate notice or notifying the appropriate person or designee of an absence, but not receiving approval for absence. Each nonscheduled or unauthorized absence must be reported to the appropriate supervisor. Frequent or excessive absences cannot be tolerated, and progressive disciplinary action will be at the discretion and judgment of the employee's supervisor as outlined below:

        1) First formal counseling: Verbal warning.

        2) Second formal counseling: Written warning.

        3) Third formal counseling: Suspension for up to five days and written warning.

        4) Fourth formal counseling: Discharge.

3. Tardiness

    a. Tardiness occurs when an employee does not report to his or her department in appropriate attire on time. Every employee is required to call to report lateness greater than 30 minutes.

    b. Penalties for tardiness are:

        1) First violation: Verbal warning.

        2) Second violation: Suspension for up to three days and written warning.

        3) Third violation: Discharge.

4. Leaving without permission

    a. Permission for an employee to leave his or her work area during the workday must be obtained in advance from his or her immediate supervisor.

    b. Penalties for leaving without permission are:

        1) First violation: Verbal warning.

        2) Second violation: Suspension for up to three days and written warning.

        3) Third violation: Discharge.

5. Loafing and loitering

    a. Employees are expected to work each hour for which they are paid. Penalties for loafing, loitering, or engaging in unauthorized visiting during work time or after work hours on Practice property are as follows:

        1) First violation: Verbal warning.

        2) Second violation: Suspension for up to three days and written warning.

        3) Third violation: Discharge.

6. Sleeping

    a. Sleeping on the job is penalized as follows:

        1) First violation: Verbal warning.

        2) Second violation: Suspension for up to three days and written warning.

        3) Third violation: Discharge.

7. Solicitations

    To prevent interference with the Practice's patient care responsibilities, the following rules must be observed:

    a. Nonemployees: Persons who are not currently employed by the Practice are not permitted to distribute material or to solicit employees for any purpose whatsoever at the Practice at any time.

    b. Employees: Every employee's work deserves his or her full attention during scheduled working time. Therefore, employees may not distribute third-party literature in the Practice at any time.

c. Employees may not solicit other employees for any purpose at any time.

d. Penalties for solicitation are as follows:

1) First violation: Verbal warning.

2) Second violation: Suspension for up to three days and written warning.

3) Third violation: Discharge.

8. Intent to harm

Acts on Practice property intended to destroy property or to inflict bodily injury, whether or not the destruction or injury actually occurs, results in immediate discharge.

9. Misconduct

a. The term "misconduct" includes being discourteous to patients, employees, or visitors, and fighting, threatening, or abusing (verbally or physically) any employee, patient, or visitor.

b. Misconduct away from the Practice facilities that causes problems for the Practice is dealt with separately and may lead to immediate discharge.

c. Misconduct of a very serious nature can result in immediate discharge for the first incident, i.e., assaulting a patient or fellow employee.

d. Penalties for misconduct are as follows:

1) First violation: Suspension for up to three days and written warning.

2) Second violation: Discharge.

10. Alcohol consumption

a. Consumption of alcoholic beverages on Practice property results in immediate discharge unless the Administration has approved such consumption for a special social function or reception.

b. Being unfit to work at usual efficiency or effectiveness as a result of consumption of alcoholic beverages is dealt with as follows:

1) First violation: Suspension for up to five days and written warning.

2) Second violation: Discharge.

11. Narcotics

    Illegal possession of or illegal use of narcotics or other drugs listed under Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 during working time or on Practice property results in immediate discharge.

12. Explosives and firearms

    Possession of explosives or firearms on Practice property or any attempt to bring explosives or firearms onto Practice property results in immediate discharge.

13. Negligence

    During working hours or on Practice property, commission of negligent or careless acts that result in personal injury or property damage or cause expense to be incurred by the Practice is dealt with as follows:

    a. First violation: Suspension for up to five days and written warning.

    b. Second violation: Discharge.

14. Unauthorized possession of property (theft)

    Unauthorized possession or use of any property, equipment, or materials may result in immediate discharge.

15. Falsification of records

    Falsification of time sheets or clocking out another employee's time sheet results in disciplinary action as outlined in the absenteeism documentation policy.

16. Fraudulent statements

    In applications for employment and in any other work situations, fraudulent statements of any nature are dealt with according to the nature of the statements, with penalties ranging from three days suspension to discharge.

17. Overtime

    a. All overtime, including beginning work before the regularly scheduled starting time, must have prior approval from an employee's supervisor.

    b. Penalties for failure to comply are as follows:

        1) First violation: Verbal warning.

        2) Second violation: Written warning.

3) Third violation: Suspension for up to three days and written warning.

4) Fourth violation: Discharge.

18. Slowdowns

Willful holding back, slowing down, hindering, or limiting of work is penalized as follows:

a. First violation: Written warning.

b. Second violation: Discharge.

19. Encouraging violation of work rules

Encouraging, coercing, inciting, bribing, or otherwise inducing any employee(s) to engage in any Practice rule violation results in immediate discharge.

20. Insubordination

a. Each employee is expected to comply with a proper request from his or supervisor. Refusing to accept work, a specific shift, or work location assigned by the supervisor or refusal to otherwise cooperate with management is considered insubordination.

b. If insubordination becomes an issue, the employee is warned that immediate discharge will be the result of continuing refusal to cooperate.

c. If the employee does not cooperate after being so informed, immediate discharge results.

d. In all work situations, an employee is expected to obey all orders. Later, he or she may protest through the grievance and arbitration procedure. (See related policy 2.52 on Grievance.) However, if an employee knows or believes that a person's health or safety will be endangered or the order is unreasonable, he or she may refuse to obey. The degree of a potential hazard is important in later determination of insubordinate action.

21. Unsatisfactory work

When an employee's work does not meet the standards of his or her department, he or she is penalized as follows:

a. First violation: Verbal warning

b. Second violation: Written warning clarifying problem and possible solutions.

c. Third violation: Discharge

22. Law violation

Employees are expected to obey all national, state, and local laws. If an employee is charged with a law violation (other than a minor traffic offense), he or she may be suspended until the charge is settled.

23. Improper use of fire and other emergency alarm systems

Any employee who activates the Practice fire alarm system, the elevator emergency bell, or other alarm system for other than the intended purpose will receive penalties ranging from a verbal warning to discharge.

24. Dress code

If, in the judgment of the supervisor, an employee exhibits non-compliance with the dress code of the Practice, the penalties are as follows:

a. First violation: Written warning with employee sent home to correct problem and return immediately.

b. Second violation: Suspension for three days.

c. Third violation: Discharge.

25. Abandoned job

a. An employee is considered to have abandoned his or her position if absent from work for 48 hours without due notice to his or her supervisor.

b. Abandonment results in immediate discharge.

26. Multiple violations

a. Three violations of one or more work rules during one 12-month period, where disciplinary action for any one of the violations resulted in a suspension from work, will be cause for immediate discharge.

b. Multiple violations resulting in an employee accumulating three or more written or verbal warnings may be cause for discharge.

27. Confidential information—Unauthorized access or release

Unauthorized access, possession, release, disclosure, or other use of confidential information results in immediate discharge, unless there are mitigating circumstances that suggest a lesser disciplinary action.

COMMENTS/EXPLANATIONS

Suspension

A suspension is defined as a temporary separation from work without pay at the will of the employer.

The department head is fully authorized to direct the employee to immediately leave the work area should it be necessary. A suspension may be waived at the discretion of the department head. However, the employee must be notified of this waiver and verbally informed that the gravity of the offense warrants temporary expulsion from work. The action must be referred to as a suspension, even if waived. If subsequent investigation finds the suspension unwarranted or unjust, the employee incurs no loss of pay or employment status and the results of the investigation are included in the employee's personnel records.

Termination

No discharge or dismissal of any employee may occur without the consultation of the Administrator or designee and the Practice's human resources department.

It is recognized that the employee's supervisor is normally the best-informed authority to judge the merit of a termination. It is, therefore, not generally the function of the Administrator to question the supervisor's decision to discharge an employee unless there is cause for further investigation.

The purpose of a review is to assure that the proper disciplinary procedure was followed for each employee. If there is a disagreement concerning policy between the Administrator and the supervisor that cannot be reconciled after discussion, the matter will be brought to the board of directors for a decision, which shall be binding to all parties.

NOTICE OF DISCIPLINARY ACTION

Name: _____ Date: _____

Department: _____ Job title: _____

Supervisor: _____

This is an official notice of the following disciplinary action:

___Written reprimand Demotion (effective date) _____

___Suspension (from_____ to_____) Dismissal (effective date) _____

Report back to work _____ (Date) _____

This disciplinary action is being taken for offense or failure to perform for the following reasons:

___Absenteeism	___Unsatisfactory working relationships	___Discourtesy
___Tardiness	___Unsatisfactory performance	___Unauthorized use of equipment
___Unauthorized absences	___Violation of safety regulations	___Lying
___Abuse of sick leave	___Insubordination	___Immoral conduct
___Carelessness	___Violation of department or employer regulations	___Divulging confidential information
___Negligence	___Fighting, abusing employees	___Gross misconduct
___Being under the influence of alcohol	___Engaging in illegal strike, sabotage, or slowdown	___Damage to or of property
___Illegal use of controlled substances	___Falsification of records	___Theft
___Conviction of crime	___Any other just cause affecting job performance	

Give details of above infractions: _____

The following warnings have been given prior to this disciplinary action: _____

_____

Previous warning for this offense: _____

_____

Previous warning for other infractions: _____

_____

There must be an immediate improvement in:_____

If corrective action is not immediately taken, further discipline or dismissal may result. Under appropriate circumstances, immediate dismissal may be warranted. A copy of this notice will be placed in your personnel file.

Supervisor signature: _____ Date: _____

I have read and understand the contents of this disciplinary action.

Employee signature: _____ Date: _____

PERSONNEL • POLICY 2.48

Employee Conduct

It is the policy of the Practice to require high standards of honest and moral behavior. All employees are expected to know and maintain high standards of commonly accepted, honest behavior. For the purposes of this policy, an employee is defined as any individual who works for the Practice including, but not limited to, physicians, advanced practice providers, contracted labor, interns, temporary employees, temporary agency employees, part-time, full-time, and per diem employees. Although most employees never need to be reminded of the type of behavior that satisfies appropriate standards of conduct, each employee is expected to become familiar with and abide by the Practice's expectations. The expectations outlined are not meant to be all-inclusive and do not cover every situation or possible infraction.

The policy of the Practice is that certain rules and regulations regarding employee behavior are necessary for the professional and efficient operation of the business. This policy benefits and protects the rights and safety of all. Conduct that interferes with the Practice operations and discredits and/or is offensive to patients and/or employees is not tolerated. Violation of these rules of conduct may result in immediate termination.

PROCEDURES

1. Employees are expected to act in the Practice's best interest, upholding the highest ethical standards. Employees should avoid any activities that may compromise these standards.
2. Employees are expected to behave in a manner conducive to efficient and dignified patient care.
3. Employees treat patients, visitors, and all staff members courteously and with the utmost respect.
4. Employees respect the privacy and confidentiality of patients and all protected health information (PHI), and do not disclose any information pertaining to patients of the Practice.

5. Employees refrain from causing, contributing to, or creating a negative work environment.

6. Employees project a professional and mature attitude toward patients, visitors, and co-workers.

7. Employees who display an unprofessional, aggressive, or demeaning manner may be placed on probation or terminated.

8. Employees may not criticize co-workers in the presence of patients or visitors. Employees may not make careless remarks that may negatively reflect on the Practice.

9. Employees demonstrate respect for each other and may not conduct themselves in any way that either interferes with a co-worker's performance or creates an intimidating, hostile, or offensive work environment.

10. Respect for employees is unrestricted by conditions of his or her marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law.

11. Employees may not make sexual advances, requests for sexual favors, or engage in any other verbal or physical conduct that is offensive to others.

12. Violation of these standards of conduct may result in disciplinary action up to and including immediate discharge.

PERSONNEL • POLICY 2.49

Harassment and Discrimination

It is the policy of the Practice to provide a work environment in which employees are treated with courtesy, respect, and dignity. The Practice is committed to maintaining an environment that is free of discrimination and harassment based on a person's *marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law.*

The Practice does not tolerate or condone any form of harassment, whether it originates from another employee, member of management, provider, patient, visitor, or vendor. Violation of this policy may result in immediate termination.

DEFINITIONS

The following are descriptions of actions and behaviors that are unacceptable and strictly prohibited. The examples used should not be considered all-inclusive. They are used only to illustrate prohibited actions, behavior, and/or conduct.

1. Harassment

Harassment includes verbal or physical conduct that belittles another, shows hostility or intense dislike toward an individual because of his or her marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law and that:

a. Has the purpose or effect of creating an intimidating, hostile, or offensive working environment;

b. Has the purpose or effect of unreasonably interfering with an individual's work performance; or

c. Otherwise adversely affects an individual's employment opportunities.

2. Unwelcome behavior

   This behavior includes verbal abuse and unwanted or unwelcome verbal comments or behaviors that have overtones related to an individual's marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law, or that which the employee regards as offensive. This behavior also includes:

   a. Epithets;

   b. Slurs;

   c. Negative stereotypes;

   d. Threatening, intimidating, or hostile acts; and

   e. Written or graphic material on paper or in electronic format that belittles or shows hostility to another employee.

3. Discrimination

   This behavior is an unlawful practice and undermines the integrity of the Practice. Discrimination occurs whenever employment decisions are made based on marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local laws. The Practice prohibits such actions.

4. Sexual harassment

   Sexual harassment is illegal and undermines the integrity of the employment relationship. Such behavior is not tolerated at the Practice. Sexual harassment includes, but is not limited to, unwelcome sexual advances; requests for sexual favors; and other verbal, written, or physical conduct of a sexual nature by employees, including providers, administration, vendors, visitors, and patients when such conduct:

   a. Is made an explicit or implicit term or condition of employment (quid pro quo);

   b. Is used as a basis for employment decisions affecting employees; or

   c. Has the purpose or effect of substantially interfering with an employee's work by creating an intimidating, hostile, or offensive working environment.

5. Additional examples of violations of this policy

   Violations that subject the offender to disciplinary actions, including immediate discharge, are as follows:

   a. Deliberate, repeated, and unsolicited comments with sexual overtones;

   b. Sexual jokes, drawings, and/or pictures;

   c. Uninvited touching;

   d. Physical gestures or actions of a sexual nature; and

   e. Invasion of employee's personal space in an intimidating fashion.

PROCEDURES

1. A complaint of harassment, unwanted behavior, discrimination, or sexual harassment should be directed to the Administrator or designee.

   a. If the Administrator is involved in the complaint, the employee should go to any member of the Grievance Committee, who promptly and fully investigates the complaint to ensure compliance with this policy.

   b. Confidentiality is maintained to the maximum extent possible, consistent with the need to investigate the complaint.

   c. Appropriate disciplinary action is taken if the complaint is found to be valid.

2. No retaliatory employment action is taken against any employee who truthfully reports a violation of this policy or participates in the investigation of such a violation.

3. All complaints are promptly and thoroughly investigated. An employee has no obligation to complain first to the person who is harassing him or her.

4. Dishonest complaints, false accusations, and false reports are also against the policy, and the Practice takes appropriate disciplinary action up to and including immediate discharge if an investigation shows that a dishonest and/or bad faith accusation has been made.

5. Employees who are aware of cases of unwelcome behavior, discrimination, or harassment of any kind in our workplace should report such cases promptly to the Administrator, human resources, or to the Grievance Committee. (See related policy 2.52 on Grievance.)

PERSONNEL • POLICY 2.50

Workplace Violence Prevention

The Practice prevents workplace violence and maintains a safe work environment. To accomplish these goals, the Practice has enacted the following guidelines to prevent intimidation, unlawful harassment, and other threats or acts of violence from occurring during business hours or on its premises.

PROCEDURES

1. Practice employees and providers will treat all fellow employees, including supervisors and temporary employees, patients, vendors, solicitors, and other members of the public, with courtesy and respect at all times.

2. Practice employees will refrain from fighting, "horseplay," and other conduct that may endanger others.

3. Conduct that threatens, intimidates, and/or coerces another employee, a patient, or a member of the public at any time, including off-duty periods, is not tolerated. This prohibition includes all acts of unlawful harassment, including harassment that is based on an individual's marital status, race, color, religion, gender, sexual orientation, gender identity, national origin, physical or mental disability, age, or any other class protected by federal, state, or local law.

4. Practice employees will report all threats or acts of violence, both direct and indirect, to their immediate supervisor or other member of management as soon as possible. This includes threats by employees, as well as threats by employees' family members, patients, patients' family members, vendors, solicitors, or other members of the public. When reporting a threat or act of violence, the employee shall be as specific and detailed as possible.

5. Employees will report all suspicious individuals and/or activities to a supervisor as soon as possible. If an employee sees or hears a disturbance, he or she should not place himself or herself in danger by observing, listening, or interceding. Instead, the employee should seek assistance immediately from management.

6. Management promptly and thoroughly investigates all reports of threats or acts of violence and suspicious individuals and/or activities.

7. Management will protect the identity of the individual making a report as far as is practical. To maintain workplace safety and the integrity of its investigation, the Practice may suspend employees, either with or without pay, pending investigation.

8. Any employee who threatens or commits violence or other conduct in violation of these guidelines is subject to prompt disciplinary action, including termination.

9. Employees should bring disputes and/or differences with other employees to the supervisor's attention. If an employee believes he or she receives an inadequate response from his or her supervisor, the employee should notify human resources.

10. The Practice is committed to resolving all employee concerns and disputes, and also holds each employee responsible for his or her behavior in the workplace.

PERSONNEL • POLICY 2.51

Safety and Health Rules

It is the policy of the Practice that safety rules are provided as guidelines for safe operations. All employees must follow these rules as a condition of employment. The rules also apply to all Practice vendors and business partners.

PROCEDURES

1. Safety and health rules

    a. All employees are given a copy of the safety and health rules upon initial employment.

    b. All employees must sign and return the acknowledgment form after they have been given a chance to review the safety rules and ask any questions.

    c. The safety rules are periodically reviewed to ensure they are applicable and current.

2. Disciplinary responses to safety and health rules

    a. Employees are subject to disciplinary action for violations of safety rules.

    b. Management may enforce any disciplinary action it deems appropriate.

    c. Such action may include any one or more of the following, depending on the severity of the violation:

        1) Instructive counseling or training to ensure clear understanding of the infraction and the proper conduct under organizational guidelines;

        2) Verbal warning with documentation in personnel file;

        3) Written warning outlining nature of the offense, and necessary corrective action with documentation in personnel file; and

        4) Termination.

3. Management employees, including supervisory personnel, are subject to the above disciplinary action for the following reasons:

    a. Repeated safety rule violation by employees under their supervision;

    b. Failure to provide adequate training prior to job assignment;

    c. Failure to report accidents and provide medical attention to employees injured at work;

    d. Failure to control unsafe conditions or work practices; and

    e. Failure to maintain proper housekeeping standards and cleanliness in their departments.

PERSONNEL • POLICY 2.52

Grievance

It is the policy of the Practice to be fair and reasonable with employees at all times and resolve problems so that a constructive, pleasant work environment prevails. In the employer-to-employee or employee-to-employer relationships, problems may develop. In the event that an employee has a grievance, a formal process to understand and discuss the complaint is afforded to the employee.

If an employee has a question about the interpretation or application of a policy; is in disagreement with a fellow employee, supervisor, Administrator, physician, advanced practice provider, or owner; feels that he or she has been treated unfairly; or a problem has not been resolved to his or her satisfaction, the employee may use the grievance procedure for resolving such problems without fear of recrimination. Failure to comply with this protocol constitutes a waiver of the grievance.

Notwithstanding this policy, as noted above, all employees serve the Practice in an "at-will" capacity, and any employee may be disciplined or terminated at any time by the Practice in its sole discretion, with or without cause, to the maximum extent permitted by law.

PROCEDURES

1. Employees are encouraged to express dissatisfaction and reconcile any concerns about their employment directly with their supervisors.

2. A grievance is defined as written dissatisfaction filed by an employee in connection with his or her employment. It generally refers to a formal complaint initiated by an employee concerning conditions of employment. Conditions of employment in this instance refer to "working conditions" (i.e., hours, terms and limitations of employment, or management actions that adversely affect the employee's status, pay, or tenure, and any conduct that affects or interferes with an employee's work performance or creates an intimidating, hostile, or offensive working environment).

3. The Practice maintains a Grievance Committee, which consists of four individuals selected to participate as well as the human resources director. Members of the committee are appointed for two-year terms and include administration, physicians, advanced practice providers and employees. Members should ordinarily excuse themselves from considering a grievance if an issue is too closely related to their area and a conflict of interest may arise or be perceived as arising. In such instances, an alternate member serves by appointment.

4. An employee with a grievance should present it in writing to his or her immediate supervisor. If the immediate supervisor is involved in the grievance, the written complaint may be given to the Administrator. All grievances must be signed and dated. The written grievance should be submitted detailing the complaint and the employee's proposed solution. It should be filed within five working days of the incident causing the complaint. The supervisor is to provide a written response within five working days of the receipt of the grievance. The response provides an explanation or solution, including how the decision was reached. If the issue involves the employee's supervisor, the employee should proceed to the Administrator, who performs the same role as the supervisor in providing a response to the employee within five working days.

5. If the employee is not satisfied with the response given, he or she may appeal the decision with the Grievance Committee. This committee meets with the complainant within one week, and then investigates the claim. A written report is prepared and given to the Administrator with the committee's recommendation for resolution. If the issue involves the Administrator, an owner of the Practice reads the report and works with the Grievance Committee.

6. If the employee is not satisfied with the response given in Step 2, he or she is to appeal the decision to the Administrator. (If the Administrator is part of the complaint, the employee should proceed directly to the physician head of the Practice.) This appeal must also be in writing and presented within 10 working days. If the complaint is of a highly personal or confidential nature, the complainant can go directly to the Administrator with his or her written grievance. Upon hearing the complaint the Practice Administrator (or owner when applicable) investigates the grievance. Within 10 days, the Administrator provides a written report of his or her decision to the complainant including the reason for the decision. The decision is final. Employees are expected to act in a mature fashion during and after a grievance process. Employees must respect this decision and refrain from any negative attitudes or comments once the matter has been resolved whether or not the decision was the one desired.

7. Should any party fail to respond within the time limits imposed, the decision will be made against the party failing to meet the time deadline. Extension of time limits may be granted by mutual agreement, in writing, of all concerned parties.

8. The grievance procedure does not apply to the following issues unless the grievant alleges discrimination or process violation:

    - Rate of pay;
    - Employee benefits;
    - Position classification;
    - Actions caused by a reduction in workforce; and
    - Non-selection for promotion when the sole basis for the grievance is the employee's allegation that they are better qualified than the person selected.

9. Grievances, and related discussions and actions, are to be held in the strictest confidence. No discussion of issues outside of the committee is tolerated. This includes the employee making the complaint.

10. Participants in the grievance procedure have the right to present their grievances under this procedure without fear of reprisal.

CHAPTER 3

Scheduling

POLICY 3.01 • Appointment Scheduling

POLICY 3.02 • Appointment Template

POLICY 3.03 • Appointment Recalls

POLICY 3.04 • Self Scheduling for Patients

POLICY 3.05 • Appointment Wait List

POLICY 3.06 • Deleting as Appointment

POLICY 3.07 • Appointment Confirmation

POLICY 3.08 • Cancellations

POLICY 3.09 • Preparing for Appointments

POLICY 3.10 • Delinquent Balance Appointment

POLICY 3.11 • Patient Wait Time

POLICY 3.12 • Appointment Status

POLICY 3.13 • Appointment No-Shows

POLICY 3.14 • Late Arrivals

POLICY 3.15 • Walk-ins

POLICY 3.16 • Follow-Up Appointments

POLICY 3.17 • Same-Day Appointments

POLICY 3.18 • Surgery/Procedure Scheduling

POLICY 3.19 • Provider Bumps

POLICY 3.20 • Referral Communication

POLICY 3.21 • Referral Response

SCHEDULING • POLICY 3.01

Appointment Scheduling

It is the policy of the Practice to schedule all appointments in the scheduling module of the practice management system in a consistent manner.

PROCEDURES

1. Employees who schedule patient appointments must receive training on the practice management system and be granted authorization to use the system from the Administrator or designee. Trained must also include definitions and protocols related to appointment templates, scheduling algorithms and provider matching. Training and authorization are required because of the complex nature of scheduling and the problems that occur if an appointment is scheduled incorrectly.

2. Employees can schedule an appointment by telephone, in person, or via an online request. The following information must be obtained from the patient or referring physician's office to schedule an appointment:

    a. Patient name (first and last);

    b. Status with practice (new or established);

    c. Telephone number;

    d. Reason for visit;

    e. Date of birth; and

    f. Insurance coverage, including guarantor, policy number, and group number. (The Administrator and business office manager determine the minimum information required based on data necessary for insurance verification.)

3. Practice employees use the appointment-scheduling module to assign a date, time and provider for the appointment.

4. At the time of scheduling, a mini-registration is performed for all new patients, and limited registration information is verified for established patients. The business office manager or designee determines this process, and it may change periodically due to insurance changes. Specific procedures are outlined in employee training manuals.

5. A Practice employee reviews the appointment details with the patient prior to hanging up the telephone or the patient leaving the office. (In the event that an appointment is scheduled online, the transmission of the appointment details must be secure, complete. And timely) If the patient is in person, the employee completes and presents a written notification of the appointment (e.g., an appointment card) to the patient before the patient leaves the office.

6. The script of the appointment scheduling phone call is conducted as printed below, or as modified by the Administrator or designee.

    a. Greet the caller: *"XYZ Practice, this is [your name], how may I help you?"*

    b. Identify the nature of the complaint or problem the patient is having.

    c. If the patient was not referred to a specific physician, determine the appropriate physician or advanced practice provider based on the patient's complaint.

    d. Verify the office location that the patient prefers, e.g., *"Did you want your appointment scheduled at our satellite office on Main Street?"*

    e. Ask for the patient's name and verify the correct spelling.

    f. Determine if this is an established or new patient to the Practice. Ask the caller, *"Have you ever been seen at one of our offices?"*

    g. If an established patient, verify the patient's identity by confirming the patient's date of birth, address, or another identifying characteristic.

    h. If a new patient, perform a mini registration on the patient by gathering appropriate information like name, date of birth, address, phone numbers, insurance information, and those data elements required by the business manager or designee,

    i. Say to the patient, *"While I'm looking for the best appointment for you, please go ahead and locate your insurance card so that after we make the appointment, I can collect your correct insurance information."* (This allows time for the patient to retrieve his or her insurance card.)

    j. Locate the appropriate appointment slot by reviewing the schedule. Offer the first available appointment to the patient, and continue to offer appointments until the patient accepts one that meets his or her needs.

k. Conduct a mini-registration according to the protocols established by the business office. Confirm that the name under which you registered the patient matches the name as it appears on the patient's insurance card.

l. Determine the source of the referral, if applicable, by asking, *"Whom can we thank for referring you to our Practice?"*

    1) Record the referral source in the appropriate field in the practice management system.

    2) If the referring physician is not in the system, contact the business office with the new referring physician's name and contact information.

m. Ask for the patient's daytime phone number, cellular phone number, and where the patient can be reached in the event of an emergency.

n. When an appointment is made, slowly restate the date of appointment, time, office location, and provider name to the patient. This ensures all information was accurately communicated to and received by the patient.

o. Ask the patient if he or she has any questions.

p. Thank the patient for choosing the Practice, conclude the call, and hang up the telephone.

7. For appointments that are made available online (via the Practice's Website, portal, third party vendor or other platform), the protocols for self-scheduling will mirror the process as outlined in this policy and procedure.

SCHEDULING • POLICY 3.02

Appointment Template

It is the policy of the Practice to manage the appointment template in a standard, consistent manner that promotes the goals of the Practice to achieve patient satisfaction, as well as optimal patient access and provider productivity.

PROCEDURES

1. The Administrator or designee manages the scheduling template.

2. Full-time physicians and advanced practice providers work nine half-day sessions per week. Sessions are 240 minutes of scheduled patient care time.

3. Morning half-day sessions will begin at 7:30 a.m. or 8:00 a.m.; afternoon sessions will begin at 12:30 or 1:00 p.m. Exceptions must be approved by the board of directors with a majority vote.

4. Appointment durations will be 10 or 15 minutes for established patients, and 15 or 30 minutes for new patients or those scheduled for physicals. Exceptions must be presented in writing by the requesting physician or advanced practice provider and discussed with the board of directors, and approved by a majority vote.

5. Frozen and blocked slots are not allowed without the permission of the Administrator and the lead physician or or designee. If appointments are frozen or blocked on the template (i.e., permanently embedded), these will be reviewed every quarter.

6. Any changes to the template must be requested and approved no later than 60 days prior to the effective date of the change.

7. Physicians and advanced practice providers that maintain an average wait time that exceeds 45 minutes will receive an internal consulting review to determine if opportunities exist to improve the appointment template.

8. A minimum of 10% of appointment slots will be made available to established patients to self-schedule online via the Practice's portal. This percentage may be altered if demand exceeds the supply of slots available.

SCHEDULING • POLICY 3.03

Appointment Recalls

It is the policy of the Practice to accommodate patients with follow-up visits. If the visit is far in the future, the Practice may choose to record the follow-up appointment on a recall list.

PROCEDURES

1. Determine the most appropriate scheduling horizon for the Practice, noting that the reschedule, cancellation and bump rate is much higher for patients pre-scheduled far in advance.

2. Once that timeframe is determined, open templates accordingly.

3. For patients who are recommended to return for an appointment that is outside of the recommended scheduling horizon for the Practice, place them on the recall list when they check-out. Indicate to the patient that he or she is scheduled to return but that a specific date and time will be determined in the future (e.g., six weeks prior to the appointment). Let the patient know to expect a call or secure electronic message to schedule an appointment about six weeks prior to when they should return to the practice.

4. Organize the recall list based on date, ideally using the recall function in the practice management system. For a manual system, use a spreadsheet or index cards stored in a box; organize by month.

5. Approximately six weeks prior to the recommended date of the appointment, pull patients from the recall list. Reach out to the patient by telephone and/or electronic message. Make three attempts to reach the patient; document each communication. Transmit a letter to the patient requesting that he or she contact your office to schedule an appointment for their recommended care; scan a copy of the letter and index it in the patient's record.

6. When the appointment is made, denote "from recall list" on the patient's account.

7. Make an annual assessment about the parameters of the recall list.

SCHEDULING • POLICY 3.04

Self-Scheduling for Patients

It is the policy of the Practice to offer established patients the ability to schedule appointments themselves. Self-scheduling is encouraged to reduce overhead costs, decrease the no-show rate, and exceed patients' expectations for exceptional customer service.

PROCEDURES

1. The Practice offers self-scheduling through one or all of the following channels:
    - Patient portal
    - Practice website
    - Smart phone app
2. Patients are informed about the functionality upon registering for the Practice. All established patients are invited to self-schedule.
3. The manager is responsible for maintaining the appointment template that is made available for self-scheduling. At minimum, routine follow-up appointment slots are made available for self-scheduling. The platform will direct the patient to call if there is a need for an appointment outside of the slots designated. Patients will be instructed to record a brief description of their chief complaint. Open (unfilled) slots will be assessed each day, releasing those slots to the schedulers to fill with call-in patients so as to avoid any open appointments. Ideally, this process is automated through the self-scheduling application. The manager will serve to troubleshoot any problems or complaints from patients about functionality, accessibility or other challenges.
4. The Practice will seek feedback from patients and employees regarding the self-scheduling function to determine any improvements available. This assessment will be performed, at minimum, annually.

SCHEDULING • POLICY 3.05

Deleting an Appointment

It is the policy of the Practice to delete patient appointments only when they have been entered in error.

PROCEDURES

1. Patient appointments are deleted only as a means of eliminating an incorrectly entered appointment.

2. In most other cases, the CANCEL, BUMP, or NO SHOW functions are more appropriate indicators of the status of an appointment. (See related policies 3.05 on Cancellations, 3.10 on Appointment No-Shows, and 3.16 on Appointment Bumps.) An appointment that is deleted has no record of ever existing. As such, problems may arise in providing the best patient service if the patient was not informed of the corrected appointment time.

SCHEDULING • POLICY 3.06

Appointment Wait List

It is the policy of the Practice to maintain a wait list for patients who wish to be seen earlier than can be accommodated by the current schedule. This service is an excellent way to exceed patient expectations and to fulfill potentially underutilized appointment slots.

PROCEDURES

1. The schedulers maintains a wait list of patients in the practice management system's designated wait list, or a computer spreadsheet or database program which is accessible to all staff on the Practice's shared network drive. Each entry includes the patient's full name, account number, cellular telephone number, and the date the patient is placed on the list.

2. Patients scheduled for procedures and other visit types, as determined by the Administrator or designee, are called approximatley 36 hours prior to the appointment. Such patients are requested to call the Practice back to confirm the appointment by 2 p.m. on the day prior to the appointment. If the confirmation is not received, a patient on the wait list (based on date) is called to determine if the appointment time in question is convenient.

3. If the appointment time is confirmed for the patient on the wait list, the scheduler indicates on that patient's entry that he or she is removed from the wait list.

4. The patient who fails to confirm is removed from the schedule with a note, "failed to confirm." A courtesy call is placed to the patient to indicate that, per Practice policy, his or her appointment must be rescheduled, and a request to reschedule is made. The patient pulled from the wait list is scheduled for that slot. The patient's original appointment is deleted, with a note, "wait list; moved to [Date of new (earlier) appointment]."

5. The wait list is accessed for patients who call to cancel 48 hours (or less) in advance. In the event of a last-minute cancellation, the scheduler who cancels the appointment is responsible for accessing the wait list, and contacting patients. Unless otherwise directed, the scheduler contacts a minimum of five patients in an attempt to schedule an appointment in the

cancelled appointment slot. (Note that this process may be automated, if the function is available in the Practice's practice management system.)

6. The scheduler will not leave a message on the wait list patients' telephone number (given the challenges of managing the return calls). Patients will be contacted in waitlist order until reached, and the first person who confirms his or her availability will be scheduled into the appointment slot.

7. The Practice will make all attempts to automate the wait list functionality in its practice management system, allowing open or recently cancelled slots to be filled by patients who have selected to be on a wait list.

SCHEDULING • POLICY 3.07

Appointment Confirmation

It is the policy of the Practice to confirm patients' appointments approximately 36 hours in advance of the scheduled appointment via a phone call or, with the patient's permission, secure electronic communication.

PROCEDURES

1. Each appointment is confirmed via a phone call or electronic communication (with the patient's permission) approximately 36 hours prior to the scheduled appointment. Telephony-based confirmations will be placed between 5 p.m. and 7 p.m., and electronic-based confirmations will be transmitted between 12 noon and 5 p.m. The confirmation is documented in the practice management system and/or a manual copy of the schedule.

2. Employees are instructed to record the time of the confirmation, the person(s) to whom the confirmation is given, if applicable, and any requests for rescheduling. Any automated system for confirmation will allow the patient to cancel or make a request to reschedule. These requests will be addressed immediately, but no later than 12 noon on the day prior to the appointment, so as to accommodate other patients and fill all appointment slots. If applicable, employees should reschedule cancelled appointments immediately, thus opening appointment slots for other patients who call and/or are on the wait list (see related policy 3.03 on Appointment Wait list).

3. A patient scheduled for a procedure or other service deemed applicable or confirmed by the Administrator and providers is contacted two days prior to the appointment. The patient is requested to inform the Practice regarding his or her intention to retain the appointment by 2 p.m. on the day prior to the scheduled time. If the patient does not confirm, a patient on the wait list (based on date) is called to determine if the appointment time in question is convenient. This confirmation policy is provided verbally and in writing to all patients scheduled for services that require a confirmation.

4. To preserve the patient's confidentiality, the script for appointment confirmations is: "You have an appointment with Dr. [Provider's Last Name] on [day of the week and time]. Please

call our office at [888-888-8888] if you have any questions or need to reschedule the appointment." (A similar script is established for electronic communications.) The specialty of the provider is not to be revealed unless the employee speaks directly to the patient, and only then if it is relevant to the conversation. If applicable, information regarding the site of the appointment is provided.

5. The Practice also reminds the patient to bring his or her insurance card(s) and time-of-service payments. If the patient has an outstanding balance, the employee confirming the appointment requests payment to be made before or when the patient arrives for the appointment. The employee confirming the appointment reminds the patient that the Practice would appreciate payment and provides the phone number of the business office to contact with questions.

SCHEDULING • POLICY 3.08

Cancellations

It is the policy of the Practice that patients requesting appointment cancellations will be accommodated as efficiently as possible.

The Practice establishes a direct cancellation telephone line and secure electronic communication, available 24 hours per day, seven days a week. The phone number and electronic communication are published for patients on all appointment-related material in the Practice. An employee responsible for scheduling will be accountable for checking the voice mail and electronic communication, at minimum, every two hours.

PROCEDURES

1. In the event that a patient requests to cancel his or her appointment, ask the patient for his or her last name and date of birth (or other identifying information), as well as the date and time of the appointment to be cancelled.

2. Cancel the appointment in the practice management system.

3. Reschedule the patient visit at the first available appointment date and time that is convenient for the patient.

4. If the patient cancels an appointment that is a follow-up visit that cannot be rescheduled in a timely manner, communicate the situation via a form or secure internal electronic message (or task) to the clinical team with instructions to review the situation and communicate with the patient. It is the full responsibility of the clinical team to take action on the request.

SCHEDULING • POLICY 3.09

Preparing for Appointments

It is the policy of the Practice to prepare for patients who are scheduled for the following day.

PROCEDURES

1. Employees responsible for greeting and registering arriving patients perform an electronic or manual review of the schedule for the following day.

    a. If applicable, Practice employees provide appointment lists to the clinical team for the following day.

    b. The schedule is reviewed for the following:

        1) Required patient/guarantor signatures (e.g., Privacy Notice);

        2) Payments (e.g., past-due and time of service);

        3) Waivers (e.g., non-covered services); and

        4) Insurance verification and benefits eligibility.

2. Unless performed automatically, insurance coverage and benefits eligibility (based on appointment type and/or chief complaint) are verified with the insurance company.

3. If applicable, employees contact patients to request clarification or to gather missing or inaccurate information. If contact is not confirmed, an employee notes the outstanding item(s) to review or request when the patient arrives.

4. See related policy on Pre-Visit Chart Review for preparing for the patient from a clinical perspective.

SCHEDULING • POLICY 3.10

Delinquent Balance Appointment

It is the policy of the Practice that patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused to the patient at the discretion of the Administrator or the provider.

PROCEDURES

1. For a patient with a delinquent balance seeking the first appointment after the past-due balance was created, the appointment is scheduled with the verbal advisement that the patient will be requested to pay the balance in full at or before the next scheduled appointment.

2. If payment is not made after the first appointment, or the patient does not arrive for his or her appointment, the patient with a delinquent balance is required to pay the balance in full before a future appointment will be scheduled.

3. Any such patient with a delinquent balance is brought to the attention of the Administrator and/or provider on the day prior to the next appointment. The Administrator and the provider(s) use their discretion in denying services to patients based on the clinical circumstances.

4. The patient is asked to contact the business office to settle the account.

5. As noted in related policy 6.14 on Termination of Provider-Patient Relationship for non-payment, any patient who maintains a delinquent balance over 150 days without making any payments or seeking assistance via financial hardship is given 30 days to locate another provider before being dismissed from the Practice.

6. Before refusing to see the patient or denying services to the patient when he or she presents for the visit, the Administrator communicates with the Practice's liability carrier in the event that the patient with the delinquent balance may present a risk management situation.

SCHEDULING • POLICY 3.11

Patient Wait Time

It is the policy of the Practice to limit the amount of time a patient waits at the Practice office for an appointment and to keep the patient informed of any prolonged delays. Wait time includes the time from when the patient arrives at the Practice until he or she is escorted to the clinical area, as well as the time he or she waits in the exam room or for ancillary services.

PROCEDURES

1. Monitoring patient wait time

   The Practice monitors patient wait time by having employees manually mark a patient's arrival time on the charge ticket, track it via electronic timers, or automatically monitor it in the practice management or electronic health records system. The provider also notes his or her arrival in the exam room at the start of the patient's appointment manually or, ideally, it is captured automatically. The Administrator and providers monitor these times as well as the appointment times. If the average patient wait time is found to exceed 45 minutes for any provider during a period of one month or more, a performance improvement initiative is started immediately to determine the causes of the delay and ways to improve it.

   a. The Practice's goal is for patient wait time upon arriving and being escorted to the clinical area to be less than 20 minutes. If the patient is kept waiting more than 20 minutes, he or she is approached directly and told the reason for the delay.

2. Provider delay

   a. If an emergency or unplanned event causes the provider to be delayed in getting to the Practice, all employees (clinical and front office) are informed immediately and provided with information about the delay, including the provider's expected time of arrival.

b. The clinical assistant team working with the delayed provider informs each patient impacted by the delay and includes the time when the provider is expected. Patients are given the option of waiting or rescheduling the appointment. If they choose to reschedule, the front office assists them in immediately rescheduling the appointment.

c. If there are patients who are scheduled during the period of the provider's delay but have not yet arrived at the Practice, the Practice will contact these patients immediately to inform them of the delay and reschedule their appointments.

SCHEDULING • POLICY 3.12

Appointment Status

It is the policy of the Practice to track the specifics regarding the appointment status for all patients. Patient appointment status is entered and/or automatically updated in the practice management system when a patient arrives for an appointment ("A" for arrived), cancels an appointment ("C" for cancel), fails to show for an appointment ("N" for no-show), or is bumped (cannot be seen when scheduled) ("B" for bumped), due to provider circumstances.

PROCEDURES

1. The appointment status is marked "A" for arrived when a patient arrives for an appointment. Marking patients "arrived" enables employees and providers to note the arrival time of the patient, as well as the patient wait time.

2. The appointment status is marked "C" for cancel if the patient calls or electronically communicates with the Practice to cancel an appointment more than 24 hours prior to the scheduled time. Employees should make all efforts to schedule another patient into the newly available appointment slot.

3. The appointment status is marked "N" for no-show if the patient calls the office to cancel an appointment within 24 hours or less of the scheduled appointment.

4. At the time of the daily system close, the appointment status is automatically marked "N" for no-show if the patient did not present for the scheduled appointment. (See related policy 3.10 on Appointment No-Shows.)

5. The appointment status is marked "B" for bumped when the physician or advanced practice provider must cancel a patient appointment. (See related policy 3.16 on Appointment Bumps.)

SCHEDULING • POLICY 3.13

Appointment No-Shows

It is the policy of the Practice to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment or who fails to cancel with appointment more than24 hours prior to the scheduled time is considered a "no-show." A no-show patient is charged a fee, as established by the Practice, for failure to show. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times is dismissed from the Practice.

PROCEDURES

1. A patient is notified of the no-show policy at the time of his or her initial registration. The no-show policy is provided in writing upon the patient's arrival, along with the Practice's registration forms. The policy is also displayed on the Practice's website and patient portal.

2. A patient's appointment status is automatically or manually updated by marking the system "N" for no-show when the patient cancels an appointment within 24 hours prior to the scheduled appointment.

3. By the end of the same day the appointment is missed, the clinical assistant and the scheduled provider review the chart of the patient who failed to present for his or her appointment.

4. "No show" is denoted in the patient's chart. The clinical assistant and the provider determine one of the following actions, which is documented in the patient's chart in the drop-down menu designated in the system to record the reason for the no-show:

    a. No follow-up necessary.

    b. Follow-up urgent. Locate patient immediately.

c. Follow-up advised. Contact patient and schedule visit in ____ weeks.

Date _____ Time _____ Clinical Assistant/Provider _____

Record details of the communication with the patient:

_____

5. Action must be taken according to the decision of the clinical team reviewing the chart. If necessary, responsibility is assigned for follow-up. If the patient is to be contacted in the future, a recall is generated in the practice management system to alert the Practice that the contact should be made in the specified time period. For non-urgent recalls, the Practice will send correspondence to the patient via secure e-mail or letter in the following format:

NO-SHOW CORRESPONDENCE

Name _____

We noticed that you missed your appointment!

Provider _____

Date _____

Time _____

Your provider has recommended that you return to the practice so that effective healthcare can be provided to you.

Please contact us at 888-888-8888 to schedule another appointment.

Thank you, _____

6. The Practice charges each no-show patient a missed appointment fee.

7. A patient who fails to present for his or her scheduled appointment more than once is considered a chronic no-show. This type of patient is only given certain appointment slots (e.g., the last of the morning) and may be required to prepay for certain services and/or to provide a credit card number with an agreement that a service fee is charged if he or she fails to present for an appointment.

8. A patient who fails to present for his or her scheduled appointment three or more times without the requested advanced notification is dismissed from the Practice. (See related policy 6.14 on Termination of Provider–Patient Relationship.)

SCHEDULING • POLICY 3.14

Late Arrivals

It is the policy of the Practice that a patient who arrives more than 15 minutes after his or her appointment time is handled as a late arrival.

PROCEDURES

1. If the delay is the responsibility of the Practice, the patient is received and registered as usual.
2. If the patient arrives more than 15 minutes after his or her scheduled appointment and is late for reasons not considered to be the responsibility of the Practice, an employee follows these steps:
    a. Informs the patient that he or she is late for the appointment.
    b. Registers the patient.
    c. Tells the patient that he or she will be worked in as soon as possible, and may take a seat until he or she is called.
    d. Informs the personnel assisting the appropriate provider that the late patient has arrived.
3. If the patient arrives more than 30 minutes late or after hours of operation, an employee reschedules the patient, unless the clinical circumstances dictate otherwise.

SCHEDULING • POLICY 3.15

Walk-ins

Alert: *This policy is formulated for a Practice that does not accept walk-in patients. Your practice is encouraged to consider how you will most effectively accommodate your patient, and adjust your walk-in policy accordingly.*

It is the policy of the Practice that patients presenting to the office with no appointment (walk-in) should be handled in an appropriate manner, following a standard protocol.

PROCEDURES

A front office employee responds to a walk-in patient in the following way:

1. Ask the patient to explain his or her problem or condition. If the problem or condition is an emergency, immediately contact the clinical team for assistance. As appropriate, the team may instruct the patient to proceed to the nearest emergency room. The clinical team is responsible for determining if the patient can be seen that day.

    a. If the patient can be seen and his or her condition is not an emergency, tell the patient that the Practice does not accept walk-ins and ask him or her to please contact the Practice prior to walking in next time. Explain that an exception will be made in this circumstance, and that he or she will be seen when the clinical team has a break in their schedule.

    b. If the patient cannot be seen, inform the patient that his or her request cannot be accommodated. Offer to schedule a future appointment. Provide information about the closest emergency department or treatment center. Document the instructions in the patient's record.

2. Register the patient, collect any time-of-service payments, and schedule the patient for the next available slot, double-booking if necessary.

3. Record the patient's walk-in status in the practice management system.

4. Ask the patient to be seated and indicate that there will be a wait.

5. Inform the appropriate clinical assistant or provider that a walk-in patient is waiting to be seen.

6. Prepare the patient's chart.

SCHEDULING • POLICY 3.16

Follow-Up Appointments

It is the policy of the Practice to schedule or arrange for recall all follow-up appointments recommendation by the patient's provider at check-out. The purpose of this policy is to provide a convenience to the patient, reduce incoming phone calls, and mitigate the Practice's legal responsibility.

PROCEDURES

1. The provider records, in a legible format, the time and nature of any follow-up appointments recommended for the patient, in the electronic health record system or on a charge ticket.

2. Unless the patient refuses, an employee schedules the follow-up appointment(s) or places the patient on the recall list upon reviewing the provider's request.

3. The employee reviews the period of time for medication approval to ensure that the follow-up appointment is timed prior to the medication approval period running out. If such is the case, the provider is immediately alerted to approve a longer time period or additional refill.

4. The patient is provided with written documentation listing the date and time of the next appointment, or the notification and explanation regarding the recall.

5. If follow-up appointments are made at the time of the patient's departure, the Practice maintains active appointment scheduling templates for six months from the current date (or the maximum time that the provider routinely requests follow-up visits).

SCHEDULING • POLICY 3.17

Same-Day Appointments

It is the policy of the Practice to accommodate same-day appointment requests whenever possible.

PROCEDURES

Patients requesting same-day appointments should be handled in the most appropriate manner, according to the following steps:

1. Request the patient to explain his or her problem or condition.

2. If appointments with providers are available, schedule the patient using the appointment scheduling protocols. (See related policy 3.01 on Appointment Scheduling.) Communicate to the patient the time he or she should present.

3. If no appointments with a provider are available, tell the patient that the provider would like him or her to see the triage/access nurse, and book the patient on the nurse's schedule. Tell the patient when he or she should present.

4. Schedule the patient in the first available appointment slot with a provider who can be double-booked if the patient: (a) refuses to see the triage nurse; (b) has insurance that requires same-day appointments (the Practice should maintain list of payers that qualify); or (c) indicates having a problem or condition that needs to be seen immediately. Tell the patient when he or she should present and that he or she may have to wait.

5. Alert the clinical team to the new appointment created. Prepare for the patient to the extent that time allows.

6. If the same-day appointment request is an emergency, instruct the patient to immediately proceed to the nearest emergency room. Document the instructions in the patient's chart.

SCHEDULING • POLICY 3.18

Surgery/Procedure Scheduling

It is the policy of the Practice to schedule all surgeries and procedures in a consistent and timely manner.

PROCEDURES

1. Upon the direction of the provider and in conjunction with the patient, a Practice employee schedules the surgery or procedure and records the appointment in the provider's designated manual or electronic surgery or procedure calendar, as well as the practice management system.

2. Inform the patient of all necessary information, including preoperative or preprocedure preparations.

3. Collect payment as per the protocols established by the Practice's business office.

4. Communicate with the hospital or ambulatory surgery center and submit all necessary information.

5. Contact the patient's insurance company to obtain any necessary authorizations or certifications. Should a referral be needed from the patient's primary care physician (PCP), communicate with the PCP. Note the appropriate number in the practice management system, as well as the date and contact at the insurance company. This administrative requirement should be in place no less than one week before the surgery or procedure, unless there are extenuating circumstances.

6. Capture information regarding the surgery on an electronic or manual Surgery/Procedure Scheduling Form (see next page).

SURGERY/PROCEDURE SCHEDULING FORM

Patient's name: _____

Date: _____ Birth date: _____

Social Security No.: _____

Phone (h): _____ Phone (w): _____ Phone (c): _____

Address: _____

Primary insurance company: _____

Policy number: _____

Secondary insurance company: _____

Policy number: _____

Referral requirements met? ___Yes ___ No Pending _____

PRE-CERTIFICATION

Obtained by: _____

Name of certifier: _____

Number: _____ Date: _____

Referring physician: _____

Phone: _____

Will they do the history and physical (H&P)? ___ Yes ___ No

Diagnosis: _____

Procedure/surgery: _____

Scheduled for: Day_____ Time _____

Location: _____

Anesthesia: _____

PRE-OPERATIVE INSTRUCTIONS

Has patient spoken to pre-op?	__Yes	__No
Has patient spoken to Anesthesiology?	__Yes	__No
Does patient have all instructions?	__Yes	__No
Are all consent forms complete?	__Yes	__No

Notes: _____

SCHEDULING • POLICY 3.19

Provider Bumps

It is the policy of the Practice to manage the appointment template in a manner that is consistent among all physicians and advanced practice providers (APPs), as well as to provide the least disruption to patient care. The Practice discourages providers from bumping appointments.

PROCEDURES

1. Physicians will not cancel office hours or scheduled patient appointments unless it is absolutely necessary. Requests for leave require at least 60 days' notice unless there is an emergency.

2. If a patient must be bumped from a designated appointment slot, the physician or advanced practice provider will make the request in writing, with specific instructions regarding the placement of the patients. If there is no room for the patient to be accommodated within one week, the physician or provider is requested to open additional office hours to facilitate the timely access to appointments. Those who cannot be accommodated in a timely manner will be seen by another physician or provider.

3. The scheduling template will be formulated in a timeframe that mitigates the possibility of provider-driven bumps. Patients who need appointments outside of the timeframe will be given the opportunity to be placed on the recall list. (See Appointment Recall policy and procedure.) Changes to the master template must be requested and approved no later than 60 day prior to the effective date of the changes.

4. If a change in the schedule affects a patient, the patient will be contacted immediately by telephone to reschedule. If applicable, an electronic message will be sent as well.

5. If reschedules are more than two percent (or that which is considered excessive) of all scheduled patients that physician or provider will assume the financial responsibility of the cost of the process.

6. Appointment bumps are monitored and reported. Bumping patients based on cancelling clinics is grounds for disciplinary action.

SCHEDULING • POLICY 3.20

Referral Communications

It is the policy of the Practice to communicate with the PCP or referring clinician regarding referrals in a thorough and efficient manner that ensures coordination of care between the Practice and its referral partners.

It is the policy of the Practice to communicate with the patient, family and caregiver in a method that is most convenient and effective for the Practice and the patient. The Practice discusses the test results, plan of care and treatment options with the patient in a manner that is as informative, thorough and collaborative as possible.

PROCEDURES

1. The Practice electronically notifies the PCP or the referring clinician of the receipt and acceptance of the referral request in addition to the date and time of the patient's appointment. This tracking process is vitally important in establishing effective communication and collaboration and gives the PCP or referring clinician the specifics about the appointment in the event that follow up is needed.

2. The Practice obtains the necessary information about the patient from the PCP or referring clinician by specifying exactly what information, records, and results are needed on the referral request form. The Practice requests that the PCP or referring clinician specifies what "clinical question" should be addressed and answered by the specialist in the consultation with the patient, along with a relevant history and test results, if applicable.

3. The Practice specifies within what time period the PCP or referring clinician can expect to receive a summary of care record (or referral summary/consultation note) after seeing the patient, in addition to the type of information that will be included. Unless there are extenuating circumstances, the timeframe is three business days following the patient's appointment.

4. The Practice communicates electronically, fax and/or telephone with the PCP or the referring clinician. The Practice transmits the documentation of the patient's visit with the specialist to the PCP or referring clinician as a summary of care record, as well as the patient's test results and all other pertinent information. The content and mode of communication are based on what is the most effective option to ensure good coordination of care between the Practice and the PCP or referring clinician, but it is notable that the Practice strives to communicate the summary of care record electronically to ensure that the records are transmitted in a timely manner.

5. From these records, the specialist and the PCP or referring clinician communicate about treatment options, follow-up care, and further coordination regarding the patient.

6. The Practice follows the agreement that was made with the PCP or referring clinician with regards to communicating with the patient. The agreement specifies who is responsible for communicating with the patient, family and caregiver (as is applicable for the patient), about the test results, treatment plan and management of specialty care.

7. The Practice communicates with its patients in a variety of ways, depending on the patient and his or her accessibility, such as telephone calls, during office appointments, and via secure electronic messaging. In accordance with the written agreement between the Practice and the PCP or referring clinician, the patient, family and caregiver are kept informed regarding any changes to the plan of care during the treatment process.

SCHEDULING • POLICY 3.21

Referral Response

It is the policy of the Practice to ensure that PCPs and referring clinicians receive timely and thorough responses to all referral requests, including the acknowledgement of the referral request and the date and time of the appointment. The Practice tracks the confirmation of the receipt of the referral through monitoring "open" referral requests.

It is the policy of the Practice to ensure that PCPs and referring clinicians receive timely and thorough documentation for the referral. The documentation includes, but is not limited to, the answers to clinical question(s), test results, diagnoses, treatment options, plans of care, and possible recommendations for follow-up appointments.

It is the policy of the Practice to use the electronic health record (EHR) system to provide an electronic summary of care record to PCPs and referring clinicians for all referrals. The alternative is a referral summary or consultation note that is faxed or mailed to the PCP or referring clinician.

PROCEDURES

1. The Practice has a documented tracking system to confirm when a referral is received. PCPs and referring clinicians are invited to participate in the Practice's electronic referral request system.

2. In the event that a referral is received by mail, fax or in person, the request is transferred to the electronic system by the Practice's referral coordinator on the same business day.

3. The referral is scanned into the referral request system for documentation. Once a referral request form is received, the Practice generates a response of acknowledgement to the PCP or referring clinician immediately.

4. The referral request is then transmitted to the referral coordinator, who contacts the patients (or other designated party) to schedule the appointment within one business day. Once determined, the date and time of the appointment, as well as other pertinent details are transmitted to the PCP or referring clinician electronically.

5. The Practice monitors the timeliness of the initial acknowledgement, as well as the transmission of the date and time of the appointment. Referral requests are closed once the date and time of the appointment have been sent to the PCP or referring clinician.

6. The expectation is for the referral request to be closed within three business days, having meant that the referral request is acknowledged, the patient is contacted, the date and time of the appointment is determined and confirmed, and the PCP or the referring clinician is contacted with said appointment information.

7. In the event that the referral coordinator makes three attempts to communicate with the patient, without any response, the PCP or referring clinician is contacted with regards to the details of the attempts and a request to initiate follow-up in a different manner. Once the documentation of the three attempts with no response is transmitted to the PCP or referring clinician, the referral request is marked completed by the referral coordinator. It is re-opened should the PCP or referring clinician communicate with additional or alternative instructions.

8. After the patient is seen, the Practice responds to the referral by transmitting a record of the visit via an electronic summary of care record, which may also be called the referral summary or the consultation note.

9. All attempts are made by the Practice to transmit the documentation of the visit electronically to the PCP or referring clinician via a summary of care record. Regardless of the nature of the documentation of the visit (summary of care record or referral summary), the record is transmitted within three business days of the appointment. As noted, every effort is made to transmit the record electronically; alternatively, the documentation is sent via fax or mail.

10. In the record of the visit, the Practice addresses every question or request made by the PCP or referring clinician. This includes, but is not limited to:

    - Answer(s) to clinical question(s) posed by the PCP or referring clinician in the referral (for self-referrals, the Practice provides findings addressing the patient's reported complaint);
    - Diagnosis (as determined or confirmed by the specialist);
    - Results of procedure(s) and test(s) as performed as part of the patient evaluation and treatment;

- Recommended plan of care, care management, patient education and/or secondary specialty referrals, as performed in coordination with the PCP or referring clinician's plan of care, made in collaboration with the patient, family and caregiver; and
- Follow-up needed, if applicable, with the specialist including further coordination.
- The electronic summary of care record contains the following elements, including, but not limited to:
- Patient name;
- PCP or referring clinician's name and contact information;
- Reason for referral;
- Procedure(s);
- Encounter diagnosis(es);
- Immunizations;
- Test results;
- Vital signs (height, weight, blood pressure, body mass index [BMI]);
- Smoking status;
- Functional status including activities of daily living, as well as cognitive and disability status;
- Demographic information (preferred language, gender, race, ethnicity, date of birth);
- Care plan, including goals and instructions;
- Care team including the specialist of record and any additional known care team members;
- Current problem list (may include historical problems if determined relevant); and
- Current medication list and medication allergy list.
- "Care plan" is defined by the Centers for Medicare & Medicaid Services (CMS) as the "structure used to define the management actions for the various conditions, problems or issue. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome), and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome)."

11. The Practice has a tracking system for monitoring the timeliness of transmission of the summary of care record or referral summary.

CHAPTER 4

Patient Administrative Services

POLICY 4.01 • Patient Arrival Notification

POLICY 4.02 • Patient Account Assignment

POLICY 4.03 • New Patient Registration

POLICY 4.04 • Patient Check-In

POLICY 4.05 • Patient Signature

POLICY 4.06 • Referrals, Preauthorizations, and Precertifications

POLICY 4.07 • Assignment of Benefits

POLICY 4.08 • Insurance Verification and Benefits Eligibility

POLICY 4.09 • Insurance Coverage Waiver

POLICY 4.10 • Parental Preauthorization for Minors

POLICY 4.11 • Post-Visit Patient Services

POLICY 4.12 • Patient Satisfaction Survey

POLICY 4.13 • Answering Service

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.01

Patient Arrival Notification

It is the policy of the Practice that after a patient arrives for his or her appointment, an employee notifies the clinical team of the patient's arrival.

PROCEDURES

1. The front office staff notifies the clinical team of a patient's arrival according to the method chosen by the Practice. The chosen method may include one of the following:

    a. Using the arrival function in the practice management or electronic health record system.

    b. Manually placing a chart in the chart rack, which can be viewed by the clinical team; or

    c. Instant messaging or text paging the clinical team responsible for the patient.

    The Practice strives to utilize all automated processes available. If the arrival function exists in the practice management and/or electronic health record system, the Practice will use it. Manual forms or other paperwork may still be placed in a chart rack or other physical location for access by the clinical team at the time the patient is escorted to the back.

2. If the clinical team does not greet the patient and escort him or her to an exam room within 20 minutes of being notified, a front office employee reminds the clinical team that the patient is waiting.

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.02

Patient Account Assignment

It is the policy of the Practice that its management information systems assign each patient an individual account number for all financial and clinical activities.

PROCEDURES

1. The practice management system assigns each patient an individual account number that is used for registration, billing and scheduling. Correspondingly, the account number is used for the patient's electronic health record.

2. The Practice posts all financial and clinical activities to the patient's individual account number, which has been assigned by the system.

3. While dependents may be linked to a patient's account when he or she is the guarantor, each patient will maintain an individual account. Family accounts and records will not be used.

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.03

New Patient Registration

It is the policy of the Practice that demographic and insurance information is collected from all new patients and is verified prior to or at the scheduled appointment.

PROCEDURES

1. To ensure correct billing, contracting, and data analysis, every patient seen by a provider is registered in the system.
2. A new patient may register by:
    a. Telephoning the Practice;
    b. Scheduling an appointment in person at the Practice; or
    c. Completing and submitting all applicable data electronically.
3. The Practice collects the following demographic and insurance information, or that which is designated by the business office manager:
    a. Patient name (first and last);
    b. Status with the Practice (new or established);
    c. Telephone number;
    d. Reason for the visit;
    e. Date of birth; and
    f. Insurance coverage, including guarantor, policy number, and group number. (The business office manager determines the minimum information required based on data necessary for insurance verification.)

4. A Practice employee ensures all available information is collected before the patient/guarantor leaves the office or ends the telephone conversation. If applicable, the registration process is performed electronically via the Practice's website, patient portal, scheduling vendor or other electronic platform.

5. Upon registration, all new patients are provided information about the Practice, which includes the following:

    a. Basic information about the Practice to include the address, telephone number and office hours;

    b. Registration for the Practice's patient portal, application programming interface (PI) or other electronic communication platform;

    c. The Practice's no-show policy;

    d. The Practice's financial policy; and

    e. Other information as designated by the physician, advanced practice provider and/or the administration of the Practice.

6. The patient's insurance coverage and benefits eligibility are confirmed prior to the patient's scheduled appointment, via a process as determined by the Practice. All exceptions are identified by 12 noon on the business day prior to the appointment to allow an employee to contact the patient. An employee is assigned to communicate with patients regarding all exceptions identified. If the Practice cannot verify insurance coverage or if the patient is not eligible for benefits that cover the appointment, the patient is contacted to determine if additional coverage is available or to alert him or her that full payment is expected for all non-covered services. If alternate coverage is provided, the employee communicating with the patient performs real-time eligibility to confirm the insurance coverage and benefits eligibility.

7. A new patient is fully registered prior to seeing the physician or advanced practice provider. When the patient arrives for his or her appointment, insurance and identification cards are scanned and indexed, and all remaining signatures are collected. Signatures may include, but are not limited to, acknowledging receipt of the Practice's privacy notice, the medical records release, and the assignment of benefits.

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.04

Patient Check-In

It is the policy of the Practice that all patients are greeted, registered and arrived at the front office prior to being seen by the physician and advanced practice provider in order to complete the registration process.

PROCEDURES

1. When a patient arrives for an appointment, an employee at the front office greets him or her with a smile, and if known, the patient's name.

2. An employee asks the patient to complete all applicable registration paperwork, as designated by the Administrator and business office manager. An employee scans and indexes the paperwork into the patient's account.

3. If not performed prior to the day of the appointment, complete demographic and insurance information is collected and verified with the insurance company through the real-time eligibility tool, or that which is utilized by the Practice to confirm coverage and benefits eligibility.

4. An employee asks the patient to provide a valid insurance card and identification card (e.g., a driver's license) at the time of the scheduled appointment. A scan of the front and back of each card is made and indexed in the patient's account.

5. If applicable, an employee asks the patient to be photographed, and proceeds with taking a picture of the patient. The picture is then uploaded into the patient's account.

6. Patients with insufficient insurance information at the time of service are registered as self-pay patients. Payment is required at the time of service.

7. The employee enters all demographic and insurance data provided into the patient's account in the practice management system.

8. Upon completion of the tasks, the employee marks the patient's account with an appointment status "A" for arrived in the practice management system.

9. If applicable, an employee prints a charge ticket after the registration information is entered into the practice management system. The ticket is printed directly to the clinical station or placed in a designated area for the clinical team to retrieve.

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.05

Patient Signature

It is the policy of the Practice that each patient provides a signature to indicate his or her presence at the Practice for the encounter.

PROCEDURES

1. A front office employee asks the patient to provide his or her signature in one of the following ways:

    a. Write his or her signature on an electronic signature pad, which also records the time and date, integrated with the Practice's practice management and/or electronic health record system;

    b. Sign the charge ticket (or other document created specifically for the patient's encounter), which also maintains the time and date of the appointment; or

    c. Complete a sign-in form when he or she arrives at the front office.

2. To maintain patient confidentiality, if applicable, the sign-in form features individual pieces of paper or labels that are preprinted with identifying numbers in sequential order. The numbers allow the front office staff to maintain knowledge about the flow of patients.

SIGN-IN FORM

Please sign in

Name _____

Provider you are here to see _____

Time of appointment _____ Insurer _____

Has your phone number, address, e-mail address, or insurance company changed since your last visit? Yes___ No____

If yes, note changes below:

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.06

Referrals, Preauthorizations, and Precertifications

It is the policy of the Practice to abide by all applicable rules and regulations regarding referrals, preauthorizations, and precertifications for the insurance companies with which it participates.

PROCEDURES

1. The Practice obtains protocols for processing referrals, preauthorizations and precertifications from the insurance companies with which it participates. These protocols may include specific forms, online requests/applications, and/or telephone authorizations.

2. All attempts are made to identify the need for a referral, preauthorization or precertification at the time the appointment is scheduled. These efforts are based on the Practice's understanding of insurers' protocols for these administrative requirements. These requirements, when known, are recorded in writing. They are shared with the schedulers.

3. All encounters which require a referral, preauthorization or precertification are forwarded to the employee designated to process these administrative requirements. All referrals, preauthorizations and precertifications are obtained no later than five business days prior to the patient's encounter. If the insurance company indicates that a referral, preauthorization or precertification is not necessary, the employee records the communication, to include the date, time and reference number designated for the telephone call.

4. All efforts are made to utilize an automated system to obtain referrals, preauthorizations and precertifications.

5. A minimum of three days prior to a patient's appointment, a designated employee confirms all applicable referrals, preauthorizations and precertifications, and the applicable number or code identifying approval.

    a. If not identified, depending on its protocols, the employee contacts the referring provider and/or the insurance company for the referral, preauthorization or precertification.

    b. Efforts to obtain such information are documented in the patient's account notes.

6. If the necessary referral, preauthorization or precertification cannot be obtained, an employee contacts the patient a minimum of one day prior to the appointment.

    a. The patient is informed that the Practice could not obtain the referral, preauthorization or precertification as required by the patient's insurance company.

    b. The Practice informs the patient that he or she is fully responsible for the charges, unless he or she can obtain the appropriate authorization.

    c. A patient who cannot provide a referral, preauthorization, or precertification upon arrival at the Practice is required to sign a consent to indicate the recognition of financial responsibility prior to obtaining services. A deposit is required upon arrival, and the remaining amount is collected at departure.

7. The patient is cautioned that a referral, preauthorization, or precertification obtained from their insurance company is not a guarantee of payment from the insurer and that the patient may be liable for the balance in full or in part according to his or her contract.

8. The referral, preauthorization or precertification are recorded in the appropriate field of the practice management system. The practice management system automatically reports the number or code on the claim form.

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.07

Assignment of Benefits

It is the policy of the Practice that all patients are presented with an assignment of benefits statement to sign.

PROCEDURES

The following statement is integrated into the registration forms and completed by patients when they check in for appointments.

ASSIGNMENT OF BENEFITS

I hereby assign to XYZ Practice any insurance or other third-party benefits available for healthcare services provided to me. I understand that XYZ Practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to XYZ Practice, I agree to forward the Practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

_____

Signature of Patient/Legal Guardian *Date*

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.08

Insurance Verification and Benefits Eligibility

The Practice confirms that patients have active coverage for the insurance on record. The Practice confirms that the medical services patients receive are covered by their chosen benefit plan. Employees are required to verify active insurance coverage and benefits eligibility prior to patients' appointments.

PROCEDURES

1. Patient accounts are queried electronically or manually pulled a minimum of two days prior to the appointment date.

2. For each account, the insurance company is contacted to verify coverage and benefits eligibility electronically through automated batch processing. If an automated option is not available, the employee will utilize any and all methods made available by the insurance company to confirm coverage and benefits. The Practice makes all attempts to perform the process automatically, or provides the tools and resources to employees to seamlessly confirm coverage and benefits. These tools may include insurers' websites, portals or a swipe machine for patients' insurance cards.

3. If the Practice performs these tasks automatically, this policy only applies to the exceptions (i.e., patients for whom no coverage can be confirmed).

4. Employees complete an Insurance Verification Form (see next page) for each pulled account or all applicable information is electronically recorded for each account.

5. If insurance coverage or benefits for the services scheduled to be rendered cannot be verified, an employee contacts the patient immediately. All exceptions are identified and action is taken to communicate with the patient as soon as possible.

    a. The patient is informed of the situation and asked to provide coverage information.

    b. If coverage is not available, the patient is informed of his or her responsibility to pay for the services to be rendered at the appointment.

    c. If the patient chooses, the appointment may be rescheduled. If time does not permit, this information is provided when the patient registers.

    d. Whether by phone or in person, each patient is asked for policy information he or she has for any alternative coverage.

    e. If the patient has alternative coverage, the employee communicating with the patient confirms insurance coverage and benefits eligibility through real-time eligibility or an alternative process according to Practice protocols.

6. If the appointment scheduler knows the patient's health plan does not cover services to be rendered, the patient is informed at the time of scheduling. The scheduler also tells the patient that payment in full is expected when services are rendered.

7. An employee informs each patient for whom no coverage is confirmed for insurance and/or benefits that payment is expected in full at the time of the appointment. Accordingly, collections are attempted upon arrival.

8. Consistent with time-of-service collections procedures, a Practice employee gives a receipt to the patient that indicates the amount charged for non-covered services and the amount paid by the patient.

9. A patient who arrives for an appointment without insurance or benefits for the services to be rendered is requested to sign a waiver form to indicate expectation for payment. (For Medicare patients, see related policy 13.07 on Medicare Non-covered Services.)

INSURANCE VERIFICATION FORM

Patient name: _____ Date of verification: _____

Patient phone number: _____ Date of birth: _____

Physician or Advanced Practice Provider the patient is seeing: _____

Appointment time and date: _____ Chief complaint: _____

Primary insurance company: _____ Network: _____

PCP (if in an HMO or POS plan):_____ Name of insured person: _____

Relationship to patient: _____ Insured's date of birth: _____

Employer: _____

Effective date: _____

Person contacted: _____ Telephone number: _____

Who is covered under this plan? _____

Send claim to: _____ Group number: _____

Policy number: _____ Co-pay: _____

Deductible: _____ or – For family: _____ For individual: _____

Unmet Deductible: _____ or – For family: _____ For individual: _____

Policy coverage notes: _____ Lab and X-ray: _____

Immunizations: _____Well visits: _____

Other: _____

Key: HMO = health maintenance organization; PCP = primary care physician; POS = point of service

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.09

Insurance Coverage Waiver

It is the policy of the Practice that proof of insurance is provided when patients register for all appointments. The Practice verifies the information provided directly with the insurance company. (See related policy 4.09 on Insurance Verification and Benefits Eligibility.) If proof of insurance is not available or cannot be verified, patients are informed that that they are responsible for paying for the services to be rendered.

PROCEDURES

1. Each patient arriving for an appointment without insurance coverage or coverage that cannot be verified is informed of his or her payment responsibility and given an Insurance Coverage Waiver to sign.

2. If the patient refuses to sign the waiver, the employee is instructed to ask the patient if he or she would like to reschedule the appointment or contact his or her insurance company to have proof of coverage transmitted to the Practice.

3. If the patient does not cooperate, the employee is instructed to contact the business office immediately.

4. A minimum payment, as determined by the business office, is required. The payment is collected from the patient prior to being seen by the provider.

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by _____ (name of insurance company) cannot be confirmed at this time. I wish to receive medical services from _____ (name of the provider). If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____

Signature of Patient/Legal Guardian *Date*

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.10

Parental Preauthorization for Minors

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law.*

It is the policy of the Practice to comply with state laws that govern the treatment of children under the age of 18.

PROCEDURES

1. The Practice seeks legal counsel regarding compliance with all applicable state laws for treating minors.

2. At the initial visit, provide information regarding all applicable state laws to the parent/guardian.

   For example, if state law dictates that a parent or guardian must be present for the child to receive medical care, otherwise a preauthorization form signed by the parent/guardian must be provided, the Practice should provide a copy of this form at the initial visit.

3. In the event that a minor presents for care without a parent/guardian or preauthorization form, the Practice attempts to contact the parent/guardian, unless state law dictates otherwise. Upon contact, two employees are requested to listen to the parent's/guardian's authorization. The verbal authorization will be documented in the patient's record, and the witnesses will both sign to acknowledge that they heard the verbal authorization. In the event that the parent/guardian cannot be reached, a member of the clinical staff will be consulted to determine if the situation is urgent or emergent. If so, this fact will be documented and the patient will be seen. If not, the patient will be rescheduled. This situation may be altered or amended based on compliance with state laws.

4. A sample authorization form follows; however, it is considered a sample only, and the Practice must comply with applicable state laws. A Practice employee scans the completed form into the patient's medical record.

MINOR AUTHORIZATION

For families who are ongoing patients of the Practice, it may be more convenient to have prior authorization for medical care delivered to minors without a parent or guardian having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

Name: _____ Date of birth: _____

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

Parent's name: _____

Phone (office/home): _____

Parent's name: _____

Phone (office/home/cell): _____

Other (relationship): _____

Phone (office/home/cell): _____

Signature: _____

Date: _____

Print name and relationship: _____

NOTE: *If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.*

_____

_____

_____

Signature: _____

Printed name: _____

Phone: _____

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.11

Post-Visit Patient Services

It is the policy of the Practice that patients are provided timely and consistent post-visit services.

PROCEDURES

1. All patients are directed to the check-out desk after being seen by the physician or advanced practice provider. Alternatively, some or all of the post-visit services may be provided in the exam room.

2. Patients are offered a copy of their after-visit clinical summary. The Practice also transmits it to the patient via the Practice's patient portal, application programming interface (API) or other electronic communication platform. If applicable, the patient is asked if he or she needs assistance in registering for the portal.

3. The Practice develops and implements a system of informing the Practice employees working in this function regarding the following information:

    a. Closure of the visit;

    b. Procedure and diagnosis codes, including appropriate linkage, if applicable;

    c. Charges incurred;

    d. Applicable time-of-service payment;

    e. Follow-up appointment(s) requested to schedule or recall and all applicable details; and

    f. Ancillary tests requested and all applicable details to facilitate scheduling.

4. If the information is provided manually, handwriting must be legible.

5. Based on the post-visit services requested, the Practice employee performs all tasks to accomplish the provider's requests. These tasks may include, but are not limited to, the following:

    a. Keying, reviewing (for accuracy and completeness) and/or finalizing the procedure and diagnosis codes;

    b. Collecting time-of-service payments;

    c. Posting time-of-service payments;

    d. Providing an after-visit clinical summary to the patient;

    e. Handing a receipt to the patient;

    f. Scheduling appointment(s) and/or tests; and

    g. Providing the patient with a record of all appointment(s) or tests with any applicable information, such as clinical preparations and location maps for off-site appointments.

6. To conclude the post-visit process, a Practice employee asks the patient if he or she has any additional questions or needs with which the Practice can assist.

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.12

Patient Satisfaction Survey

It is the policy of the Practice to seek feedback from patients regarding opportunities for improvement. Patient satisfaction surveys will be conducted on a periodic basis to maintain the Practice's commitment to excellence.

PROCEDURES

1. A patient satisfaction survey will be used to measure and monitor patient satisfaction. The Practice will use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for the instrument.[8] CG-CAHPS is an initiative of the Agency for Healthcare Research and Quality (AHRQ), an agency of the federal government.

2. Surveys will be administered to allow for an adequate sample size from which to derive statistically significant results. .

3. A designated employee or third party vendor will collate the results of the survey and provide a summary and detailed reports by provider and site to the Administrator.

4. The Administrator will transmit all findings to physicians, advanced practice providers and managers. Depending on the findings, stakeholders will be assigned to produce a corrective action report or commendation strategy for any efficiencies/positive results noted on the report within two weeks of receipt of the site report.

5. All commendation communications will be summarized and distributed to all employees. If applicable, a list of strategies that increase patient satisfaction will be included.

[8] 1 https://cahps.ahrq.gov/surveys-guidance/index.html. Accessed February 6, 2016.

PATIENT ADMINISTRATIVE SERVICES • POLICY 4.13

Answering Service

It is the policy of the Practice to use an answering service to effectively handle calls received during non-office hours. The primary incoming telephone line is placed on call-forwarding to the current answering service each weekday evening and on Fridays for the weekend. The service ensures that all patients, referring providers, and hospital emergency departments have immediate access to the provider on call.

PROCEDURES

1. A designated Practice employee transfers the phones to the answering service at 5:00 p.m. each evening. The protocol for the transfer is as follows or as otherwise designated by the Practice's telephone system and answering service:

    a. Select line number 1.

    b. Dial the designated number for the answering service.

    c. Listen to the recording and wait for the service to answer.

    d. Tell the service the Practice is going on service.

    e. Tell the service the name of the provider who is on call and how long he or she is on call (e.g., 8:00 a.m. Monday morning, for the weekend, etc.).

    f. Hang up and push the "Night" button on the keypad (the button light will be on).

    g. If you have a problem reaching the answering service, call the service at [xxx-xxx-xxxx] to speak directly to an operator at [xxx-xxx-xxxx]. Require the service to manually transfer the phones, and request that an operator confirms this is accomplished by calling the Practice on the back line after transferring manually.

    h. Complete the electronic answering service log maintained on the Practice's shared drive. Document your name and the person with whom you spoke.

2. A designated Practice employee transfers the phones off the answering service at 7:30 a.m. each morning. The protocol for the transfer is as follows or as otherwise designated by the Practice's telephone system and answering service:

    a. Select the main line.

    b. Dial the designated number to take the phones off service.

    c. Press the "Night" button (the button light will be off).

3. Gather messages from the answering service taken during the evening and/or weekend, ideally transmitted in an electronic format.

    a. Review messages for completeness.

    b. Distribute all applicable messages via a task within the Practice's electronic health record system to the appropriate employee(s) who can take action.

CHAPTER 5

Medical Records

POLICY 5.01 • Medical Records

POLICY 5.02 • Medical Records Standards

POLICY 5.03 • Access to Medical Records

POLICY 5.04 • Patient Access to Medical Records

POLICY 5.05 • Records Transfer

POLICY 5.06 • Clinical Decision Support

POLICY 5.07 • Documentation Cloning

POLICY 5.08 • Signature Log

POLICY 5.09 • Documentation

POLICY 5.10 • Medical Record Audits

POLICY 5.11 • Subpoena Compliance

POLICY 5.12 • Subpoena Duces Tecum

POLICY 5.13 • Search Warrants

POLICY 5.14 • Authorization to Release

POLICY 5.15 • Medical Record Duplication and Form Completion

POLICY 5.16 • Employees' Medical Records

POLICY 5.17 • Return to Work — Medical Status Report Form

MEDICAL RECORDS • POLICY 5.01

Medical Records

Alert: *Different state agencies may regulate the permitted charges, timing and protocol for duplicating, transferring, and providing medical records. Each practice should apply the requirements of its own jurisdiction.*

It is the policy of the Practice to provide an organized medical record for each patient that is legible, accurate, readily accessible, and easily retrievable.

PROCEDURES

1. The Practice maintains a complete and accurate medical record for each patient. The medical record is the compilation of all paper and electronic information into a single document that describes all aspects of the patient's care, as rendered at the Practice. The record is maintained electronically in the Practice's electronic health record (EHR) system.

2. All medical records, regardless of whether they are created at, or received by, the Practice are the property of the Practice.

3. The Practice will convert all paper-based documentation into an electronic format within 48 business hours of its receipt by scanning and creating an electronic file. The electronic file will be indexed in the appropriate section of the patient's chart in the EHR system. The indexing protocols will be created and maintained in writing; compliance is expected by all employees involved in the process. (See related policy 5.15 on Medical Records Duplication and Form Completion.)

4. The Practice makes all efforts to maintain the privacy and security of protected health information (PHI), abiding by all state and federal laws regarding PHI. The Practice keeps all records in a secure, encrypted environment and ensures that access is limited to only those physicians, advanced practice providers and employees who need it.

5. Standard templates are utilized for all office notes, unless specifically exempted by the medical director. (See related policy 5.02 on Medical Records Standards.) All other

documentation of services provided to the patient is directly incorporated into the EHR system, or scanned and indexed. The Practice makes all efforts to maintain the patient's information electronically from the source of the data.

6. The Practice abides by all applicable state and federal laws regarding the patient's right to access and amend his or her PHI. A patient may request to view, download and/or transmit his or her medical records in an electronic format. Under the HIPAA Privacy Rule, a patient has the right to access and/or amend his or her medical records as defined by that which is contained in a "designated record set." The term "designated record set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about an individual. These requests are honored only when accompanied by a signed release-of-information form. (See related policy 5.14 on Authorization to Release).

7. If applicable, the Practice reserves the right to charge for duplication costs involved with transferring medical records, in accordance with state law. (See related policy 5.15 on Medical Record Duplication and Form Completion.)

8. Paper medical records archived in storage can be retrieved through a written request to the medical records department. (See related policy 5.14 Authorization to Release medical records.)

MEDICAL RECORDS • POLICY 5.02

Medical Records Standards

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law.*

It is the policy of the Practice to establish for the content, maintenance, and confidentiality of patient medical records that meet the requirements set forth in federal and state laws and regulations, and to define the portion of a patient's healthcare information, whether in paper or electronic format, that comprises the medical record. Patient medical information may be contained within multiple electronic and paper records systems in combination with financial and other types of data. This policy defines requirements for those components of information that comprise a patient's complete "Legal Medical Record."

DEFINITIONS

1. Medical record: The collection of information concerning a patient and his or her healthcare that is created and maintained in the regular course of business of the Practice and is made by an authorized provider or person who has knowledge of the acts, events, opinions, or diagnoses relating to the patient, and made at or around the time indicated in the documentation. The medical record may also be known as the legal medical record (LMR) in that it serves as the documentation of the healthcare services provided to a patient by a provider of the Practice. The LMR is a subset of the designated record set and is the record that will be released for legal proceedings or in response to a request to release patient medical records. The LMR can be certified as such by a court of law.

    a. The medical record may include records maintained in an electronic medical record system that integrates data from multiple sources, captures data at the point of care, and supports caregiver services.

b. The medical record excludes health records that are not official business records of the Practice such as personal health records maintained by the patient.

c. Each medical record shall contain sufficient, accurate information to uniquely identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among healthcare providers.

d. The information in the medical record may be from any source in any format including, but not limited to, print medium, digital images, photographs, audio/visual recording, and/or electronic display.

2. Designated record set (DRS): A group of records that include protected health information (PHI) and that is maintained, collected, used, or disseminated by or for a covered entity (e.g., the Practice) for each individual who receives care from a covered individual or institution. Any research activities that create PHI should be maintained as part of the DRS and are accessible to research participants unless there is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule permitted exception. The DRS includes:

   a. The medical records and billing records about a patient maintained by or for a covered healthcare provider (can be in a business associate's records);

   b. The enrollment, payment, claims adjudication, and case or medical management records maintained by or for a third-party payer; or

   c. The information used, in part or in whole, to make decisions about patients.

3. Protected health information (PHI): Individually identifiable health information that is transmitted or maintained in any medium, including oral statements.

4. Authentication: The process that ensures that users are who they say they are. The purpose is to prevent unauthorized persons from accessing data or using another person's identity to sign documents.

5. Signature: A signature identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document.

6. Clinic record/shadow file: A folder containing copies only of information from the medical record used primarily by providers in their office or clinic setting. These copies of the relevant documents from the original medical record are not part of the LMR.

7. Macros: Computer macros enable a provider to record and replay a series of typed characters or other keystrokes or one-word commands at the same time in a manner that makes it possible for a physician or provider to quickly document an entire medical note while accomplishing efficient use of time and resources and or repetitive documentation.

PROCEDURES

1. Maintenance of the medical record
    a. A medical record shall be maintained for every patient who is evaluated or treated by a provider in the Practice in all places of service.
    b. The medical record is a documentation of all paper and electronic information regarding the patient's care.
    c. The medical record contents will be maintained in an electronic format.
    d. Original medical record documentation must be sent to the designated medical records scanning department or area.
    e. Any paper information will be scanned and indexed within 48 business hours of receipt at the Practice.
    f. If patient identifiable source information, such as photographs, films, digital images, and various monitor strips, cannot be incorporated in the patient's medical record electronically, the information will be summarized in a written interpretation and the location of the paper-based image will be referenced in the record.
    g. Shadow files containing copies of selected material are prohibited unless an exception is granted by the medical director.
2. Confidentiality
    a. The medial record is confidential and is protected from unauthorized disclosure by law.
    b. The circumstances under which the Practice may use and disclose confidential medical information is set forth in the Practice's privacy policy. (See related policy 16.1 on Right to Privacy.)
3. Content
    a. Medical record content shall meet all state and federal legal regulatory and accreditation requirements.
    b. If applicable, the Practice includes reference to specific state regulations.
    c. The Practice complies with the documentation requirements promulgated by the Centers for Medicare and Medicaid Services (CMS)[9]:
        1) The medical record should be complete and legible.
        2) The documentation of each patient encounter should include:

[9] Centers for Medicare and Medicaid Services. Documentation Guidelines for Evaluation and Management Services. Available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html. Accessed February 6, 2016.

a) The reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;

b) Assessment, clinical impression, or diagnosis;

c) Plan for care; and

d) Date and legible identity of the observer.

3) If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4) Past and present diagnoses should be accessible to the treating and/or consulting physician.

5) Appropriate health risk factors should be identified. The patient's progress, response to, and changes in treatment and revision of diagnosis should be documented.

6) The Current Procedural Terminology (CPT®) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code sets reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

d. All documentation and entries in the medical record, both paper and electronic, must be identified with the patient's full name and a Practice-specific unique medical record number. For paper-based documentation, each page of a multipage document must be marked with both the patient's full name and the unique medical record number, as single pages may be photocopied, faxed, or imaged and separated from the whole record.

e. All medical record entries must be made as soon as possible after the care is provided or an event or observation is made. An entry should never be made in the medical record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

f. Refer to the appendix at the end of this policy for a listing of the additional required medical record documentation content.

4. Medical records versus designated record set

a. Under the HIPAA Privacy Rule, an individual (i.e., patient) has the right to access and/or amend his or her PHI that is contained in a designated record set. The provider has the right not to amend the record; however, the patient's request to amend must be noted in the document.

b. The term "designated record set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about a patient. In compliance with the HIPAA Privacy Rule, the Practice has defined

a "designated record set" to mean the group of records maintained for each patient who receives medical services delivered by a Practice provider, which is comprised of the following elements:

1) The medical record, whether in paper or electronic format, to include patient identifiable source information such as photographs, films, digital images, and monitor strips created by various testing devices;

2) Billing records including claim information; and

3) All physician or other provider notes, written or dictated, in which medical decision making is documented, and which are not otherwise included in the LMR (e.g., outside records and e-mail when applicable for treatment).

c. The medical record generally excludes records from providers outside of the Practice (i.e., health information that was not documented during the normal course of business at the Practice). However, if information from another provider or healthcare facility or personal health record is used in providing patient care or making medical decisions, it may be considered part of the DRS and may be subject to disclosure on specific request or under subpoena. Disclosures from medical records in response to subpoenas are made in accordance with applicable Practice policies.

5. Those authorized to document in the medical record

Only the following Practice employees and/or employees of contracted clinical and social service providers may document entries in the notes section of the medical record:

- Advanced practice providers;
- Audiologists;
- Behavioral health specialists;
- Child health specialists;
- Clinical social workers;
- Diabetic educators;
- Dietitians;
- Home health coordinators;
- Interpreters (employees of Practice);
- Medical assistants;
- Nurse practitioners;
- Occupational therapists;
- Pastoral care providers;
- Pharmacists;
- Physical therapists;

- Physician assistants;
- Physicians;
- Podiatrists;
- Psychologists;
- Registered nurses;
- Midwives;
- Respiratory therapists;
- Speech pathologists; and
- Others as designated by the Practice.

6. Completion, timeliness, and authentication of medical records

   a. All inpatient medical records must be completed within seven (7) days from the date of discharge or date designated by hospital medical staff or individual state regulations. [Practice may include specific hospital medical staff or state regulations here.] Additional requirements may also be included in the applicable hospital medical staff by-laws and or rules and regulations.

   b. All office notes must be completed on the same day as the date of service; all operative and procedure reports must be completed within 24 hours unless there are extenuating circumstances. No more than 48 hours should transpire in the event of an extenuating circumstance. The practice will maintain a report with such lag times, and communicate with the board of directors about any outliers beyond these recommended standards.

   c. All medical record entries must be signed with the EHR system automatically inserting the user, date and time of the entry.

   d. Certain electronic methods of authenticating the medical record including methods such as passwords, access codes, biometric identification, or key cards may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with the Practice electronic signature standards (see Section 12 on Electronic Authentication of Entries).

   e. Electronic signatures are acceptable.

   f. Fax signatures are acceptable.

7. Routing requests for medical records for treatment, payment, and healthcare operations (TPO)

   Only authorized Practice employees may access medical records in accordance with the Practice's policy on employee access to PHI. (See related policy 16.01 on Right to Privacy.) Practice employees who access medical records for payment or healthcare operations are responsible to access only the amount of information in medical records

that is necessary to complete job responsibilities so as to remain in compliance with the HIPAA "need to know" guidelines. Access is allowed for the following purposes:

a Access to medical records for treatment purposes. Medical providers who are directly involved in the care of the patient may access the full medical record.

b Authorized and designated Practice employees may access the patient's medical record for purposes of obtaining payment for services, including the following uses:

1) Coding and abstracting;

2) Billing, including claims preparation, claims adjudication, and substantiation of services;

3) Utilization review;

4) Compliance (internal compliance officer); and

5) Capture and report data for external auditors (e.g., third-party payer reviews.

6) All policies and procedures regarding access to PHI will be followed when querying and reporting PHI.

c Patient medical records may be accessed for routine healthcare operation purposes including, but not limited to:

1) Peer review activities;

2) Quality management reviews including outcome and safety reviews;

3) Documentation reviews; and

4) Teaching.

5) All policies and procedures regarding access to PHI will be followed when querying and reporting PHI.

d. Personnel who access the electronic medical record are required to have a unique user identification and password (or biometric access), and access to information is limited according to the minimum necessary rule and managed by role, as approved by designated management personnel.

8. Ownership, responsibility, and security of medical records

a. All patient medical records, regardless of whether they are created at, or received by, the Practice; patient lists; and billing information are the property of the Practice. The information contained within the medial record must be accessible to the patient and thus made available to the patient and/or his or her representative upon appropriate request and authorization by the patient or his or her legal representative. (See related policy 16.01 on Right to Privacy.)

b. The director of medical records or designee is assigned as the person responsible for assuring that there is a complete and accurate medical record for every patient. The medical staff and other healthcare professionals are responsible for the documentation

in the medical record within required and appropriate time frames to support patient care.

c. Paper-based records may not be removed from any Practice facility and/or office except by court order, subpoena, or otherwise required by law. If a physician or provider separates from or is terminated from the Practice for any reason, he or she may not remove any documentation containing PHI, patient lists, and/or billing information from the Practice facilities and/or offices. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request that an electronic copy of their records be forwarded to another provider upon written, authorized request.

d. The EHR system shall be maintained with complete security. Paper-based records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction, and tampering are maintained as appropriate, and shall be in compliance with all applicable state and federal laws.

e. Records are released from the medical records department only in accordance with the provisions of this policy and other Practice privacy policies and procedures.

f. Special care is exercised with medical records protected by state and federal laws covering issues including, but not limited to, mental health, alcohol and substance abuse, suspected elder/dependent adult abuse and child abuse.

g. Organization and chronology are essential, and close attention shall be given to assure that documents are accurately scanned and indexed properly and that information is entered in the correct encounter and/or section for the correct patient.

9. Retention and destruction of medical records

a. All paper-based medical records are retained for at least as long as required by state and federal law and regulations, and Practice policies and procedures.

b. The EHR system, and all records contained within it, must be maintained per the legal retention requirements as specified in this policy as well or by consult with the Practice's legal counsel. If applicable, the EHR system shall have backup and redundant backup performed minimally on a daily basis, or that which is recommended based on the Practice's existing security risk analysis.

10. Maintenance and legibility of record

a. All medical records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the Practice's medical record destruction policy. (See related policy 5.09 on Purging Paper Medical Records.)

b. All entries in the medical record must be identified by the EHR system with a record of the user, time and date so as to audit any changes or alterations in records maintained in the EHR system.

c. Handwritten entries on paper-based documents should be made with permanent black or blue ink, with medium point pens. This is to ensure the quality of electronic scanning, photocopying, and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

11. Corrections and amendments to records

a. When an error is made in a medical record entry, the original entry must not be obliterated and the inaccurate information should still be accessible via the auditing capability of the Practice's EHR system.

b. The correction must indicate the reason for the correction, and the correction entry must be stamped by the author's identification, date and time, which is the standard protocol for the Practice's EHR system. Examples of reasons for incorrect entries may include "wrong patient," etc. The original content of the medical record must not be edited, altered, or removed. Patients may request a medical record amendment and or a medical record addendum. (See related policy 16.01 on Right to Privacy.)

c. Documents that are in paper format must be corrected in the following manner:

1) Labels must not be placed over entries for correction of information.

2) If information in a paper record must be corrected or revised, the author must draw a line through the incorrect entry, annotate the record with the reason for the revision, and then sign and date the annotation.

3) If the document was originally created in a paper format and then scanned, the electronic version must be corrected by printing the documentation, correcting as described in (2) above, and rescanning the document.

d. Documents that are created electronically must be corrected by one of the following mechanisms:

1) Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.

2) Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered prior to signing (i.e., wrong date, wrong attending assigned, etc.). If the preliminary document is visible to providers other than the author, this document must be part of the legal health record.

3) Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated in (1) above. Examples of documentation errors that are corrected by addendum include: wrong date, wrong location, duplicate documents, and incomplete documents. The amended version must be reviewed and signed by the provider.

4) On rare occasions, it may be necessary to recreate a document or move a document if it was originally posted incorrectly or indexed to the incorrect patient record.

e. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

1) Identify the new entry as a "late entry."

2) Enter the current date and time and sign the entry. (Do not attempt to give the appearance that the entry was made on a previous date or an earlier time.)

3) Identify or refer to the date and circumstance for which the late entry or addendum is written.

4) When making a late entry, document as soon as possible. There is no time limit for writing a later entry; however, the longer the time lapse, the less reliable the entry becomes.

f. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. When an addendum is necessary, the author must meet the following requirements:

1) Comply with the protocols as outlined by the Practice's EHR system, which must include a record of the author, date, time, and revisions made.

2) For paper-based records, document the date and time on which the addendum was made. Write "addendum" and state the reason for creating the addendum, referring back to the original entry.

3) When documenting an addendum on the EHR system or a paper-based record, complete it as soon as possible after the original note.

g. Errors in scanning documents

1) If a document is scanned with a wrong encounter date or to the wrong patient, the following must be done:

a) Reprint the scanned document;

b) Rescan the document to the correct date or patient; and

c) Void the incorrectly scanned document in the permanent document repository.

h. Electronic documentation

1) In general, correcting an error in an EHR should follow the same basic principles as corrections to the paper record. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

2) The Practice may insert guidelines for making corrections to direct entry of clinical documentation, as specified by the EHR system in use.

i. Copy and paste guidelines

1) The copy and paste function available for records maintained electronically eliminates duplication of effort and saves time; however, it must be used carefully to ensure accurate documentation and must be kept to a minimum or as-needed basis.

a) Copying from another clinician's entry — If a provider copies all or part of an entry made by another provider, the provider making the entry is responsible for making the appropriate reference to the source from which the entry is copied (e.g., Dr. Smith notes on 8/15/17). The provider who copies the entry is responsible for assuring the accuracy of the copied information.

b) Copying test results — If a provider copies and pastes test results into an encounter note, the provider is responsible for ensuring the copied data are sourced appropriately and are relevant and accurate.

c) Copying for re-use of data — A provider may copy and paste entries made in a patient's record during his or her previous encounter with the patient into a current record as long as care is taken to ensure that the provider's previously recorded information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded. (See related policy 5.03 on Documentation Cloning.)

12. Electronic authentication of entries

a. Electronic signatures are acceptable forms of acknowledgement in an EHR system. Electronic signatures must meet standards for the following:

1) Data integrity — To protect data from accidental or unauthorized change (e.g., locking the entry so that once signed no further untracked changes can be made to the entry).

2) Authentication — To validate the correctness of the information and confirm the identity of the signer (e.g., requiring the signer to authenticate with a password or other mechanism).

3) Non-repudiation — To prevent the signer from denying that he or she signed the document (e.g., public/private key architecture). This process entails validation of the signature to assure authenticity.

b. At a minimum, the electronic signature must include the full name and either the credentials of the author or a unique identifier, and the date and time signed.

13. Designation of secondary patient information

a. The following four categories of data contain secondary patient information and must be afforded the same level of confidentiality as the LMR, but are not considered part of the LMR:

1) Patient-identifiable source data — Data from which interpretations, summaries, notes, etc., are derived. They often are maintained in a separate location or database, and are retrievable only upon request. Examples include, but are not limited to:

a) Photographs for identification purposes, audio recordings of dictation notes, or patient phone calls;

b) Video recordings of an office visit for reasons other than patient care purposes;

c) Video recordings or pictures of a procedure for reasons other than patient care purposes;

d) Video recordings of a telemedicine consultation;

e) Communication tools (e.g., patient lists, work lists, administrative in-baskets, messaging, sign-out reports, "FYIs," drafts of notes, or summary reports prepared by providers);

f) Protocols, clinical pathways, clinical decision support and best practice alerts, and other knowledge sources; and

g) Alerts, reminders, pop-ups, flags, clinical decision support and similar tools used as aids in the clinical decision-making process. (The tools themselves are not considered part of the LMR. However, the associated documentation of subsequent actions taken by the provider, including the condition acted upon and the associated notes detailing the exam, are considered a component of the LMR. Similarly, any annotations, notes, and results created by the provider as a result of the alert, reminder, or other tools are also considered part of the LMR.)

2) Administrative data — Patient-identifiable data used for administrative, regulatory, healthcare operations, and payment purposes. Examples include, but are not limited to:

a) Authorization forms for release of information;

b) Correspondence concerning requests for records;

c) Birth and death certificates;

d) Event history/audit logs;

e) Patient-identifiable abstracts in coding system;

f) Patient-identifiable data reviewed for quality assurance or utilization management; and

g) Administrative reports.

3) Derived data — Data that consists of information aggregated or summarized from patient records so that there are no means to identify patients. Examples include, but are not limited to:

a) Accreditation reports;

b) Best practice guidelines created from aggregate patient data; and

c) Public health records and statistical reports.

4) Draft documents/work in progress — A draft document is not considered an official medical record document until it has been signed by an authorized signer.

14. Enforcement, corrective, and disciplinary actions

a. Compliance with this policy is monitored by the Practice, and any violations are reported to the appropriate supervising authority for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with the section(s) violated.

APPENDIX

The medical record shall include, at a minimum, the following items, if applicable and appropriate to the individual patient and provider type.

1. Identification information, which includes, but is not limited to, the following:

    - Name (including first, middle, and last);
    - Address;
    - Date of birth;
    - Last four digits of the Social Security number;
    - Account number, as generated by Practice's information system;
    - Gender;
    - Marital status;
    - Legal status;
    - Guarantor name, address, and contact information;
    - Emergency contact name, address, and contact information;
    - Legal authorization for treatment;
    - School grade, if applicable;
    - Date and time of arrival for care;
    - Name of patient's attending provider;
    - Initial diagnostic impression;
    - Diagnosis(es);
    - Allergy records;
    - Advance directives, if applicable;
    - Medical history, including as appropriate, immunization record; screening tests; nutritional evaluation; psychiatric, surgical, and past medical history; social and family history; and, for pediatric patients, a neonatal history;
    - Physical exam;

- Consultation reports;
- Orders including medication, treatment, prescriptions, diet, lab, radiology, and other ancillary services;
- Progress notes that include subjective, objective, assessment, and plan of care;
- Nurse or clinical assistant notes;
- Vital signs;
- Results of all tests performed (i.e., lab, X-ray);
- Consent forms for care, treatment, and research, if applicable;
- Assessments and treatment records created by the patient's other clinicians;
- Patient/family self-care and education plan;
- Patient care plan (see Policy 6.21 "Care Plan" in Chapter 6: Clinical Care);
- Clinical data from other providers;
- Patient photographs when used for identification or treatment;
- Patient instructions; and
- Copies of letters to patients.

2. Non-face-to-face communication.

   a. Documentation is required for all telephone, electronic, and other non-face-to-face communication with patients and/or their caregivers, or other care providers who:

      1) Provide new or renewal of prescription medications;

      2) Alter the current plan of care, including treatments and medications;

      3) Identify a new system or problem and provide a plan of care;

      4) Provide self-care advice for symptom/problem management;

      5) Provide authorization for care; and

      6) Provide or reinforce patient education.

   b. All non-face-to-face communication between patients and providers regarding the care and treatment of the patient, to include electronic messages, are documentation to be

incorporated in the medical record.

c. Documentation should include the date and time of communication, name of the caller (or person who submitted the electronic communication), relationship to the patient (if different than the patient), date and time of the response (or attempts to communicate), the response given, and the signature and professional title of the provider or employee handling the call.

3. Primary language of the patient.

4. Secondary language of patient.

MEDICAL RECORDS • POLICY 5.03

Access to Medical Records

It is the policy of the Practice that the medical record is available to Practice providers when the office is closed in order to provide timely and appropriate care.

PROCEDURES

1. The Practice provides hardware, training and ongoing support to physicians and advanced practice providers to access medical records remotely.

2. The Practices makes patient clinical information available to its on-call providers and to any external facilities for after-hours care through secure internet access. Remote access is limited to those providers who require it. Each provider using the remote access receives training and written guidance in the secure use of the remote log-in function.

3. The Practice issues all providers a remote log-in identification and password.

4. The Practice gives providers who use remote access a remote log-in address and a personal identification name.

5. Providers are responsible to create and maintain secure passwords according to the Practice's internet security practices.

6. The Practice assures that its providers with after-hour access can view the individual care plans or portable personal health records of patients as well as the electronic health record (EHR) system.

7. When care is provided by a facility unaffiliated with the Practice or at which there is not secure online access to patient records, the Practice makes provisions for patients to have an electronic or printed copy of a clinical summary of their medical record.

8. (Telephone consultation with the primary provider or with a provider with access to the patient's medical record is considered acceptable.)

MEDICAL RECORDS • POLICY 5.04

Patient Access to Medical Records

It is the policy of the Practice to provide patients, families and caregivers access to their health information. Families and caregivers are those with legal authorization to the information.

It is the policy of the Practice to make all information available to patients and others with authorization to access the information within four business days of its receipt by the Practice.[10]

It is the policy of the Practice to provide patients, families and caregivers online access through a secure, electronic system to their health information to view, download or transmit it to a third party. It is the policy of the Practice to provide patients, families and caregivers access to their health information in writing upon the patient, family or caregiver making a written request following the guidelines issued by the Practice.

PROCEDURES

1. The Practice makes information available to patients within four business days of its receipt by the Practice. The Practice acknowledges that the information to make available to patients includes all data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

2. Physicians and advanced practice providers may, at their discretion, withhold certain information should it be considered to be harmful in any manner to the patient.

[10] This policy is written to be in accordance with the federal government's Electronic Health Record (EHR) Incentive System criteria for meaningful use (MU), wherein information must be made available to the patient within four business days of its receipt to the practice.

3. All information is made available within four business days of its receipt by the Practice. Upon receipt of the information, the Practice complies with its policy and procedure for the review of all incoming information. Except in extenuating circumstances, the information is reviewed by the ordering or treating provider no later than three business days after its receipt. Should any negative or abnormal results or findings be received, it is the Practice's standard that the patient be contacted by telephone during the three business days. Thus, upon release of the information in four business days, all patients should have received a proactive communication by their providers in the event that there are any concerns regarding said information. As of the fourth business day, if not sooner, patients are provided online access to view, download or transmit their health information to a third party or make an appropriate written request to receive a physical copy of the record in the event that online access cannot be facilitated.

4. As applicable, the Practice consults with its attorney regarding the legal issues related to the access to the patient's medical record. This may include, but is not limited to, guardians, foster parents, and parents (as related to adolescents).

MEDICAL RECORDS • POLICY 5.05

Records Transfer

It is the policy of the Practice to obtain records from the patient's former provider(s) in order to ensure a complete, timely and accurate patient record.

PROCEDURES

1. The Practice guides and assists new patients in transferring their medical record(s) from their former provider(s). New patients are requested by the Practice's scheduler to initiate the transfer of records during the conversation related to the initial appointment request. If the patient presents for his or her first appointment without the records, the care team working with the patient is responsible for

    a. Giving the patient a medical records release form and requesting his or her signature;

    b. Capturing a point of contact at the transferring practice to help coordinate the transition and

    c. Faxing or electronically transmitting the release on behalf of the patient, with the written consent of the patient.

    d. Simply waiting and hoping that records will be transferred is not acceptable, particularly as patients often do not possess the knowledge and understanding of the process, or the technology to facilitate it (e.g., access to a fax machine).

2. In the event that a patient does not present for a visit, but needs assistance, the scheduler provides the patient with the contact information for the medical records associate at the Practice, who strives to streamline the process in collaboration with the patient, family and caregiver. (Notably, the scheduler also transmits a message to the medical records associate with the details of the request, and the patient's contact information to ensure that the patient is assisted.)

MEDICAL RECORDS • POLICY 5.06

Clinical Decision Support

It is the policy of the Practice to use evidence-based guidelines for clinical decision support for conditions managed by the Practice.

PROCEDURES

1. The Practice uses evidence-based guidelines through clinical decision support tools as embedded in the electronic health record (EHR) system and registry, for use in day-to-day operations. The tools prompt alerts in the EHR system for the physicians, advanced practice providers and the clinical support employees. The tools include computerized reminders built into the EHR system, clinical protocols, patient education materials, self-care recommendations, patient checklists, preprinted orders, and algorithms.

2. The clinical decision support tools are adopted on the basis of their application to the Practice's specialty, practicality and strength of evidence.

3. All clinical decision support resources are reviewed annually to ensure currency for maintenance purposes.

MEDICAL RECORDS • POLICY 5.07

Documentation Cloning

It is the policy of the Practice to establish guidelines as to the degree which providers and users of the electronic health record (EHR) may use the "copy" functionality when documenting in the EHR to clone information in the medical record. For the purpose of this policy, "copy" shall include copy/paste, copy forward, cloning, and any other intent to move the original documentation from one part of a record to another. Providers documenting in the EHR must avoid indiscriminately copying and pasting progress notes and duplicate or redundant information provided in other parts of the EHR or from other patient notes.

PROCEDURES

1. Physicians and advanced practice providers are responsible for the total content of their documentation, whether the content is original, copied and pasted, imported, or reused.

2. If any information is copied or reused from a prior note, the treating physician or advanced practice provider is responsible for the accuracy and medical necessity of the documentation.

3. Progress notes are to provide accurate representation of treatment surrounding a specific date of service and episode of care.

    a. Copied information must be reconfirmed and revised as necessary to accurately reflect the specific date of service; and

    b. It is not necessary to duplicate information that does not specifically impact a specific date of service.

4. Physicians and advanced practice providers are limited to copying from their own office notes (exception: see 5c on the next page). Information that is copied must meet the following requirements:

    a. Copying is limited to progress notes of a specific individual patient (i.e., copying from one patient's notes to another patient's record is prohibited);

b. Copying of subjective data (e.g., history of present illness, diagnosis, and plan of care) is prohibited;

c. Copying physician or advanced practice provider attestations from previous notes is prohibited;

d. Information that is allowed to be copied should not exceed six months from the date of the original note;

e. Information copied from the original notes of the physician or advanced practice provider should be closely examined for accuracy, completeness, and relevance to the current episode of care; and

f. Copied documentation must include the following:

1) Attribution to the original source;

2) A reference to the date of the original note; and

3) A reference to the location of the original note if not within the same EHR system (e.g., "copied from my previous note dated…").

5. Physicians and advanced practice providers are responsible for citing and summarizing applicable lab data, pathology results, and radiology interpretations rather than copy such reports in their entirety in the notes.

a. To clarify treatment, it is appropriate to include specific results from lab data, pathology results, and radiology interpretations on a selective, as-needed basis.

b. Copying demographic information and other non-essential data to clinical care is discouraged.

c. Copied documentation must include the following when citing applicable data:

1) Attribution to the original source/provider; and

2) A reference to the date of the original note (e.g., "below is a copy of Dr. Radiologist's interpretation dated…").

6. Physicians and advanced practice providers are responsible for correcting any errors identified within their own documentation using an amendment of the note already signed.

a. Any errors in the physician's or advanced practice provider's original source notes must be corrected using an amendment to the note.

b. All notes copied from the original source that contains errors must be corrected.

c. If the information is copied from a lab, pathology, or radiology report, the author should be contacted to discuss and correct the original document, and this communication should be noted in the physician's or advanced practice provider's current note.

7. Physicians and advanced practice providers are required to document in compliance with all federal, state, and local laws and with Practice policies.

MEDICAL RECORDS • POLICY 5.08

Signature Log

It is the policy of the Practice to maintain a log of signatures and initials of all physicians, advanced practice providers and employees who document information maintained by the Practice. Although electronic signatures are the standard for the Practice, there are forms and other paperwork that may be initialed or signed from time to time. With an electronic signature log, the initials and signatures may be identified when needed.

PROCEDURES

1. A signature log is maintained by the Practice for the purpose of identifying any initials or signatures placed on any document that is scanned and included in the record. If necessary, a copy of the log is kept at the nurses' station.

2. Every Practice employee and provider who is documenting is required to record his or her name and initials in the log. The log is to reflect the current signature and initials of each individual who is employed by or otherwise works at the practice.

3. Every new physician, advanced practice provider, and employee writes his or her signature and initials in this log as part of the orientation process. The original log is stored in the human resources department.

4. A sample log is presented below.

MEDICAL RECORDS • POLICY 5.09

Documentation

It is the policy of the Practice to require that all documentation of medical records is completed on the day of the patient's encounter. Regardless of the method of documentation, the final record must be available no later than 24 business hours after the encounter.

PROCEDURES

1. A progress note must be included in the medical record of all patients seen and evaluated at the Practice by a physician, advanced practice provider or other health care professional.

2. The documentation of the encounter should be performed during the patient's encounter. The final record must be completed no later than 24 business hours after the encounter.

3. The Practice offers training in documentation using the electronic health record (EHR) system and voice recognition software to all new physicians and advanced practice providers. Re-training is available upon request for established physicians and advanced practice providers.

4. The Practice may approve a scribe to perform the documentation. The business case for the scribe is to be presented to the board of directors, who must approve the expense. If a scribe is approved to hire, he or she must be trained in documenting in the Practice's EHR system.

5. If a voice recognition system is used, the notes are uploaded, reviewed, and approved by the dictating physician or advanced practice provider within 24 business hours.

6. The physician or advanced practice provider reviews, corrects, and signs the progress notes before they become a permanent part of each medical record. An electronic signature is acceptable. The process of reviewing, correcting, and signing the note is completed within 24 business hours.

MEDICAL RECORDS • POLICY 5.10

Medical Record Audits

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law.*

It is the policy of the Practice to conduct comprehensive medical record audit on a periodic basis. The Practice develops medical record audit protocols based on its internal compliance program, and in conjunction with consulting a qualified attorney prior to establishing the audit process in order to determine the appropriate protocols.

Consistent and complete documentation in the medical record is an essential component of quality patient care. The following guidelines and the Medical Record Review Summary Sheet (see below) are used to conduct the reviews. Reviewers look carefully at a sample of records during an external records review, using the Medical Record Review Summary Sheet. The summary sheet and the guidelines are provided for use in self-evaluation prior to an external audit.

PROCEDURES

1. Each and every page in the medical record contains the patient's name and identification number.

2. Personal/biographical data includes address, employer, home and work telephone numbers, and marital status.

3. All entries in the medical record contain provider/author identification.

4. All entries are dated.

5. The record is legible to someone other than the writer. A second reviewer evaluates any record judged illegible by one provider reviewer.

6. Significant illnesses and medical conditions are indicated on the problem list.

7. Medication allergies and adverse reactions are prominently noted in the record.

8. Past medical history is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years old and younger), past medical history related to prenatal care, birth, operations, and childhood illnesses is included.

9. The use of cigarettes, alcohol, and substance abuse is present.

10. The history and physical exam documents, with appropriate subjective and objective information for presenting complaints, are present.

11. Self-explanatory.

12. Self-explanatory.

13. Self-explanatory.

14. When indicated, the documentation includes the recommendation regarding follow-up care, calls, and/or visits. The specific time of return is noted in days, weeks, months, or as needed.

15. Unresolved problems from previous office visits are addressed in subsequent visits.

16. Review for appropriate use of consultants is noted.

17. If a consultant is requested, a note from the consultant is in the record.

18. The provider initials consultation, lab results, and imaging reports to signify review. Consultation and abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.

20. For a pediatric patient, the chart contains a completed immunization record.

21. There is evidence that preventive screening and health maintenance are offered and documented in accordance with the Practice guidelines.

MEDICAL RECORD REVIEW SUMMARY SHEET

		Yes	No	Not applicable
1.	Do all pages contain patient ID?			
2.	Is there biographical/personal data?			
3.	Is the provider identified on each entry?			
4.	Are all entries dated?			
5.	Is the record legible?			
6.	Is there a completed problem list?			
7.	Are allergies and adverse reactions to medications prominently displayed?			
8.	Is there an appropriate past medical history in the record?			
9.	Is there documentation of smoking habits and history of alcohol use or substance abuse?			
10.	Is there a pertinent history and a physical exam?			
11.	Are lab and other studies ordered as appropriate?			
12.	Are working diagnoses consistent with the diagnosis or diagnoses?			
13.	Are plans of action/treatment consistent with the diagnosis or diagnoses?			
14.	Is there a date for a return visit or other follow-up plan for each encounter?			
15.	Are problems from previous visits addressed?			

16.	Is there evidence of appropriate use of consultants?			
17.	Is there evidence of continuity and coordination of care between primary and specialty providers?			
18.	Do consultants' summaries, lab results, and imaging study results reflect provider review?			
19.	Does the care appear to be medically appropriate?			
20.	Is there a completed immunization record?			
21.	Are preventive services appropriately used and documented?			

MEDICAL RECORDS • POLICY 5.11

Subpoena Compliance

It is the policy of the Practice to cooperate with civil authorities and to comply with state and federal laws regarding subpoenas for clinical or administrative records.

PROCEDURES

1. Practice employees process all subpoenas served for medical records within the time constraints demanded. The relevant sections (which may be all) of the patient's medical record is queried and printed.

2. A printed copy of the requested medical records and the subpoena are then forwarded to the Administrator or designee for review and delivery to the designated place.

3. Any time there is a question about the subpoena and appropriate release of documents, the Administrator or designee reviews the subpoena prior to processing. The Administrator may consult with the Practice's attorney regarding the subpoena and the subsequent actions to take.

4. All subpoenas for any other type of records or for personal testimony of individuals are forwarded to the Administrator or designee, who determines the parties responsible for follow-up.

5. All Practice physicians and advanced practice providers involved in the care of a patient whose records have been subpoenaed are notified of the subpoena request.

6. As deemed necessary, the Administrator or designee notifies all other personnel.

7. All questions regarding confidentiality of the patient's protected health information (PHI) and the application of physician–patient privilege must be specifically reviewed by the Administrator or his/her designee prior to compliance with the subpoena, subject to advice from legal counsel and/or the Practice's malpractice insurance carrier on an as-needed basis.

MEDICAL RECORDS • POLICY 5.12

Subpoena Duces Tecum

Alert: *The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law. Consult with legal counsel and/or the Practice's malpractice insurance carrier to determine a treating physician's obligations and right to compensation, if any, in particular circumstances; cross reference policy 12.42.*

It is the policy of the Practice to require all subpoenas to be personally delivered to the Administrator. When a medical record is requested for a court case by way of a *subpoena duces tecum* (witness and documents are required to appear), the subpoena must be personally delivered to the Administrator. The Administrator designates a Practice supervisor, such as the medical records manager, to receive the subpoena. These shall be processed in a timely manner.

PROCEDURES

1. All employees

    a. Direct the sheriff, deputy, or subpoena server who bears *a subpoena duces tecum* to the Administrator or designee.

    b. If the *subpoena duces tecum* is for a deposition rather than a court case, there is no change in procedure, other than delivering the record to the established location rather than to the courthouse.

2. Administrator

    a. While the server is still present, check to ensure:

        1) The name and number of the responsible attorney is on the subpoena;

        2) The docket number of the court case is on the subpoena; and

3) The day and place of the trial, as well as the approximate time the medical record is needed, are documented on the subpoena.

b. Understand exactly what must be produced and when. Don't hesitate to contact the attorney generating the subpoena for clarification, if needed.

c. If a physician is subpoenaed for deposition or trial, consult the Practice's policy regarding compensation to determine applicability, and communicate with legal counsel as needed.

3. Designated medical records manager

a. Query and print the sections (which may include all) of the subpoenaed record and review it and the subpoena document completely. Call and provide the Administrator or designee with the following information:

1) Whether this is a federal or a state court subpoena;

2) The date and time of requested appearance and the date and time the subpoena was served;

3) The relationship of the party requesting the subpoena for records to the patient;

4) Whether the patient has signed an authorization to release the medical records; and

5) The name of the party to whom the records are authorized to be released.

b. Notify the medical director and the treating physician or advanced practice provider that a subpoena has been received for the records of the particular patient.

c. Keep a log of charts that are delivered to court. Include the following information:

1) Name of patient;

2) Date of court case;

3) Name of attorney who initiated the subpoena;

4) Location to which material was delivered; and

5) Whether the original or the copy was delivered.

d. Ensure the delivery of the subpoenaed record on the indicated day and time, unless the Administrator directs the representative of the Practice not to do so due to an objection for compliance that legal counsel has filed.

e. Ask the person to whom the record is delivered to sign, date and time, to acknowledge the receipt of the records. Scan and index the receipt, along with a copy of the subpoena, in the correspondence section of the patient's chart.

4. Administrator

a. Notify legal counsel for possible filing of an objection to compliance with the subpoena if:

1) A subpoena is received without an accompanying authorization signed by the patient or the patient's legal representative;

2) A subpoena is received with fewer than 10 days from the date requested for appearance in court; and/or

3) The patient's medical record contains information about documentation that may be subject to specific confidentiality requirements and restrictions on disclosure of PHI pursuant to state or federal law; or

4) There are other unusual issues or compliance considerations.

b. Consult legal counsel if there are any questions or problems.

5. Treating physician or advanced practice provider

a. Ensure that this policy and procedure is followed and patient confidentiality is maintained.

MEDICAL RECORDS • POLICY 5.13

Search Warrants

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law. Consider consulting legal counsel and/or the Practice's malpractice insurance carrier for further guidance.*

It is the policy of the Practice to comply with search warrants issued for patient records.

PROCEDURES

1. It is the responsibility of the Administrator or designee to perform the following functions:

   a) Attempt to review the search warrant to verify its validity but do not interfere with or obstruct the process. Attempt to verify the identification of the law enforcement officer and make a note thereof.

   b) Query and print the relevant sections (which may be all) of the patient's record. Photocopy the record before the law enforcement officer seizes the record so that there is a documentation of exactly what was provided to law enforcement.

   c) Request to photocopy the search warrant.

   d) Contact the medical director and board chair immediately.

   e) Consult legal counsel as soon as possible.

MEDICAL RECORDS • POLICY 5.14

Authorization to Release

Alert: *Please consult state law regarding specific applicability of these policies, since relevant requirements may vary among different jurisdictions.*

It is the policy of the Practice to assign the appropriate designee to approve all medical record information releases and ensure that all employees are aware of relevant guidelines. (Additional information is provided in Chapter 16, Privacy and Security.)

PROCEDURES

1. Property of medical record

    a. The medical record is the property of the Practice.

        1) It is maintained for the benefit of the patient and the physicians, advanced practice providers and employees providing care for him or her.

        2) It is the Practice's responsibility to protect the record and all protected health information (PHI) contained in it against external access, loss, defacement, and tampering, as well as unauthorized use.

    b. A written "consent" of the patient or legally qualified representative is required for the use and disclosure of a patient's PHI for purposes of treatment, payment, and healthcare operations (i.e., quality assessment, auditing, business planning, and general administrative functions).

    c. A written "authorization" is required for uses and disclosures of PHI for any other purposes to any person not otherwise authorized to receive this information. The consent is obtained on a Consent for Release of Medical Information form (see below).

2. General regulatory requirements and release information

    a. All persons, including medical providers who are not employed by the Practice and are requesting the release of their patients' records, must present written authorization from the patient or authorized representative before information from the record may be released or transferred to them, subject only to applicable state and federal law providing exceptions for information needed in urgent or emergent circumstances. There is no charge for this service to another provider for purposes of continuity of care when a record is transferred for the purposes of a referral; for other transfers, the current fee charged by the Practice for printing is assessed as allowed by state law. (See related policy 5.15 on Medical Record Duplication and Form Completion.)

    b. PHI is not to be released to insurance companies or any other requesting entity without a written authorization from the patient and/or guardian.

        1) Note that insurance companies frequently utilize written consents signed at the time of the application to obtain information.

        2) The specific provisions of any release must be carefully scrutinized (score, duration, authority of signatory, etc.) to assure that the patient's directions are accurately followed.

    c. For any case involving extenuating circumstances (the PHI of an adopted child prior to his or her adoption, the PHI of an egg donor, the PHI of a child requested by a non-custodial parent, and so forth), the Administrator shall consult with a legal expert to determine the protocols that will serve to comply with all applicable state and federal laws.

3. Release of medical information without consent

    a. PHI may be disclosed without authorization to public health authorities for public health purposes.

    b. PHI may be used or disclosed for research without authorization if approved by an institutional review board or a privacy board.

    c. State licensing boards may have access to the medical record as required by law or regulation.

    d. Verbal requests for medical information are discouraged and should be limited to situations in which physicians or healthcare facilities treating the patient request information to provide good continuity of care in urgent or emergent situations, consistent with applicable state and federal law.

e. Care should be taken to verify any caller's identity as needed.

f. The details of all verbal communication are documented, including when the request is made, by whom, contact information, and the nature of the verbal request. All questions about disclosure should be directed to the Administrator or medical director.

4. Patient access to medical information

a. Upon request, the Practice provides a patient or authorized representative the ability to view online, download or transmit to a third party a copy of his or her medical record. The Practice may also print a copy of the patient's record for the patient or authorized representative, with appropriate authorization as outlined herein this policy. All information can be accessed within four business days of receipt by the Practice.

b. The Practice provides access to the patient's entire medical record as authorized by the patient, including notes and information contained from an outside provider, with the exception of any information that is suppressed by the treating physician or advanced practice provider based on the best interest of the patient.

c. Electronic or manual requests for medical records must contain:

1) The name and address of the requestor (patient, authorized representative or another provider treating the patient);

2) The person or organization to which information is to be released;

3) A statement that the request may be revoked by the patient, if applicable;

4) The specific information requested;

5) The date of the request;

6) The purpose and the signature of the patient (an electronic signature is acceptable for the purposes of this policy); and

7) A statement that the request complies with this policy in all material respects.

d. If a patient or authorized representative requests a printed copy of PHI and as allowed by state law, the Practice may charge a reasonable fee for the copying. (See related policy 5.15 on Medical Record Duplication and Form Completion.)

CONSENT FOR RELEASE OF MEDICAL INFORMATION PAGE 1

I hereby authorize the Practice, or any of its employees, staff, or agents, to use and disclose protected health information (PHI) from the medical record(s) of:

Patient name: _____

Address: _____
(Street) (City) (State) (ZIP)

Date of birth: _____ Medical record #: _____

Date(s) of treatment: _____

Release information to: _____

(Name of individual or organization)

_____

Address: _____
(Street) (City) (State) (ZIP)

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care

_____ Drug and alcohol treatment care

_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

_____ Emergency room visit

_____ Psychiatric care

*requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Entire medical record

_____ Other: _____Labs _____Slides** _____X-rays**

**I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc.

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment

Consent for Release of Medical Information Page 2

_____ Litigation for review

_____ Insurance (company name): _____

_____ Other (specify reason): _____

This consent permits the Practice to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____ (Print patient's name)

_____ (Signature of patient) Date: _____

_____ (Signature of legally authorized person)

MEDICAL RECORDS • POLICY 5.15

Medical Record Duplication and Form Completion

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law. Consider consulting legal counsel or the Practice's malpractice insurance carrier for guidance.*

It is the policy of the Practice to routinely charge a fee to cover the duplication expenses involved in the printing and transfer of records outside the system and for the completion of forms requested by outside entities. The Administrator evaluates the fees presented in this policy annually to ensure that they are reasonable, based on the Practice's cost, and that they comply with fees set by individual states. The fee can only include the cost of:

- Printing and copying, including the cost of supplies and labor, up to a maximum per page fee, if required by state law; and
- Postage, when the individual has requested the copy be mailed.

It is critical that charges are handled in a standard manner including billing the requesting party who is responsible for the payment of such fees. In general, all requested material (i.e., the entire record) should be produced if requested; consult with the Administrator or legal counsel if there are questions. If a summary report is requested, there is a reasonable fee as established by the Practice for preparation of this report.

PROCEDURES

1. The Practice provides a patient or authorized representative the ability to view online, download or transmit to a third party a copy of his or her medical record. Upon request, the Practice may also print a copy of the patient's record for the patient or authorized representative, with appropriate authorization for medical records release. (See related

policy 5.14 on Authorization to Release.) The Practice charges the requestor only in the event of the record being printed; electronic access is facilitated at no charge.

2. Upon a request for a printed copy of a medical record, the Practice generates an invoice (or other documentation of the charge, as per the Practice's protocols). Unless otherwise dictated by state law, charges are $10 for the first 10 (or fewer) pages, plus $0.25 per each page thereafter, plus postage. The charges are not to exceed $25 per chart, plus postage. The patient may make payment online or via a credit card taken over the telephone. The invoice must be paid before the patient's record is printed and mailed.

3. When payment is confirmed, a designated employee prints a copy of the patient's record, and prepares a mailing envelope. The employee completes a cover letter, which includes the amount of total charges, and attaches a copy of the receipt of payment, if applicable. The employee notes the record mailing in the patient's chart, to include the date, time, employee facilitating the mailing and the person and address to which the mailing of the record is shipped.

4. The medical record employee mails the envelope to the patient or authorized representative.

5. In the event of another medical provider who is treating or consulting on the patient, the records are released in accordance with the release policy without charge for electronic or printed copy.

MEDICAL RECORDS • POLICY 5.16

Employees' Medical Records

It is the policy of the Practice to maintain current and confidential medical records for all employees who are seen in the Practice.

PROCEDURES

1. A medical record is maintained for each employee seen in the Practice. Like all patients, the Practice maintains employees' records and all protected health information (PHI) in a secure, encrypted electronic health record (EHR) system.

2. Employees' medical records in the EHR may be restricted from access by all system users except his or her treating physician(s), advanced practice provider(s) or designee. The application of the restriction is dictated by the medical director.

MEDICAL RECORDS • POLICY 5.17

Return to Work — Medical Status Report Form

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice to use a medical status report form for reporting the medical status of a patient whose illness or condition causes him or her to be absent from work.

PROCEDURES

1. The Return to Work Status Form (see below) is used for reporting the medical status of a patient whose illness or condition causes him or her to be absent from work. (This form is provided for illustrative purposes; the Practice complies with any form required by state law.)

2. A copy of the completed form will be scanned and filed in the patient's record.

RETURN TO WORK STATUS FORM

___ WORK RELATED ___ NON-WORK RELATED

_____

Patient Diagnosis

May not return to work until: Date_____

May return to work with no restrictions on: Date_____

May return to work with the following restrictions on: Date_____

	Limitations (provide brief description)
___No activity	
___Sitting	_____
___Walking	_____
___Lifting	_____
___Squatting	_____
___Climbing	_____
___Kneeling	_____
___Twisting	_____
___Standing	_____
___Pushing or pulling	_____
___Gripping	_____
___Driving	_____
___Other	_____

CHAPTER 6

Clinical Care

POLICY 6.01 • Patient Rights and Responsibilities

POLICY 6.02 • Record Preview

POLICY 6.03 • Questions to Ask the Provider

POLICY 6.04 • Patient Clinical Intake

POLICY 6.05 • Consent for Treatment

POLICY 6.06 • Informed Consent for Procedures

POLICY 6.07 • HIV Testing

POLICY 6.08 • Preconscious Sedation Evaluation

POLICY 6.09 • Procedure Follow-Up

POLICY 6.10 • Review of Test Results and Clinical Correspondence

POLICY 6.11 • Test Tracking and Follow-up

POLICY 6.12 • Test Result Notification via Telephone

POLICY 6.13 • Medical Emergencies

POLICY 6.14 • Termination of Provider—Patient Relationship

POLICY 6.15 • Chaperones

POLICY 6.16 • Patient Education Resources

POLICY 6.17 • Agreements with Referring Providers

POLICY 6.18 • Clinical Advice by Telephone

POLICY 6.19 • Electronic Messaging

POLICY 6.20 • Panel Management

POLICY 6.21 • Care Plans

POLICY 6.22 • Transition of Care

CLINICAL CARE • POLICY 6.01

Patient Rights and Responsibilities

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law. Consultation with your malpractice insurance carrier and/or legal counsel is strongly recommended prior to implementation.*

It is the policy of the Practice to preserve the rights and responsibilities of every patient.

PROCEDURES

This policy does not presume to be all inclusive of incidents related to patients' rights and responsibilities. It is intended to express the Practice's commitment to maintain a professional relationship with the patient and to emphasize the need to observe the rights and responsibilities of the patient.

These rights and responsibilities, such as the following, which have been developed and espoused by the National Health Council, are published and communicated to all patients.[11\]

[11] National Health Council Board of Directors. "Principles of Patients' Rights and Responsibilities," (National Health Council, 1995) Washington, D.C. http://www.nationalhealthcouncil.org/resources/nhc-publications/principles-patients-rights-and-responsibilities, Accessed February 6, 2016.

PRINCIPLES OF PATIENTS' RIGHTS AND RESPONSIBILITIES

1. All patients have the right to informed consent in treatment decisions, timely access to specialty care, and confidentiality protections.

   Patients should be treated courteously with dignity and respect. Before consenting to specific care choices, they should receive complete and easily understood information about their condition and treatment options. Patients should be entitled to coverage for qualified second opinions; timely referral and access to needed specialty care and other services; confidentiality of their medical records and communications with providers; and, respect for their legal advanced directives or living wills.

2. All patients have the right to concise and easily understood information about their coverage.

   This information should include the range of covered benefits, required authorizations, and service restrictions or limitations (such as on the use of certain healthcare providers, prescription drugs, and "experimental" treatments). Plans should also be encouraged to provide information assistance through patient ombudsmen knowledgeable about coverage provisions and processes.

3. All patients have the right to know how coverage payment decisions are made and how they can be fairly and openly appealed.

   Patients are entitled to information about how coverage decisions are made, i.e., how "medically necessary" treatment is determined, and how quality assurance is conducted. Patients and their family caregivers should have access to an open, simple, and timely process to appeal negative coverage decisions on tests and treatments they believe to be necessary.

4. All patients have the right to complete and easily understood information about the costs of their coverage and care.

   This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, copayments, and additional premiums), and any catastrophic cost limits. Upon request, patients should be informed of the costs of services they've been rendered and treatment options proposed.

5. All patients have the right to a reasonable choice of providers and useful information about provider options.

   Patients are entitled to a reasonable choice of healthcare providers and the ability to change providers if dissatisfied with their care. Information should be available on provider credentials and facility accreditation reports, provider expertise relative to specific diseases and disorders, and the criteria used by provider networks to select and retain providers. The latter should include information about whether and how a patient can remain with a provider who leaves or is not part of a plan network.

6. All patients have the right to know what provider incentives or restrictions might influence practice patterns.

   Patients also have the right to know the basis for provider payments, any potential conflicts of interest that may exist, and any financial incentives and clinical rules (e.g., quality assurance procedures, treatment protocols or practice guidelines, and utilization review requirements) that could affect provider practice patterns.

ALL PATIENTS, TO THE EXTENT CAPABLE, HAVE THE RESPONSIBILITY TO:

(It is recognized that patients may suffer significant physical and/or mental conditions that may limit their ability to fulfill these responsibilities.)

1. Pursue healthy lifestyles.

   Patients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.

2. Become knowledgeable about their health plans.

   Patients should read and become familiar with the terms, coverage provisions, rules, and restrictions of their health plans. They should not be hesitant to inquire with appropriate sources when additional information or clarification is needed about these matters.

3. Actively participate in decisions about their healthcare.

   Patients should seek, when recommended for their age group, an annual medical examination and be present at all other scheduled healthcare appointments. They should provide accurate information to providers regarding their medical and personal histories, and current symptoms and conditions. They should ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives. Where appropriate, this should include information about the availability and accessibility of experimental treatments and clinical trials. Additionally, patients should also seek and read literature about their conditions and weigh all pertinent factors in making informed decisions about their care.

4. Cooperate on mutually accepted courses of treatment.

   Patients should cooperate fully with providers in complying with mutually accepted treatment regimens and regularly reporting on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they are pursuing simultaneously.

CLINICAL CARE • POLICY 6.02

Record Preview

It is the policy of the Practice to preview every patient's medical record prior to the patient presenting for the appointment.

PROCEDURES

1. A patient's medical record is queried one to two days prior to the patient's scheduled appointment.

2. A clinical assistant assigned to this responsibility verifies that:

   a. All reports and interpretations are received from tests ordered and consultant physicians, and indexed correctly;

   b. A record of the previous visit is documented and indexed;

   c. The patient's care plan is current; and

   d. Any forms that may be necessary for the impending appointment are scanned and filed in the record, or placed in a folder that will be made available for the physician or advanced practice provider when the patient is seen.

   e. The clinical assistant identifies and documents any changes in medications, devices or other orders that may have been pursued on a non-face-to-face basis and documented via electronic or telephonic correspondence only; he or she makes notes of the changes.

   f. The clinical assistant documents any missing information.

   g. The clinical assistant identifies and documents standing orders.

   h. The clinical assistant notes all alerts as per the clinical decision support in the electronic health record (EHR) system, identifying and documenting any gaps in care for the patient.

i. The clinical assistant identifies any records that need to be reviewed by the physician or advanced practice provider before the patient is roomed (e.g., a question about a standing order).

j. The clinical assistant confirms that the preview is complete by denoting such on the patient's chart, in accordance with the EHR system's protocols.

3. The Practice establishes step-by-step protocols for missing information to be shared with all clinical assistants. For example, if an interpretation from the local imaging center is missing, the protocols include the contact and telephone number for the center's records supervisor to contact for the missing documentation. The protocol should be updated regularly.

4. Physicians and advanced practice providers follow a protocol for responding to missing or unavailable documentation, including when an appointment should be rescheduled if information cannot be located. This also includes rescheduling protocols in the event that the patient did not pursue a recommended test or other ancillary service.

5. For a patient who presents as a walk-in or for a same-day appointment, an abbreviated medical record preview is conducted by the clinical assistant assigned to the patient if and when time permits.

6. The Practice integrates the accuracy, timeliness and comprehensiveness of medical record previews in performance reviews of clinical assistants.

CLINICAL CARE • POLICY 6.03

Questions to Ask the Provider

It is the policy of the Practice to facilitate efficient patient visits by asking patients to consider the information they wish to share with their provider prior to entering the exam room.

PROCEDURES

Notepads and/or tablets with "questions to ask the provider" are available in the reception area and exam rooms for patients to use. The Practice may elect to substitute "physician" for "provider" if only physicians provide care at the Practice.

If tablets are used, all data are erased following each patient's use to ensure that all protected health information (PHI) is maintained secure and confidentially.

QUESTIONS TO ASK THE PROVIDER

Make the most of your time with your provider. Write down your concerns and questions for your provider. That way you'll be sure to cover all your concerns and questions during your appointment. You are also encouraged to write down the medications you wish to discuss with your provider.

My concerns and questions:

_____

_____

_____

Prescription renewals I wish to discuss:

_____

_____

_____

CLINICAL CARE • POLICY 6.04

Patient Clinical Intake

It is the policy of the Practice to perform an initial intake of every patient seen in the office. A consistent intake procedure is used for each patient to achieve comprehensive collection of information regarding the patient's medical visits. This also allows providers more time to focus on patients' clinical needs.

PROCEDURES

1. Upon notification of a patient's arrival, a clinical assistant assigned to room the patient walks into the reception area to greet the patient.

2. The clinical assistant introduces himself or herself by name and function. For example, "Ms. Smith, my name is Betty Jones and I am Dr. Walker's medical assistant."

3. The clinical assistant escorts the patient into an exam room.

4. The clinical assistant describes his or her role and asks the patient if he or she has any questions. For example, "As Dr. Walker's medical assistant, I will be collecting information about your current health, including your vital signs, so that Dr. Walker has all the information he (or she) needs before your appointment. Do you have any questions?"

5. The clinical assistant collects and documents in the electronic health record (EHR) system the following vitals at every visit, unless otherwise dictated by the medical director:

    a. Height;

    b. Weight;

    c. Temperature (if applicable);

    d. Blood pressure;

    e. Pulse;

f. Smoking status;

f. Allergies and medication allergies;

g. Last menstrual period (if female and applicable);

h. Description of current complaint;

j. Medical history form (which patient should have already completed); and

k. Other applicable protocols based on the patient's chief complaint.

6. The clinical assistant reviews and keys the data recorded on the medical history form by the patient into the patient's medical record.

7. The Practice makes all efforts to maintain equipment and processes that allow information to flow directly into the EHR system, thus minimizing errors and employee time. However, the clinical assistant reviews the data that is transferred to ensure its accuracy.

8. The clinical assistant performs a medication reconciliation. According to the Joint Commission, medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions…This process comprises five steps:

   a. Develop a list of current medications;

   b. Develop a list of medications to be prescribed;

   c. Compare the medications on the two lists;

   d. Make clinical decisions based on the comparison; and

   e. Communicate the new list to appropriate caregivers and to the patient.[12]

9. If applicable, the clinical assistant requests and documents the patient's past family and social history.

[12] Joint Commission. Sentinel Event Alert, Issue 35: Using medication reconciliation to prevent errors. January 25, 2006.

http://www.jointcommission.org/sentinel_event_alert_issue_35_using_medication_reconciliation_to_prevent_errors/. Accessed February 6, 2016.

CLINICAL CARE • POLICY 6.05

Consent for Treatment

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law. Consultation with your malpractice insurance carrier and/or legal counsel is strongly recommended prior to implementation.*

Before a patient evaluation and treatment is provided, consent must be obtained from the appropriate person according to the laws governing the state(s) in which the Practice resides.

PROCEDURES

1. In accordance with state law, the treating physician or advanced practice provider captures the patient's informed consent for all applicable encounters. Unless dictated otherwise based on state law, the Practice complies with the following guidelines:

   a. All adults, aged 18 years and older, must sign an authorization-to-treat form;

   b. All patients evaluated and treated for a work-related injury or illness must have an authorization from the employer or the employer's designee; and

   c. Consent to treat minors (patients younger than 18 years old) must be obtained.

2. For all applicable encounters, the treating physician or advanced practice provider must document informed consent in the medical record and/or on the informed consent form. Contact the state medical society for a copy of the state's recommended or required informed consent form.

3. For all applicable encounters, the treating physician or advanced practice provider must obtain informed consent by giving the patient the following:

   a. Information about the diagnosis;

   b. The nature and purpose of the proposed treatment;

c. The known risks and consequences of the proposed treatment;

d. The benefits to be expected from the proposed treatment, with an assessment of the likelihood that the benefits can be realized;

e. All alternative treatment modes that might reasonably be applied; and

f. The prognosis if no treatment is given.

4. Providers must obtain informed consent for the following (or that which is dictated by state law):

a. Major or minor surgery involving an entry into the body, either through an incision or through a natural body opening;

b. All procedures in which anesthesia is used, except in cases when local infiltration is used in repairing wounds incurred outside of the Practice;

c. Non-surgical procedures, including the administration of medicines and immunizations that involve more than a slight risk of harm to the patient or that may cause a change in the patient's body structure or scarring;

d. All forms of radiological therapy;

e. All experimental procedures;

f. All repairs of facial wounds; and

g. All procedures, including cryotherapy, that have a possible risk of infection or scarring.

5. Providers do not need to obtain consent or informed consent in the following situations (or that which is dictated by state law):

a. Emergencies. When there is immediate risk of death or serious bodily harm.

b. Therapeutic privilege. In limited circumstances if permitted by state law when disclosure of the treatment would make the patient so ill, emotionally distraught, or psychologically damaged as to preclude rational decision or complicate or hinder the treatment. Consultation with legal counsel is necessary before invoking this privilege.

c. Waiver. When a patient insists on not being informed of the nature of the procedure or the accompanying risks. The patient is required to sign a "waiver of informed consent."

d. Governmental action. Comply with terms of court and agency orders. If uncertain what is authorized, consult the court and/or legal counsel for clarification.

6. Subject to review of particular state laws, providers should follow these guidelines in treating minors:

   a. Depending on state law, minors may be permitted to consent to:

      1) Treatment for drug and alcohol abuse.

      2) Treatment for venereal disease.

      3) HIV testing.

      4) Birth control or family planning.

      5) Treatment for sexual assault.

      6) Treatment for mental health services. A minor [x] years of age or older may seek mental health services. An independent evaluation is required prior to hospitalization to determine whether admission is appropriate and is the least restrictive form of treatment.

   b. Subject to individual state laws, minors may not be permitted to consent to:

      1) Organ transplants or donation of blood.

      2) Permanent sterilization.

      3) Executive of a living will for termination of life support.

      4) Electroconvulsive therapy.

   c. Minors who can be treated as adults may include:

      1) Emancipated minors. Emancipated minors are minors aged [x] years or older, living apart from parents or legal guardians with or without consent, and who are managing their own financial affairs regardless of source of income.

      2) Legally married minors.

      3) Minor parents of minor children may give consent for treatment of their children.

   d. Carefully determine (in consultation with the Administrator or legal counsel) if any parental or other third-party notification is permitted or required in particular circumstances.

7. When faced with a parent who has refused appropriate medical care for his or her child, the treating physician or advance practice providers may follow these guidelines (or that which is dictated by state law):

    a. If the condition from which the patient is suffering is not life threatening or likely to result in serious bodily harm, accept the parent's refusal of care.

    b. If the child is likely to suffer death or serious bodily harm:

        1) Petition the appropriate court to place temporary custody of the child in a guardian ad litem;

        2) Contact the appropriate county agency or Department of Social Services to request assistance in the matter; and/or

        3) Report the parent, regardless of the severity of the illness, if there is evidence of child abuse or neglect.

    c. If care is declined, document this fact in the medical record regarding the parents' refusal to permit medical care and all the steps taken in an effort to secure care. Report the refusal of care to the medical director by the end of the business day. If requested by the medical director, consult with the Administrator. The Administrator may seek the advice of the malpractice insurance carrier and/or legal counsel. Evaluate reporting the incident to the proper authorities consistent with state law.

    d. The Administrator shall be consulted in all non-emergent situations prior to utilizing the procedures suggested in this section 7.

CLINICAL CARE • POLICY 6.06

Informed Consent for Procedures

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law. Consultation with your malpractice insurance carrier is strongly recommended prior to implementation.*

PROCEDURES

It is the policy of the Practice that a fully completed legal consent form must be signed by the patient or legally responsible party and witnessed by an employee prior to the performance of the invasive procedures outlined in this policy.

1. The provider performing a procedure is responsible for obtaining the informed consent. A Consent to Special Procedures form (see below) should be used.

2. Among other procedures the following procedures require written consent (or that which is dictated by state law):

    a. Obtaining or withdrawing body fluids from a joint, body cavity, or spinal canal;

    b. All biopsy procedures performed as outpatient procedures;

    c. Flexible sigmoidoscopies;

    d. Cauterizations;

    e. Joint injections; and

    f. Any excisions, nail removals or lacerations requiring suturing, and any procedures requiring the use of anesthesia.

3. The treating physician or advanced practice provider adequately informs and advises his or her patient about the type of procedure to be performed and alternative methods of treatment available, if any. If the patient is a minor or legally incompetent, the information described above is given to the parent or guardian.

4. The patient's name, provider's name, the procedure to be performed, and the date and time of the consent must be completed prior to the form being signed by the patient. Abbreviations should not be used.

5. The patient must read the consent form prior to signing, or the consent form must be read to him or her.

6. The consent is witnessed only after being signed by the patient or responsible party.

7. In each case, the provider performing the procedure must sign the affirmation prior to performing the procedure.

8. A clinical assistant ensures that the form is properly completed and scanned and indexed in the patient's medical record.

CONSENT TO SPECIAL PROCEDURES

I hereby authorize _____ and the staff of _____
(Practice name) (Provider's name)

to: _____ on: _____ .
(Patient's name)

As my signature below indicates, I understand the nature and purpose of the proposed procedure or service, possible alternative methods of treatment, the risks involved, and the possible complications, and I have no further questions. No guarantee has been given to me by anyone regarding the results that may be obtained. I consent to the administration of any anesthetics as may be considered necessary or advisable by the provider responsible, except _____ (state none or any exceptions).

Signed: _____ Date: _____
(Patient's signature)

Time: _____

OR

Signed: _____ Date: _____
(Responsible person)

Witness: _____ Date: _____

Provider affirmation

I have discussed the nature, purpose, risks, possible alternative methods of treatment, and possible complications with my patient and his or her family, and have given them time to ask any questions.

Signed: _____

Date:_____ Time: _____

CLINICAL CARE • POLICY 6.07

HIV Testing

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice that a provider may only order a human immunodeficiency virus (HIV) test after personally obtaining written, informed consent from a patient and making the following information available to the patient:

1. Information about the meaning of the test results;
2. The availability of additional or confirmatory testing (if appropriate); and
3. The availability of referrals for further information or counseling.

Subject to applicable law, exceptions pertinent to the Practice setting are:

1. Written informed consent, information, and counseling are not required when, in the judgment of the provider, such testing is medically indicated to provide the appropriate diagnosis and treatment to the subject of the test, provided the patient has otherwise consented to medical treatment by such provider, which otherwise encompasses the testing.
2. To the extent permitted by applicable state law, written informed consent is not required when an employee of the Practice, another healthcare provider, a fire fighter, an emergency medical technician (EMT), or a police officer has been involved in the line of duty in an accidental direct skin or mucous membrane contact with the blood or bodily fluids of an individual who a provider determines, in his or her medical judgment, is of a nature that may transmit HIV. However, should the test result be positive, the affected individual is offered appropriate counseling or directed to other appropriate healthcare resources.

PROCEDURES

1. Testing process

    a. It is the provider's responsibility to ensure that the Informed Consent to Perform HIV Testing form (see below) is completed prior to testing a patient.

    b. The responsible Practice employee must receive the consent prior to drawing the patient's blood; otherwise the patient is sent back to the ordering provider for compliance with this policy.

    c. The HIV consent form is filed in the patient's medical record.

    d. A request for an HIV test is placed on a separate requisition slip, regardless of which lab receives the specimen. This ensures that the report includes only the HIV results and no other test results.

    e. [Optional] For patients who desire anonymity, the requisition, log, and identifier are marked with a coded identifier. This coded identifier is the account number assigned at the date of service by the Practice and the first initial of the first name and the first initial of the last name. Only the lab personnel and the provider are privy to the coded patient identifier.

    f. A separate invoice is issued for all HIV tests.

    g. The Practice asks the patient if he or she wants this information to be kept undisclosed to his or her insurance company and document the patient's request in the medical chart.

    h. The patient is advised that for test results to remain undisclosed to the payer, he or she must pay for the test at the time of service. If the test is to be billed to the insurance company, the patient must sign to acknowledge his or her consent to allow the Practice to bill for the service.

2. Receipt and notification of results

    a. Upon receipt of the results, lab personnel notify the order physician or advanced practice provider. If the results are positive, the provider attempts to contact the patient directly (during a follow-up visit whenever possible) to communicate the results and provide appropriate counseling or referral. The results are marked to indicate that they have been reviewed. When the patient is informed, the results are marked to indicate that the patient has been notified.

    b. The identity of the individual tested and the results of any HIV test are confidential and cannot be disclosed except to:

1) The patient receiving the test or a legally authorized representative;

2) Another organization providing healthcare and its authorized employees or agents who are involved in treating the patient and need to know such results for clinical purposes;

3) The (state) department of public health in accordance with the rules of reporting and controlling the spread of disease as otherwise provided by state law;

4) A patient's insurance company, if the patient has consented to submit data to receive third-party reimbursement as noted above;

5) A person allowed access to that information in accordance with a court order;

6) Release protected health information as indicated in a written, signed HIPAA-compliant authorization that specifically allows the release of HIV information; and

7) As otherwise required or permitted by law to protect the health and well being of the patient and/or other third parties.

INFORMED CONSENT TO PERFORM HIV TESTING

My healthcare provider has answered any questions I have regarding human immunodeficiency virus (HIV) testing and has given me written information with the following details about HIV testing:

- HIV is the virus that causes AIDS (Autoimmune Deficiency Syndrome).
- The only way to know you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law may protect (confirm the law in your state) the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My healthcare provider will talk with me about notifying my sex or needle-sharing partners of possible exposure if I test positive.

I agree to test for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing that may occur on the sample I provided today to determine the best treatment for me. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

Signature: _____ Date: _____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject: _____

_____

Printed name: _____

Medical record #: _____

CERTIFICATION

I certify that the named person above has been given an opportunity to read written information about HIV and ask questions, and that he or she understands the issues presented, that his or her decision to undergo HIV testing is an informed and voluntary one, and that I have witnessed his or her signature.

Signature: _____ Date: _____
(Healthcare provider)

Printed name: _____

CLINICAL CARE • POLICY 6.08

Preconscious Sedation Evaluation

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice that all patients scheduled for procedures requiring sedation are evaluated prior to the sedation.

PROCEDURES

Using the Preconscious Sedation Evaluation Form (see next page) or that which is dictated by state law, the physician or advanced practice provider evaluates the physical condition and health history of the patient. When completed, the form is filed in the patient's record.

PRECONSCIOUS SEDATION EVALUATION FORM

Date _____ Time _____

Patient name: _____

Date of birth: _____

1. Chief complaint: _____
2. Brief HPI: _____
3. Medications: _____
4. Allergies: _____
5. Has the patient had sedation in the past? _____

   If so, how was it administered (PO or IV)? _____

   If so, were there any difficulties? _____
6. Is there any history of recent illness, fever, or respiratory problems? _____
7. Does the patient have any other medical problems? _____

   Asthma? _____

   Neurologic disease? _____

   Cardiac disease? _____

   Lung disease? _____

   Explanation: _____
8. Physical exam:

   Vital signs: _____

   HEENT: _____

   Heart: _____

   Lungs: _____

   Impression: _____
9. Plan: _____

The patient has been evaluated for conscious sedation and is an appropriate candidate.

Physician signature_____ Date: _____

Key: HEENT = head, eyes, ear, nose, throat; HPI = history of present illness; IV = intravenous; PO = per oral

CLINICAL CARE • POLICY 6.09

Procedure Follow-Up

It is the policy of the Practice to contact patients within 48 hours after they have received an in-office procedure.

PROCEDURES

1. The physician or advanced practice provider identifies and documents follow-up questions, signs of complications, and instructions for appropriate management in the patient's record.

2. A clinical assistant assigned to the procedure contacts the patient on the day following the procedure. The contact and the patient's responses to the questions listed in the Procedure Follow-Up Template are documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

3. Problems are reported to the treating or on-call provider and noted for follow-up, with appropriate means of monitoring the patient's progress, for as long as clinical protocols dictate.

PROCEDURE FOLLOW-UP TEMPLATE

Patient's name: _____

If applicable, person with whom communicated: _____

Phone number: _____ Date and time: _____ Employee: _____

Discussion with patient (or representative):

Elevated temperature? (>101.5) ___Yes ___No Nausea or vomiting? ___Yes ___No

Dressing or site unremarkable? ___Yes ___No Pain medications effective? ___Yes ___No

Other _____

Problems reported to provider? ___Yes ___No Provider: _____Time/Date:_____

Comments: _____

CLINICAL CARE • POLICY 6.10

Review of Test Results and Clinical Correspondence

It is the policy of the Practice that all electronic patient data received via the Practice's electronic health record (EHR) system will initiate the creation of a task that requires the review and electronic signature of the ordering or on-call physician or advanced practice provider. This includes data received via a direct interface with an ancillary service or provider, and data received via facsimile in which the images are converted into an electronic file. All paper-based lab results, radiologic image results, other diagnostic studies, returning consults, and any patient reports are reviewed and physically signed and dated by the provider prior to being scanned and indexed in the medical record. Under the direction of the provider(s) managing their care, patients are informed of the information provided in results and reports via online access to the Practice's patient portal, application program interface (API) or other secure electronic communication platform within four business days of its receipt at the Practice.

PROCEDURES

1. For all results, reports or other patient data received electronically, a task is immediately created to identify new or pending information. The task is automatically stamped with the date and time of creation. The task includes a direct link to the new or pending data, which is automatically associated with the patient's record via the EHR system. All electronic tasks regarding new or pending data must be reviewed and signed within 48 business hours. An electronic signature is acceptable.

2. For all results, reports or other patient data received on paper, a designated employee stamps the paper with a manual or electronic date stamp on the date of receipt. On the day of receipt, the paper report is forwarded to the ordering physician or advanced practice provider, or a designated on-call provider. All paper reports must be reviewed and signed within 48 business hours. After the paper report is signed, a designated employee scans and indexes the report in the patient's record.

3. All patients will be informed about their results via telephone, secure electronic communication or a follow-up encounter. (See related policy 6.11 Test Tracking and Follow-up.) The communication about the results will be made within four business days, unless otherwise dictated by the clinical circumstances of the situation. All communication with patients is documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

4. The Practice makes all patient data available to the patient via the patient portal, API or other secure electronic communication platform designed for patient access within four business days after its receipt, unless the provider deems it best to be suppressed from the patient's view based on his or her best clinical judgement. The patient or authorized representative can view, download or transmit the data to a third party, with a documented authorized release of records.

5. A protocol should be developed after consultation with the Practice's malpractice insurance carrier regarding patients who have positive or abnormal test results, but cannot be reached. The protocol will include written notification of the results with a recommendation to contact the Practice immediately. The letter will be sent registered and certified mail, with a confirmation request. All communication will be documented in the patient's medical record in a manner that is consistent with medical and legal prudence. The Practice's malpractice insurance carrier is consulted in extenuating circumstances.

6. Every Friday morning, a designated employee reviews all new or pending data that is outstanding for five or more days. The ordering physician or advanced practice provider, or on-call provider, is informed of the delay in the status of the review. If the result is not "closed" (reviewed and signed) by the end of the business day, the medical director is informed of the volume and content of the outstanding data.

7. Untimely or inappropriate follow-up regarding any patient data is considered grounds for disciplinary action against a physician or advanced practice provider.

CLINICAL CARE • POLICY 6.11

Test Tracking and Follow-up

It is the policy of the Practice to utilize the computerized provider order entry (CPOE) function of the electronic health record (EHR) system to record and document all test orders. The Practice requests and monitors the receipt of all test results. If applicable, it is the goal of the Practice to coordinate with the patient's primary care physician or referring provider to avoid duplication of or gaps in tests and to ensure collaboration in care management.

The Practice documents and monitors all test orders, including laboratory and radiology. The patient's treating physician or advanced practice provider is notified of all unfilled orders in a timely manner. All orders are monitored for successful completion of results. Open orders are flagged and action is taken by the Practice.

All abnormal test results are flagged and brought to the attention of the ordering and treating physician or advanced practice provider in a timely manner.

The Practice provides the PCP or referring provider with the results of relevant test results ordered by the treating physician or advanced practice provider. Providing the PCP or referring provider the results of relevant tests ordered by the treating physician or advanced practice provider is important for the effective coordination of care; failure to do so may result in less than optimal care.

PROCEDURES

1. The Practice's electronic health record (EHR) system features CPOE for laboratory and radiology orders, which is used by all treating physician or advanced practice providers to electronically record orders except in extenuating circumstances.

2. Upon presentation to the Practice, permission is sought from the patient to communicate test results to the patient's PCP or referring provider, as incorporated in the Practice's new patient registration materials.

3. The Practice tracks the orders of all laboratory and imaging tests, regardless of the location (internal or external) of the test. All results are tracked through completion (i.e., receipt of results). The Practice flags all outstanding orders, based on a designated period of expected turnaround time for the test as determined by the specific test. Flagging is a systematic method of drawing attention to results that are outstanding manually or electronically. The Practice utilizes the EHR system to order tests (through CPOE) *and* monitor outstanding results. In the event that a test is outstanding after the designated timeframe of expected results notification, an employee supporting the patient's ordering physician or advanced practice provider contacts the laboratory or diagnostic facility to determine the status of the results. If necessary, the patient is contacted. These communications are documented in a manner that is consistent with medical and legal prudence.

4. When results are received, they are documented in a manner that is consistent with medical and legal prudence. (See related policy 6.10 on Review of Test Results and Clinical Correspondence.) The Practice receives results electronically from testing facilities, with the data presented in a structured field. For imaging studies, the Practice electronically integrates the image into the patient's medical record either directly or via a scanned document that can be retrieved and reviewed electronically.

5. The Practice flags all abnormal laboratory and imaging test results. Abnormal (positive) results are immediately sent to the patient's treating physician or advanced practice provider via an electronic alert. If appropriate, the treating physician or advanced practice provider is alerted in person.

6. If applicable, the Practice provides timely results on relevant tests to the patient's PCP or referring provider, documenting the communication in the patient's record in a manner that is consistent with medical and legal prudence.

7. The Practice strives to electronically communicate with testing facilities, to include laboratories and imaging facilities. The communication includes both ordering tests and retrieving results.

8. In the event that an electronic communication cannot be achieved, the Practice establishes protocols regarding ordering tests and retrieving results (e.g., by facsimile).

9. The Practice notifies the patient (or family or caregiver) of all normal and abnormal laboratory and imaging test results. Normal test results may be communicated to patients over the telephone, in writing or via the preferred method of secure electronic communication through the patient portal, application program interface (API) or other secure electronic communication platform. Abnormal test results may be communicated to patients over the telephone, although face-to-face appointments are encouraged where appropriate. Filing the results in the patient's medical record for discussion during the next scheduled office visit is not acceptable. In the event that frequent laboratory tests are ordered for a patient, the Practice

provides the patient, family and caregiver (as appropriate) with all initial results, clear expectations of follow-up results and a plan for handling abnormal results.

10. The Practice notifies all patients of their test results within four business days of the receipt of the result at the Practice, a standard established by the Practice and one which may be periodically reviewed to ensure that it meets the needs and preferences of patients. The Practice notifies all patients of their test results within a timely manner unless there are extenuating circumstances (e.g., the patient is out of the country and cannot be reached). For patients for whom electronic communication is not established, see related policy 6.12 on Test Results Notification via Telephone.

CLINICAL CARE • POLICY 6.12

Test Results Notification via Telephone

It is the policy of the Practice to provide a personal response to every patient about every test result ordered for him or her. A physician or advanced practice provider presents all positive or abnormal results to the patient by telephone, in person, or via secure electronic means. While the Practice makes all attempts to communicate with the patient electronically, there may be circumstances in which the patient desires to receive the communication over the telephone.

PROCEDURES

1. Upon receipt and documentation of test results in a patient's medical record, a Test Results Response Template (see next page) is transmitted to the patient via the Practice's patient portal, API or other secure electronic communication platform. A notification is transmitted to the patient that a result has been posted for his or her review.

2. Should a patient choose to not activate an account through which the electronic communication can be transmitted, the patient is asked to provide written consent to having normal test results transmitted via voicemail (see below). The signed authorization is scanned and indexed in the patient's medical record.

3. Practice providers review and approve the timing and manner of test results notification, at minimum, annually.

TEST RESULTS NOTIFICATION VIA TELEPHONE

I authorize the Practice, its physicians, advanced practice providers, and employees to leave detailed messages specific to my medical care including test results on the phone number(s) listed below. I understand once a voicemail message exists, it is no longer covered under HIPAA and therefore is not protected from unauthorized access. This authorization is effective _____. I understand that this authorization can be revoked at any time by submitting a written request to the Practice. Unless revoked sooner, this authorization to release detailed medical information will expire one (1) year from the effective date listed earlier. This authorization pertains to voicemail messages only and does not extend to family members and/or other persons that may answer the telephone. This authorization is not required to receive care at the Practice. Patients opting not to sign this authorization will receive medical information such as test results personally rather than via a voice messaging system.

Telephone Number: _____

Telephone Number: _____

Telephone Number: _____

Telephone Number: _____

Patient: _____ *Date:* _____

TEST RESULTS RESPONSE TEMPLATE

Today's date:

Dear _____, [use the patient's full name]

The following tests were conducted (or ordered) on _____[date]:

[List the test(s), which may include:]

____ Urinalysis

____ Hemocrit

____ CBC

____ Biochemical Survey

____ X-ray

____ Cholesterol

____ HDL

____ Pap Smear

____ Lipid Profile

____ Culture

____ Mammogram

[List the Results and Your Comments and/or Instructions for the Patient.]

Please call if you have any questions.

[Signed and dated by Physician or Advanced Practice Provider]

CLINICAL CARE • POLICY 6.13

Medical Emergencies

It is the policy of the Practice to prepare for and respond to all medical emergencies.

PROCEDURES

1. The Practice maintains clinical staff qualified in basic cardiac life support (BCLS) because effective and efficient performance of BCLS depends on adequate training and practice.

2. The clinical staff routinely reviews "code blue" procedures and conducts drills no less than every six months.

3. The Practice maintains a "crash cart" and ensures that all equipment used in a code is accessible and in good working order. The equipment and supplies are inventoried and tested according to the recommendation of the vendor(s).

4. Any physician, advanced practice provider or employee who discovers a patient, visitor, or employee needing emergent care is responsible for activating the emergency medical system. This involves:

    a. Getting appropriate assistance, including notifying an employee who is currently trained in cardiopulmonary resuscitation (CPR).

    b. Calling 911 or the appropriate emergency number to notify them of the emergency and exact location.

    c. Notifying a provider in the immediate vicinity of the location and type of emergency.

    d. If the facility has a paging system, use the overhead page or call the Practice's main switchboard operator to notify him or her of the emergency. Direct the operator to repeat the page three times:

    e. "Attention all staff, CODE BLUE in _____ [name location]."

5. The first provider or employee on the scene currently trained in emergency response initiates CPR or basic airway management.

6. The first provider on the scene is responsible for managing the emergency situation until paramedics arrive. He or she should then assist as necessary. Until that time, the managing provider can delegate roles as he or she sees fit for the effective performance of resuscitation. The managing provider recruits and dismisses personnel as necessary to ensure a coordinated and effective resuscitation. At a minimum, this includes at least three personnel:

   a. One person responsible for airway management;

   b. One person responsible for chest compressions; and

   c. One person to record the events.

7. The emergency may also call for personnel to start an IV, administer medications, and other interventions. Vital signs should be monitored and oxygen administered in accordance with the provider's recommendations. It is the managing provider's decision to determine appropriate interventions, and the managing provider assigns the roles to trained participants.

8. An employee is assigned to the entrance door to direct paramedics to the emergency location.

9. Patients in a "code blue" status are transported by ambulance to the nearest hospital emergency department.

10. A "code blue" may only be terminated by the managing provider on the scene.

11. The person who was assigned to record the events documents the situation. If no person was assigned, the managing provider works with an employee who was at the scene to document the situation. Following the "code blue," the managing provider reviews the record for accuracy and completeness. He or she completes and submits an incident report to the Administrator and/or risk manager. Other personnel should be prepared to document the incident upon request.

12. Every actual "code blue" event is followed within two working days by a meeting of all involved providers and employees at which time performance is reviewed and suggestions for improvement are noted.

13. Equipment needs are reviewed annually based on the needs of patients, new equipment available in the industry, and the operating condition of existing equipment. The review also includes an evaluation of protocols and training requirements.

CLINICAL CARE • POLICY 6.14

Termination of Provider–Patient Relationship

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law. Consultation with your malpractice insurance carrier is strongly recommended.*

It is the policy of the Practice that its providers are not required to continue treating a patient who is uncooperative, refuses to follow treatment advice, and/or presents difficulties in the provider-patient relationship.

A "problem patient" may be characterized by the following behaviors:

- Refuses to undergo recommended treatments;
- Fails to follow prescribed diet or self-care regimen;
- Departs from a health care facility against medical advice;
- Fails to return for follow-up appointments ("no show") on three or more occasions;
- Refuses to cooperate with the physician, advanced practice provider or an employee;
- Insists on being his or her "own doctor" and disputes provider's clinical judgment;
- Threatens lawsuits;
- Repeatedly disputes fees that appear just and normal;
- Displays a threatening, hostile attitude;

- Demonstrates violent or abusive behavior;
- Abuses prescription drugs or controlled substances; or
- Refuses to pay.

PROCEDURES

A patient has no legal right to force a provider to continue a particular course of treatment. The Practice respects three overriding legal obligations when discharging the potential problem patient. These obligations are: (1) to provide for continuity of patient care; (2) to inform and make the patient aware of the consequences of following or not following the recommended treatment; and (3) to give reasonable notice of intent to discontinue treatment.

1. Providers who are confronted with a "problem patient" may elect to initiate a formal process of termination of care. The Practice has a legal right to withdraw medical services in such circumstances.

2. Reasonable notice.

   a. The treating provider gives reasonable notice, allowing the patient reasonable time to find another provider.

   b. Reasonable notice depends upon a number of factors, such as the patient's condition and availability of other providers in the community capable of treating the patient's condition. Questions are directed to the Administrator, who confers with the Practice's malpractice insurance carrier about the situation. Typically, the Practice determines that 30 days serves as a reasonable notice.

3. The treating provider informs the patient in writing that he or she does not intend to continue providing follow-up care.

   a. This notification must be documented in the patient's medical record, along with the reason(s) for withdrawing from the individual's medical care. Note that careful documentation is especially important when the reason for the termination is the patient's noncompliance or philosophical differences with respect to medical care and treatment.

   b. A letter, on the Practice's letterhead, detailing the medical recommendations made and the possible consequences of the patient's noncompliance may be additional evidence that the patient was properly advised of the seriousness of these actions. This written notification is sent by registered and certified mail with confirmation requested. A copy of the letter and the delivery receipt are filed in the patient's medical record.

   c. All communication shall be performed in a manner that is consistent with medical and legal prudence.

4. The patient is given reasonable notice to find a new provider or transfer to another office, and a specific date of termination is indicated. It is indicated in the notification letter that care is continued during the transition phase. It is also noted in the letter that copies of any medical records are forwarded at the patient's request to the subsequent treating provider. A copy of the Practice's medical record release form is included with the letter.

5. If a patient who requires further medical care terminates the provider-patient relationship, the treating provider confirms the termination with a letter clearly stating the patient should procure another provider without delay. This notification to the patient is sent by certified mail with a copy of the notification and the receipt of delivery included in the patient's medical record.

6. The physician or advanced practice provider treating the patient follows the procedures below to minimize liability exposure arising from the termination of the provider-patient relationship:

    a. The provider reviews the medical record for conditions that might require additional treatment or monitoring.

    b. The provider checks the provisions of any contract signed with the patient's health plan to ensure compliance with it. If the patient is part of a prepaid health plan, the plan may require it be notified, and the health plan should assist with the termination process.

    c. If at all possible, the provider discusses the termination with the patient in person. If that's not possible — particularly if the patient is angry and refuses to meet — the provider sends the written notice of termination to the patient by certified mail indicating the reason for termination. If the patient refuses to sign for the letter, the provider keeps the copy of the undelivered receipt and the letter in the patient's medical record. The provider sends an additional copy of the letter by regular mail.

7. Documentation of termination of the provider-patient relationship.

    a. Under some circumstances, a verbal notice may be sufficient, but always document this discussion in the chart.

    b. It is especially important to document a termination discussion with a patient who moves frequently or doesn't have a permanent address.

8. The Practice consults with its malpractice insurance carrier prior to finalizing this policy and procedure, or any protocols.

    a. The Practice reviews these procedures annually with its malpractice insurance carrier.

    b. The Practice reviews all dismissals based on non-financial matters with the Practice's malpractice insurance carrier before the dismissal occurs.

CLINICAL CARE • POLICY 6.15

Chaperones

It is the policy of the Practice to have an additional employee present to witness an exam in which a personal body area is exposed to a provider who is of the opposite gender of the patient. Female to male and male to female are treated the same.

PROCEDURES

1. The nurse or clinical assistant assigned to support the provider, chaperones the provider for all exams of an intimate nature. These exams include, but are not limited to, pelvic, breast, rectal, and genital exams.

2. In the event that the nurse or clinical assistant assigned to the provider is not available, another nurse or clinical assistant completes the task that he or she is performing, and proceeds directly to the assistance of the provider. Serving as a chaperone is given priority by clinical support staff.

3. A chaperone is also available at the request of a physician, advanced practice provider or patient, regardless of the nature of the exam.

4. All witnessed exams are documented in the patient's medical record, including the full name of the employee who served as the chaperone. This entry verifies the presence of a witness.

5. In the event that a patient declines a chaperone, this fact is documented in the medical record in a manner that is consistent with medical and legal prudence.

6. Upon request, all patients have the opportunity for a private conversation with the provider.

CLINICAL CARE • POLICY 6.16

Patient Education Resources

It is the policy of the Practice promote and encourage patient education in order to empower the patient with a clear understanding of his or her diagnosis, the treatment options available and the related self-care requirements to resolve the medical condition. Patients who have access to helpful, patient-friendly information regarding their medical condition will usually result in patients who are more able and willing to assume responsibility in the healing process.

PROCEDURES

1. Physicians and employees are trained in methods to educate patients, and provided the resources to support this initiative.

2. Patient education materials on diseases and conditions routinely treated at the Practice will be stocked and made available on paper and/or in electronic format.

3. Patients will be referred to disease-specific support groups and/or community resources based on the treating physician's or advanced practice provider's recommendation.

4. The resources provided to patients will be documented in the patient's record in accordance with the EHR system's protocols and documented in a manner that is consistent with medical and legal prudence.

CLINICAL CARE • POLICY 6.17

Agreements with Referring Providers

It is the policy of the Practice to maintain a written process for implementing and managing referrals with primary care physicians (PCPs) and other referring providers. It is the policy of the Practice to provide care in collaboration with the patient's PCP or referring provider and his or her medical home.

It is the policy of the Practice to execute agreements with the PCPs and other providers who refer to the Practice. Agreements define the general referral guidelines and exchange of information to expedite the timeliness and appropriateness of the referrals and improve coordination of patient care.

It is the policy of the Practice to establish criteria for the agreements with referring providers. These criteria may include, but not be limited to, the factors listed herein: (1) the type of relationship the Practice has with specific PCPs; (2) the specialty; (3) the geographic service area; (4) prior relationships and (5) frequency of referrals from selected providers.

PROCEDURES

1. The Practice establishes agreements with PCPs and other providers who refer patients. The agreements may be formal or informal.
2. The Practice defines a formal agreement as one that is a written document or referral/consultation request between the treating physician or advanced practice provider and PCP or referring provider that establishes the arrangements for the exchange of information, managing and coordinating a patient's care, as well as communicating with the patient, family and caregiver.
3. Furthermore, the agreement includes the information requested by the treating physician or advanced practice provider of the PCP or referring provider – the "clinical question," history and test results.
4. Finally, the agreement incorporates the time period with which the PCP or referring provider may expect the referral summary/consultation note after the appointment, as well as the type of information that will be included. A formal agreement may be most appropriate with providers who refer patients regularly to the Practice or in those situations in which the

patient's care is being co-managed or transferred to a treating physician or advanced practice provider. An agreement between the Practice and the PCP or referring provider may also be informal.

5. In the agreement, the Practice notifies the referring provider or PCP that a specific team will be used by the treating physician or advanced practice provider, if applicable, to help avoid the need to communicate with the PCP or referring provider in the event of a secondary specialty referral.

6. The Practice establishes a workflow for managing referral activities. The workflow is defined as follows:

   - A referral request is received via electronic transmission (preferred method), fax or telephone.
   - A comprehensive set of information is gathered from the PCP, referring provider and/or patient, including records, history, results and the clinical question to be addressed, or the written referral documentation is reviewed for completeness and accuracy in accordance with the protocol.
   - Referrals marked "urgent" are prioritized, and those patients are contacted within three business hours.
   - Unless already on the line, the patient is contacted no later than two business days after receiving the referral. An appointment is scheduled with the PCP, referring provider and/or patient's treating physician or advanced practice provider of choice, or the first available. Should there be any concern regarding access, a documentation of the situation is immediately sent to the nurse. The response time for the nurse back to the scheduler is three hours, unless the communication is after 4:00 p.m. If so, the response is expected the following morning. If necessary, the physician is consulted regarding appointment availability. Should the patient not be able to be accommodated, the PCP or referring provider is contacted immediately. (Please note that the contact follows the referral within two business days, not the transfer of records.)
   - A notification is submitted to the PCP or referring provider acknowledging the receipt and acceptance of the referral, in addition to the date and time of the patient's appointment.
   - After the appointment is made, the referral or pre-authorization is obtained, as is necessary. If there is no required referral or pre-authorization in place on the two business days prior to the appointment, the PCP or referring provider and, if applicable, the patient is contacted for assistance. If there is no required referral or pre-authorization in place within one business day prior to the appointment, the treating physician or advanced practice provider is presented with the information about the patient to determine whether a future appointment may be in order.
   - Four business days prior to the appointment, all new patients are reviewed to determine whether records have been received by the PCP, referring provider and/or patient. In the event that they have not, a proactive communication is made to the referral source

to transmit the pertinent information. As noted, the PCP or referring provider is encouraged to articulate in writing the "clinical question" to be answered by the treating physician or advanced practice provider accompanied by a relevant history and test results.

- In the event of an appointment no-show, a letter or electronic message is sent to the PCP or referring provider to notify him or her of the missed appointment.
- Within three business days following the patient's appointment, the referral summary/consultation note is sent to the referring provider as has been requested by him or her, ideally in the form of a summary of care record transmitted via secure electronic communication. Subsequent actions are taken, as outlined by the agreement with the PCP or referring provider.
- The Practice maintains a similar process for managing self-referrals from patients, including a specific method of communication with patients who do not already have a regular source of primary care with a medical home.

CLINICAL CARE • POLICY 6.18

Clinical Advice by Telephone

It is the policy of the Practice that patients have access to interactive clinical advice by telephone during and after office hours. Patients can seek and receive interactive (i.e., questions are answered by a person, rather than by a recorded message) clinical advice by telephone when the office is open *or* closed. All calls are returned in the designated timeframe as defined and periodically assessed by the Practice in order to meet the clinical needs of patients. Clinical advice by telephone is communicated only to patients who are established with the Practice.

PROCEDURES

1. Telephone calls are received from patients. If the patient is experiencing an emergency, the patient is instructed to immediately proceed to the nearest emergency department (ED). The instructions provided to the patient, family or caregiver are documented in the patient's medical record in a manner that is consistent with medical and legal prudence. If an after-hours service provides said advice, the message from the answering service is recorded in the patient's record within one business day, with the actual message scanned and indexed in the patient's record as supporting documentation.

2. For non-emergency calls, the operator requests the patient's name and identification (e.g., date of birth), as well as that of the caller, if different. If the nurse is available, the patient or caller is transferred to the nurse immediately. If the nurse is not available, callers are asked for their message and two callback numbers.

3. The triage nurse is a skilled, trained clinical professional with expertise in determining if the patient's condition and needs are emergent, acute/urgent or routine based on the information provided by the patient. The triage nurse consults with the treating physician or advanced practice provider, if appropriate.

4. The triage nurse is responsible for all requests for clinical advice by telephone. Messages are checked, at minimum, every 30 minutes. The interactive communication between the

nurse and the patient (not a recorded message) are handled by the triage nurse, with consultation by the treating physician or advanced practice provider. Patient messages are responded to by telephone. Expected response time is 60 minutes.

5. After 4:00 p.m., telephone calls will be responded to by, at the latest, 9:00 a.m., on the following business day.

6. After normal business hours, callers will receive information about accessing the after-hours answering service (which is given instructions regarding the on-call treating physician or advanced practice provider) so that timely clinical advice can be provided to patients, families and caregivers.

7. As with any form of patient communication and documentation, unprofessional remarks or comments in telephone communications are prohibited. Confidentiality of patient information is maintained at all times to safeguard the integrity of protected health information (PHI). All telephone communications are performed and documented in a manner that is consistent with medical and legal prudence.

8. The Practice coordinates with the contracted after-hours answering service for efficient telephone processing of patient calls after the Practice's normal operating hours. The answering service is available from 5:00 p.m. to 8:00 a.m.; the Practice transfers its telephones back to normal internal operating mode by 8:00 a.m. every business day.

CLINICAL CARE • POLICY 6.19

Electronic Messaging

It is the policy of the Practice to establish and maintain a secure two-way platform for electronic communication with patients through a patient portal, application programming interface (API) or other secure electronic communication platform. Via its platform or API, the Practice makes secure messaging available, as well as requests for appointments, prescriptions, and test results.

All electronic messages are returned in the designated timeframe as defined and periodically assessed by the Practice in order to meet the needs and preferences of patients, families and caregivers. Two-way communication through the patient portal or API is provided only to patients who are established with the Practice. Electronic messages are reserved for conditions and situations that do not require immediate medical attention.

PROCEDURES

1. The patient portal or API is provided to patients, families and caregivers to facilitate timely and accurate two-way communication with the Practice. Electronic messaging is conducted through an interactive secure, encrypted system.

2. Established patients are asked to sign an informed consent to communicate via electronic message, with one copy being presented to the patient and the other maintained in the patient's record. An electronic signature is acceptable.

3. *Inbound messages:* Electronic messages are received by patients based on patient name and identification (as prescribed by the patient portal or API). Patients are asked for their message or request and two callback numbers. Upon submitting a message or request, patients receive an automatic reply: "Your message has been received by [Practice's name]. We will attempt to process your request within one business day. If you need immediate assistance, please call the office at [Practice's telephone number, which includes access to the after-hours answering service if after hours]. In the event that you are experiencing an emergency, please seek care at the closest emergency room."

4. The Practice assigns responsibility for all inbound electronic messages and requests; standard workflow is appointment requests processed by the scheduler, and the triage nurse handling all messages related to clinical advice, prescriptions, and test results. In the event of an employee absence, the supervisor must ensure that another employee assumes the role. Inbound messages are checked, at minimum, every 30 minutes. Patient messages are responded to electronically or by telephone, as dictated by the nature of the communication and required response. Expected response time is 60 minutes for appointment requests and clinical advice; three hours for all others.

5. If the event that a patient is messaging about a request that requires communication with a third party (e.g., a medication renewal with communication to the patient's pharmacy), the triage nurse is responsible for sending a confirmation message to the patient.

6. After 4:00 p.m., electronic messages regarding appointment requests and clinical advice will be responded to by, at the latest, 9:00 a.m., on the following business day or 11:00 a.m. for all others.

7. *Outbound messages*: The Practice encourages two-way communication with patients via electronic messaging. A consent must be on file in the patient's record before such communication is initiated (noting that this is a component of the patient's registration process with the patient portal or API). The communication may include, but not be limited to, prescriptions, reminders about recommended follow-up care, self-management support and notification of normal test results. Protocols about outbound messages may be updated periodically, but are ultimately the decision of the medical director.

8. Electronic messages are a permanent part of the patient's medical record. They are retained in the record, consistent with the state medical records retention rules.

9. As with any form of patient communication and documentation, unprofessional remarks or comments in electronic messages are prohibited. Confidentiality of patient information is maintained at all times to safeguard the integrity of protected health information (PHI). Electronic messages are performed and documented in a manner that is consistent with medical and legal prudence.

CLINICAL CARE • POLICY 6.20

Panel Management

It is the policy of the Practice to use patient information, clinical data, and evidence-based guidelines to proactively manage the patient population (the "panel") of the Practice. The Practice reminds patients, families and caregivers about condition-related services, preventive care and follow-up care. The Practice maintains timely information about patients receiving services outside of the Practice in order to identify and manage the transitions of care for its patient population.

PROCEDURES

1. The Practice designates an employee to identify patients who are due for services. To identify patients, the Practice uses a registry to query its patient database and produce lists of patients needing a specific condition-related service and those who need preventive and follow-up care related to a condition managed by his or her treating physician or advanced practice provider. The employee communicates with patients, families and caregivers if and when they are due for recommended services.

2. All communication with a patient, family member or caregiver is documented in his or her medical record in a manner that is consistent with medical and legal prudence.

3. The Practice uses secure electronic communications to remind patients when services are due. Should the patient, family and caregiver prefer such method, reminders may be sent by mail.

4. The Practice requests its local health care facilities, to include the hospital, to provide daily information about emergency department visits, admissions, discharges, or any other transitions of care. (See related policy on 6.22 Transition of Care.) The employee designated for panel management reviews the list each month, recording all activity within the applicable patient's record. Communication from the hospital – for example, the discharge summary – is populated or scanned into the patient's medical record. If the documentation has not yet been scanned into the patient's record, the employee queries the hospital's information sys-

tem and, if applicable, the community health information exchange (HIE). The documentation is incorporated into the patient's medical record in a specific field in the EHR system that can be queried and reported.

5. For all transitions of care, the employee responsible for panel management creates a task for the patient's treating physician or advanced practice provider. These tasks must be reviewed within 48 business hours. The treating provider communicates with the employee responsible for panel management or the patient himself or herself directly regarding any messages, instructions or other communication. If applicable, the employee contacts the patient with the treating provider's communication. As appropriate, the communication includes offering appropriate care to prevent worsening of the condition, responding to questions and encouraging follow-up care. In addition to scheduling an appointment, follow-up care includes, but is not limited to, counseling, referrals to community resources, self-management support, and referrals to disease or case management. All communication is documented in the patient's record in a manner that is consistent with medical and legal prudence.

6. The Practice makes all efforts to extend resources to serve its complex, high risk and/or vulnerable patients. During preparation and the initial evaluation of the patient, the treating physician or advanced practice provider assesses the risk status of the patient. Criteria for identifying complex, high risk or vulnerable patients may include the following (or a combination of the following):

    a. High level of resource use (e.g., visits, medication, treatment or other measures of cost),

    b. Frequent visits for urgent or emergent care (i.e., two or more visits in the last six months),

    c. Frequent hospitalizations (i.e., two or more in last year),

    d. Multiple co-morbidities, including mental health,

    e. Noncompliance with prescribed treatments/medications,

    f. Terminal illness,

    g. Psychosocial status, including the lack of social or financial support that impedes ability for care,

    h. Advanced age, with frailty, or

    i. Multiple risk factors.

7. In this manner, the medical director or the treating physician or advanced practice provider may identify a patient(s) for whom the employee designated for panel management is requested to communicate on a frequent basis. The communication may involve the patient, family member and/or a caregiver. Communication (including the frequency) is dictated by

the treating provider. When appropriate, the patient is referred to other internal or external resources in order to further their care management program. These may include disease management or case management programs. All communication with the patient, family member and/or caregiver is documented in patient's record in a manner that is consistent with medical and legal prudence.

CLINICAL CARE • POLICY 6.21

Care Plans

It is the policy of the Practice to manage all of a patient's care needs. To assure that each patient receives appropriately individualized care, the Practice develops an individual care plan for each patient. The individual care management plans are created by the treating physician or advanced practice provider in collaboration with the patient, the patient's family and caregiver, and/or the patient's primary care physician (PCP) or referring provider. These care plans describe treatment goals, and they are reviewed and updated at each scheduled visit. In order to support patients and their families with self-management, the Practice also includes tools beyond the counseling and guidance that are typically provided during an office visit.

PROCEDURES

The treating physician or advanced practice provider develops an individual care plan for each patient. The plan is created in collaboration with the patient, family and caregiver, and, if applicable, the provider builds upon or collaborates with the patient's PCP or referring provider. The care plan includes treatment goals, potential barriers, and the patient's self-care capacity. If applicable, the care plan delineates the services and responsibilities of the treating physician or advanced practice provider as compared to the PCP or referring provider, in order to avoid any overlaps or gaps in services and care.

In summary, a care plan considers and/or specifies including, but not limited to, the elements listed below:

Treatment goals;

- Assessment of potential barriers to meeting goals;
- Strategies for addressing potential barriers to meeting goals;
- Patient preferences and functional/lifestyle goals;

- Treating physician or advanced practice provider and his or her care team members;
- PCP or referring provider;
- Current problems (may include historical problems, at the treating physician or advanced practice provider's discretion);
- Current medications;
- Allergies and medication allergies; and
- A self-care plan.

The elements of the care plan are reviewed and updated at each relevant visit. Relevant visits may include visits for important or chronic conditions; visits that result in a change in treatment plan or goals, additional instructions, or information for the patient or the patient's family or caregiver; and visits associated with transitions of care. At each relevant visit, as determined by the patient's treating physician or advanced practice provider, the treating physician or advanced practice provider uses indicators from evidence-based guidelines to determine the patient's progress with the care plan and treatment goals. The treating physician or advanced practice provider documents "no change," if applicable. The treating physician or advanced practice provider also documents any deviations from established guidelines and includes the rationale.

The Practice provides the patient or the patient's family with a written plan of care tailored for the patient's use at home and to the health literacy and language preferences of the patient, family and caregiver. The written plan contains self-care recommendations designed to keep a patient on track with their particular goals while managing their own self-care.

The Practice provides educational resources or refers patients and patients' families to educational resources to assist in self-management. These educational resources may include information about a medical condition or about the patient's role in managing the condition. Resources may be in the format of handouts, videos, pamphlets, brochures, links to websites, and referrals to community programs or support groups. These materials may be provided in languages other than English, as determined by the Practice in the best interest of its patient population. Referrals to resources outside of the Practice may be made, and may include pharmaceutical assistance programs and transportation assistance to patients.

The Practice assesses and addresses barriers when the patient has not met treatment goals. The assessment may include discussions with the patient, the patient's family or caregiver (with the patient's permission) and/or, if applicable, the PCP or referring provider to determine the reasons for limited progress toward treatment goals. The treating physician or advanced practice provider helps the patient address barriers (e.g., insurance issues or transportation problems), as applicable. The treating physician or advanced practice provider changes the treatment plan or adds treatment, if appropriate.

If applicable, upon completion of the care plan, the Practice maintains a process for a timely transition of the patient back to his or her PCP. Upon this "graduation," the Practice's specialist communicates with the PCP via a summary of care record with all of the information needed for the PCP to manage the patient's care.

CLINICAL CARE • POLICY 6.22

Transition of Care

It is the policy of the Practice to coordinate all aspects of patients' care through all settings. This includes coordinating with facilities and managing all transitions of care. Effective transitions of care – by and between specialists, facilities, and institutional settings - ensure that the needs and preferences of patients, families and caregivers with regards to timely, comprehensive and coordinated care, as well as sharing information among stakeholders and across functions and sites are met over time.

PROCEDURES

1. The Practice receives data from all local hospitals regarding its patients who are seen through their emergency department and/or admitted to or discharged from the hospital. The data, including but not limited to, discharge summaries, are received every morning via secure electronic communication regarding encounters during the previous 24-hour period. An employee reviews the communication and updates the patient's medical record, as applicable. All encounters are recorded consistently in a specific field in the electronic health record (EHR) system that can be queried and reported. The employee sends an electronic alert via a task in the electronic health record (EHR) system to the patient's physician or advanced practice provider in order to review the activity regarding the patient's care transition. (See related policy on Panel Management.)

2. For patients who are hospitalized, the Practice provides timely and appropriate information to the hospital about the patient. The communication is a secure, two-way exchange of key clinical information via summary of care record, thus enabling timely, well-coordinated care during and after hospitalization. Upon notification and with the appropriate authorization, the Practice provides the same exchange of information with other health care facilities, including skilled nursing and long-term care.

3. Summary of care records are produced for patient during all transitions of care. The Practice maintains the capability of electronically exchanging key clinical information with other providers and facilities via an electronic summary of care record. Key clinical information includes problem lists, medication lists, allergies, medication allergies and diagnostic test results. The key clinical information is based on the judgment of the patient's physician or advanced practice provider. For community partners in the electronic exchange, the Practice obtains the proper consent for the release of information. (See chapter on Medical Records.)

CHAPTER 7

Medication Management

POLICY 7.01 • Prescription Requests and Refills

POLICY 7.02 • In-House Medications

POLICY 7.03 • Medication Preauthorization

POLICY 7.04 • Management of Controlled Substances

POLICY 7.05 • Sample Medications

POLICY 7.06 • Pharmaceutical Representatives

POLICY 7.07 • Recall

MEDICATION MANAGEMENT • POLICY 7.01

Prescription Requests and Refills

It is the policy of the Practice to manage prescription requests and refills in a timely manner that is conducive to quality patient care and patient satisfaction.

The Practice educates patients about its prescription policy. Prescriptions fall into three categories: (1) a request for a new medication; (2) a renewal for which there is an existing medication where there is no outstanding approval or where the approval period expired, and (3) a refill for which there is a standing approval already documented and available for dispensing by the pharmacy. The Practice encourages patients to directly contact their pharmacy first to determine if a refill has been approved and to request dispensing accordingly. Patients are directed to contact the Practice if no more refills are available and/or if the request is for a new prescription.

PROCEDURES

1. The treating physician or advanced practice provider is responsible for determining the best course of medical care and pharmacological treatment for the patient.

2. The Practice schedules an appointment for a patient requesting a new medication. Requests for a new prescription or from a patient not seen for more than one year are not honored over the telephone, portal or by other means, unless approved by a provider. Certain new prescriptions are not permitted at any time over the telephone even when a patient has been seen, such as controlled substances and certain high-risk medications as determined by the physicians and advanced practice providers (see 4. below).

3. The Practice schedules an appointment for a patient requesting a renewal of an existing medication if the patient has not been seen for more than one year.

4. The physicians and advanced practice providers collaborate to develop a single list of written protocols for extending renewals. The written protocols include instructions regarding medical renewals by name of medication and by patient condition, as well as the timeframe for the renewal period. Each specialty is responsible for developing its protocols and reviewing the protocols annually, or sooner, in the case of a drug recall.

5. A designated employee with appropriate training, skills and credentials manages the prescription renewal process. All patient requests as made by telephone, portal or through other communication are documented in the patient's medical record. The documentation includes detailed information about the medication, any instructions that are provided to the patient, and the identification of the employee filling the request.

6. The designated employee who manages the prescription renewal process creates a task in the electronic health record (EHR) system to notify the treating physician or advanced practice provider about the renewal. If the medication is on the list of written protocols, the task is provided as a "for your information" only; if the medication is not on the list of protocols, the task is created in order for the treating physician or advanced practice provider to review each request. The provider signs his or her approval electronically, transmitting the confirmation about the renewal to the designated nurse. When approved, pending prescriptions are transmitted to the pharmacy immediately. This process is consistent with the time frames outlined below.

7. The Practice accepts renewal requests via secure electronic communication through its patient portal. Morning requests are checked and processed immediately but no later than noon every business day, and afternoon requests are checked and processed by 5:00 p.m. every business day. Requests received after 4:00 p.m. are handled the following business day morning.

MEDICATION MANAGEMENT • POLICY 7.02

In-House Medications

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice that appropriate documentation must accompany each phase of medications provided in-house: receiving, monitoring, dispensing, and disposing. Physicians are ultimately responsible for all medications ordered for the Practice to provide its patients.

This policy was developed to assure the proper handling and storage of medications administered by the licensed medical professionals of this Practice. Medication inventory management is required to promote the provision of quality medication products and this policy is part of the Practice's ongoing quality improvement activities. The Practice designates a medication coordinator.

PROCEDURES

The Practice must follow the guidelines below for monitoring and documenting medications:

1. Injectables

    a. Receiving

        1) The contents of the shipment are compared against the shipping invoice by carefully reviewing the quantities, lot numbers and expiration dates.

        2) Controlled substances are handled in accordance with the following procedures:

            a) The receiving order is matched with the Drug Enforcement Administration (DEA) form for accuracy of quantity, strength, and medication type.

            b) Date of receipt and number received are documented on the DEA form.

c) The DEA form is filed at the ordering center for a period of two years.

3) Absent a mediation tracking log in the Practice's electronic health record, the following information about the medication received is recorded on the secured and authenticated medication log sheet:

a) Brand and/or generic/chemical name;

b) Strength;

c) Date received;

d) Number received;

e) Signature of receiving party;

f) Lot number;

g) Expiration date; and

h) Manufacturer name.

i) Quantity

4) The number of doses available is determined from the received medication.

5) The first numbered doses available are identified by striking through the remaining unavailable doses (i.e., if 10 doses are received, rows 11 through 25 will be struck through).

a) In the column under the current inventory, the number of vials is counted down in descending order. For example, if five bottles are received, the current inventory column starts with 5, and under that is 4, 3, 2, and 1.

6) The medications are promptly documented, stored and secured.

7) Injectable medications that are compromised due to inappropriate storage or shipment should be returned to the shipping vender. Wasted doses should be recorded on the log.

b. Access and Storage

1) All injectable medications are stored in a secure area. Keys that open the medication cabinets are issued to authorized medically licensed personnel. The Medication Coordinator maintains a list of all employees who were issued keys. Employees are expected to maintain possession of the keys and return them when no longer

working for the Practice. If a key goes missing, the lock will be changed within 72 business hours, or that which is possible at the earliest time period, and all keys will be reissued.

2) All medications shall be administered and stored in accordance with the manufacturer's label, including single-use vials and disposal of expired drugs.

3) Expired, contaminated or deteriorated medications are not stored with other medications so that they are not available for use. Expired and returned medications are properly disposed of in accordance with written procedures.

c. Monitoring

1) Controlled substances:

a) All controlled substances are counted daily and noted on the daily narcotics record form.

b) Only one narcotics control spreadsheet tab is used per ordered medication.

2) Medication expiration dates are checked and documented on a monthly basis by the Medication Coordinator. Further, the Medication Coordinator will complete the "Medication Compliance Checklist" once a quarter.

3) If any discrepancy in the log or inventory is identified, the Practice Administrator will be immediately notified.

4) The log shall be retained for at least three years,

d. Dispensing

1) For injectable medication administrations, all employees shall use universal and bloodborne pathogen precautions. (See Chapter 14 Exposure Control.)

2) All medications dispensed must have a written order.

3) Medications shall be prepared as close as possible to their use, particularly when the mediation threatens to lose integrity or stability.

4) Any open vial that appears to be contaminated or discolored should be discarded and not used.

5) If pre-filled syringes are used, they must be initialed, dated and timed by the employee who draws them, and labeled for content and expiration date. For multi-dose vial medications, indicate on the label of each the date and time that it was reconstituted or first opened.

6) Medications may only be administered by authorized personnel upon an order by a prescriber lawfully authorized to prescribe. Authorized personnel administering a medication are responsible for knowing a medication's usual dosage range, indications, side effects, toxicity, stability, expiration data and the patient's hypersensitivity or allergies known at the time of his or her medical care and ensuring that the fundamentals of medication administration are followed: right patient, right drug, right dose, right route and right time.

7) Upon written order from the prescribing provider, the medication log is completed and includes the following information:

   a) Date of injection;

   b) Time of injection;

   c) Patient name;

   d) Medication name;

   e) Dosage;

   f) Lot number;

   g) Manufacturer;

   h) Expiration date;

   i) Ordering provider; and

   j) Name of person administering the medication with initials.

8) If any portion of the dosage is wasted or spilled, it is documented and witnessed on the narcotics control spreadsheet.

9) The medication dispensed is from the oldest lot available.

10) Injectable medications that are drawn up into a syringe but not used should be discarded.

11) Any adverse reaction to a drug administered at the Practice shall be reported immediately to the Administrator, the physician responsible for the patient and documented into the patient's medical record.

e. Theft/loss

If any medication is lost or stolen, the Practice contacts the DEA Diversion Field Office immediately and any other appropriate entity noted below. DEA Form 106 (Report of Theft or Loss of Controlled Substances) is completed and submitted within 24 hours of the incident or that which is required by law. In the event of a stolen medication and/or if required by state law, the Practice notifies the local police.

Other entity to be notified (example: state DEA):

_____

f. Disposal

1) Controlled Substances

After conferring with the manufacturer and the DEA Diversion Field Office, the Practice establishes a protocol for handling the disposal of the drugs which is further detailed in this policy.

2) Other Injectables

a) Unopened medication is returned to the vendor.

b) Opened medication is disposed of 30 days after opening, in accordance with that which is recommended by the vendor and/or local authorities. Disposal is witnessed by two Practice employees.

g. Expiration

1) Injectable medications that are expired should be returned to the manufacturer. The Practice contacts the vendor for return instructions.

2) Expired vials and doses should be recorded on the log.

3) Expired injectable medications should be labeled “DO NOT USE” and physically separated from other injectable medications.

Medication Preauthorization

It is the policy of the Practice to preauthorize medications with the appropriate insurance company in a timely manner to ensure quality patient care and service.

PROCEDURES

1. The Practice processes the preauthorization for the medication when it is prescribed. Though this protocol may be based on inherent knowledge of the medication and the insurer's requirement for preauthorization, the Practice strives to incorporate alerts for all preauthorizations required by insurers. Processing the preauthorization at the time the prescription is provided improves the timeliness of the process for the patient, and serves to improve the efficiency of the Practice.

2. If unknown at the time of ordering the prescribing physician or advanced practice provider receives a notice of the preauthorization requirement. The Practice processes the preauthorization for the prescription within 24 hours of the receipt of the request at the Practice. For requests received on a Friday before 3 pm, the request will be processed before close of business that same day. For requests received after 3 pm, they will be processed before 12 pm the following Monday.

3. The Practice makes all attempts to perform the preauthorizations online or via the most efficient and effective means possible, which may vary by insurance company.

4. When the preauthorization is received back from the insurance company, the Practice notifies the patient and completes the prescription request with the designated and approved pharmacy.

5. If authorization is not received back from the insurance company within 48 hours, the Practice follows up with the insurance company to secure the preauthorization.

6. All efforts to communicate with the insurance company and/or the patient are documented in the patient's medical record in a manner that is consistent with medical and legal prudence.

Management of Controlled Substances

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice to be responsible for monitoring controls related to ordering, receiving, storing, dispensing, and administering controlled substances and documenting such activities. The term "controlled substance" means a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V (including IIN and IIIN) of the Controlled Substance Act. A reliable system of checks and balances with careful monitoring and accountability for controlled substances must be in place. The Practice abides by federal and state laws related to narcotic controls.

PROCEDURES

1. The purchasing, receiving, storing, dispensing, administering, and documenting of all controlled substances must be in accordance with current Drug Enforcement Agency (DEA) standards and/or state supplemental guidelines.

2. Controlled substances are kept in a secure, locked cabinet. Keys that open the medication cabinets are issued to authorized medically licensed personnel. The Medication Coordinator maintains a list of all employees who were issued keys. Employees are expected to maintain possession of the keys and return them when no longer working for the Practice. If a key goes missing, the lock will be changed within 72 business hours, or that which is possible at the earliest time period, and all keys will be reissued.

3. The acts of ordering and receiving controlled substances are performed by different individuals. The receiving process must include a reconciliation of controlled substances received against the packing slip or invoice accompanying the order as well as the DEA ordering form.

4. As described in Policy 7.02 In-House Medications, absent a tracking log in the Practice's EHR, a log is maintained for recording controlled substances received and a separate log is maintained for controlled substances dispensed. Employees responsible for the receipt and dispensing of the substances sign and date the entry.

5. Separate log should be kept for each individual medication by brand and/or generic/chemical name.

6. An inventory system that assures accuracy of all controlled substances is required. The inventory system may be manual or computerized as long as the disposition of all controlled substances (e.g., all controlled substances received, dispensed, or returned to reverse distributorship) is accurately tracked.

7. All medications dispensed must have a written order. Medications may only be administered by authorized personnel upon an order by a prescriber lawfully authorized to prescribe. All controlled substance medication administration must be validated by the prescribing provider, in compliance with state law, and the order documented in the patient's medical record. Medications should be dispensed from the oldest lot available.

8. Medication expiration dates will be checked and documented on a monthly basis by the Medication Coordinator. Further, the Medication Coordinator will complete the "Medication Compliance Checklist" once a quarter.

9. A complete entry is added to the Controlled Substance log when any controlled substance is dispensed (see below).

10. Expired, contaminated or deteriorated drugs are not available for use. Expired and returned drugs are properly disposed of in accordance with written procedures. Expired medications should be labeled "DO NOT USE" and physically separated from other injectable medications. Expired narcotics are returned through a reverse distributorship.

11. The Practice complies with the current inventory requirements of the DEA. Inventory is conducted and documented per regulatory guidelines.

12. If manual ordering, the narcotic prescription pads are maintained in a locked cabinet to ensure their security. The Administrator or designee has the key to this locked cabinet.

13. Proper record keeping and limited access to controlled substances is maintained in the Practice. The provider or nurse manager is responsible for managing narcotics; however, specific responsibilities for inventory and record keeping are delegated to the Medication Coordinator and appropriate clinical staff.

SAMPLE MEDICATION COMPLIANCE CHECKLIST

Name of Reviewer: _____

Date: _____ Initials: _____

		Yes	No	Comments
1.	Medication storage cabinet is clean and orderly. The Injectable Medication Management Policy is available.			
2.	Medications are properly received and stored in secure/located area with access limited to authorized personnel			
3.	Staff who have access to the medication cabinet are identified in writing.			
4.	Medications are labeled according to federal and state laws. Labels are altered only by persons legally authorized to do so.			
5.	Multidose injectable medications are dated and initialed when opened.			
6.	No expired, contaminated or deteriorated drugs are found.			
7.	Expired/returned drugs are disposed of per legal requirements and documented.			
8.	Sharps and hazardous waste disposal containers are stored in a secure location and disposed of properly.			
Comments:				

Reviewed by:

_____ _____

MEDICAL DIRECTOR NAME Date

MEDICATION MANAGEMENT • POLICY 7.05

Sample Medications

This policy is appropriate for practices that manage samples. State law and ethics guidelines may dictate how individual practices approach management for their samples. Please consult with appropriate local counsel to ensure appropriate compliance.

It is the policy of the Practice that samples provided by pharmaceutical companies be securely managed by the Practice and/or through a relationship with a pharmacy. The Practice uses a reliable system of checks and balances, with careful monitoring and accountability for the sample medications.

PROCEDURES

1. The Practice informs all pharmaceutical company representatives that samples are welcome, but must be presented to the Practice's Medication Coordinator or pharmacist. The Practice's Medication Coordinator or pharmacist is responsible for proper record keeping, dispensing medication samples, and monitoring the sample medication for expiration, recalls, and so forth.

2. The physician or advanced practice provider with the ability to write prescriptions within their scope of practice treating the patient is responsible for all medications. No medications of any kind, including sample medications, are available to any person without the express written directive of a licensed prescribing Practice provider.

3. If the treating provider determines the appropriateness of a sample medication, he or she gives the patient a voucher that lists the sample medication, the national drug code (NDC) or dosage, strength and formulation, quantity, and all other pertinent details about the medication, including instructions. The patient's name, date of birth and account number is also printed on the voucher. The patient is instructed to deliver the voucher to the Practice's Medication Coordinator or pharmacy. The appropriate personnel confirm the voucher and the identity of the patient, and dispense the sample medication to the patient from the oldest lot available.

4. The Practice's Medication Coordinator or pharmacist logs all of the information on the voucher, as well as the dispensing date, time, dispensing employee, NDC and lot number of the sample. This information is also entered into the patient's medical record.

5. Samples are not for personal use. Providers and employees who require medication for their personal use must by treated by a provider (other than themselves) who will issue a voucher if and when a medication is considered appropriate.

6. No samples may be distributed directly to the provider and/or a Practice employee. The Practice's Medication Coordinator or pharmacist records all of the details about the sample medications prior to distributing them to the patient. These details are maintained in a master medication tracking log or in the Practice's EHR that shall include all of the sample medications present at the Practice.

7. Pharmaceutical sales representatives are instructed to check the expiration dates on the medications they provide to the Practice. The Medication Coordinator is responsible for monitoring the expiration dates once it has taken receipt of the sample medications, and recovering, logging and properly disposing of any expired medications.

8. A patient may not be charged for any sample medication.

MEDICATION MANAGEMENT • POLICY 7.06

Pharmaceutical Representatives

It is the policy of the Practice to manage the requests for visits by pharmaceutical representatives and/or those who are representing a supply, device or other product used by the Practice in order to avoid any disruption they may present to patients' visits.

PROCEDURES

1. The Practice maintains a calendar of available appointments for pharmaceutical and manufacturer representatives. Except in extenuating circumstances, no representatives may visit on [insert days of the week]. All representatives must make an appointment to be seen by a provider. The Administrator or the manager at the Practice's office site will maintain the template for these appointments; the schedulers can make an appointment if and when one is requested by a representative.

2. The Practice will maintain and secure sample medications, as managed by its Medication Coordinator. All sample medications must be taken to the designated Medication Coordinator to be logged. Patients are given vouchers to access the samples. (See policy 7.05 Sample Medications.)

3. When a representative arrives at the office, the representative must register with the front office; the front office employee notifies the provider's nurse, medical assistant, or other designated clinical support of their arrival. If there is an appointment for a visit, the representative is escorted by the employee to see the provider. If there is another need (e.g., more sample medications), the support employee is responsible for communicating with the representative.

4. All pharmaceutical and manufacturer representatives visiting the Practice with the purpose of soliciting, marketing, or distributing information regarding the use of medications, products, equipment and services may not provide food or drink of any kind, nor personal gifts of any type (including items such as pens, magnets, pre-printed prescription pads, or tickets to events). Vendors who violate this policy may have their business privileges revoked, and

their company may be restricted from any access to the property.

5. All Practice employees should not engage in activities with pharmaceutical and manufacturer representatives if there is any commitment to do business or influence business. When there is discussion or proposal to conduct or influence business, all employees should contribute equitably to any group activities. For example, if an employee is invited by a vendor to play golf, it would be proper for the employee to contribute the cost of the greens' fees. Due to the federal Sunshine Act requirements, all activities and expenses with pharmaceutical and manufacturer representatives will be documented.

MEDICATION MANAGEMENT • POLICY 7.07

Recall

It is the policy of the Practice to expeditiously notify a patient when a medication or medical device used by a patient has been recalled.

PROCEDURES

1. In the event of the notification of a recall, the Practice immediately confirms it directly with the pharmaceutical or medical device company to identify specific details of the recall. The recall must be in writing. The Practice does not rely on media reports for recall information.

2. When the recall is confirmed, the Administrator or designee queries the electronic health record (EHR) system or electronic prescribing (e-prescribing) module for all transactions involving the medication or medical device under recall. This includes patients who were prescribed the medication, patients who have been given or recommended for the specific medical device, and patients who were provided with a sample medication of the medication being recalled. Ideally, these transactions are divided into the categories listed herein, as well as the date that the medication or medical device was prescribed.

3. Depending on the nature of the recall, these patients are contacted in a timely manner by an employee designated for the task, as assigned by the medical director. He or she will provide instructions to patients based on the recall, as determined by the medical director or the treating physician or advanced practice provider (e.g., the need for a follow-up appointment). All patients will be contacted within 10 business days of the confirmation of recall.

4. All efforts to identify and communicate with patients are maintained in the patient's medical record. The written documentation of the recall is scanned and indexed in the patient's record. All instructions provided to the patient, family member or caregiver are documented in a manner that is consistent with medical and legal prudence.

5. The medical director informs the Practice's information technology staff of the recall in writing. The medical director provides instructions about managing the transaction details related to the medication or medical device in the e-prescribing module of the EHR system. The Practice recognizes the importance of alerting a provider about the recall to prevent any more patients from potentially receiving the recalled medication or medical device.

6. The Practice's in-house medication inventory will be assessed for any recalled medications or devices in stock, which should be removed and returned or disposed of in accordance with the recommendations of the vendor and/or local authorities.

CHAPTER 8

Information Systems

POLICY 8.01 • Workstations

POLICY 8.02 • Games on Practice Computers

POLICY 8.03 • Communication via E-mail

POLICY 8.04 • Use of Electronic Communication for Protected Health Information

POLICY 8.05 • Electronic Communication with Patients

POLICY 8.06 • Information System Problems

POLICY 8.07 • System Administration

POLICY 8.08 • Security Level Designations

POLICY 8.09 • Passwords

POLICY 8.10 • Copyright Infringement

POLICY 8.11 • Employee Computer Usage

POLICY 8.12 • Mobile Device Security

POLICY 8.13 • Data Backup Procedures

POLICY 8.14 • Daily System Shutdown

POLICY 8.15 • End-of-Day Closing

POLICY 8.16 • Report Generation and Distribution

INFORMATION SYSTEMS • POLICY 8.01

Workstations

It is the policy of the Practice that all users abide by the guidelines to ensure the proper functioning and longevity of workstations for physicians, advanced practice providers and employees.

PROCEDURES

1. Credentials

    a. Each employee shall have their own credentials to log into a workstation and the Practice network.

    b. Credentials shall be issued with specific consideration to job functions and will permit access to functions and information as required for their job duties.

    c. Passwords shall expire every 60 days and must be reset using alphanumeric digits and symbols no shorter than 8 characters (preferred 14).

    d. Individual credentials and passwords are strictly prohibited from being shared with other individuals. Passwords may not be posted in and around an employee's workstation. Violations of this policy subject the employee to disciplinary actions up to and including termination of employment.

    e. Biometric authentication (e.g., fingerprint scan) may provide an alternative to credentials as described herein, should the appropriate equipment and training be available.

2. Logging off

    a. Employees must log off their assigned workstations each time they leave the workplace or leave their work area for an extended amount of time.[13] This ensures that others cannot perform any actions on the system that cannot be attributed or tracked to the actual user.

    b. Employees must log off their computers at the end of each day and be sure the system and their monitors are shut down.

3. Screen Saver

    a. The screen saver on the monitor must be set to a minimum of 5 minutes if the workstation is in an open area and can be set up to a maximum 20 minutes if it is located in a secured (limited access) location.[14]

4. Backup

    a. All applications must have files securely saved directly to the main server, the cloud, or other remote storage for the Practice to ensure appropriate backup of all information. If a user is unsure how to do this, the system administrator can assist the user to set up appropriate file paths.

5. Data retention

    a. All master records and sensitive data must be securely stored on a file server, the assigned Practice cloud or other remote storage to guarantee security and data retention.

    b. Each end user must comply with all data retention policies of the Practice.

6. Hard drive and external hardware maintenance

    a. Users should dust computers, keyboards, and monitors weekly to protect the Practice's equipment using a dry, lint free cloth or approved compressed air product.

    b. To maintain consistent processing speed, users should clean all insignificant data from the hard drive on a regular basis as recommended and supervised by the Practice's system administrator.

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[13] There are alternatives to logging off that satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule requirement. If logging off is operationally a challenge, seek advice from legal counsel regarding alternatives to manage the security of data at employees' workstations.

[14] These times — a minimum of 5 minutes and a maximum of 20 minutes — are not required by current law, at the time of this publication. A practice is encouraged to establish reasonable times for screen savers for workstations in open and limited access locations in conjunction with advice from legal counsel.

7. Virus protection

    a. All workstations are set up with virus protection and automatic, regular Internet updates.

        1) When prompted to update the virus software, users should click "yes" and wait until the update is automatically accomplished.

        2) If a user notices that a computer is not prompting him or her for this update, contact the system administrator.

        3) A user should never open an attachment to an e-mail message unless the e-mail is from a trusted source. If even the least bit suspicious, employees should contact the system administrator before opening a file.

        4) No employee should ever give out their credentials, login information or other sensitive information to third parties, even when they appear to be known, over email or the Internet. If even the least bit suspicious, employees should contact the system administrator before responding to the inquiry.

    b. If at any time an employee notices anything unusual about the operation of his or her computer, he or she should contact the system administrator immediately and not attempt to resolve unidentified problems.

8. Software maintenance

    a. All software loaded on Practice workstations is duly licensed and authorized by the software developer and/or third-party re-seller.

    b. All software is kept up-to-date with the most recent patch or version to ensure that all known or suspected security risks are kept at a minimum.

    c. Software loaded on each system is documented and monitored every quarter to ensure that any program that is not routinely used is not loaded on Practice workstations.

9. Monitoring

    a. The Practice reserves the right to access workstations, and all data stored on Practice servers and cloud drives, at its discretion.

    b. Electronic communications and data on the computers are not private and confidential. As further described in Policy 8.03 Internal Communication via E-mail, Practice employees do not have any expectation of privacy for their own communications stored on Practice email accounts.

INFORMATION SYSTEMS • POLICY 8.02

Games on Practice Computers

It is the policy of the Practice that because of the business implications and the potential for misunderstandings about employee conduct, no employee may play computer games on Practice property (e.g., computers, servers, tablets, handheld devices) at any time — before work, during work hours, after work, or during lunch or breaks.

PROCEDURES

1. No computer games may be temporarily or permanently loaded on Practice computers.

2. The term "games" maintains a broad definition, and includes, but is not limited to, any arcade, puzzles, sports or any other interactive computer-based display for the sake of entertainment. This includes games played over an Internet connection, whether or not any part of the game is downloaded onto a Practice computer, server, tablet or handheld device.

3. The system administrator immediately deletes every computer game found on Practice computers.

4. Violations of this policy subject the employee to disciplinary actions up to and including termination of employment.

INFORMATION SYSTEMS • POLICY 8.03

Communication via E-mail

It is the policy of the Practice that all employees use e-mail that is provided through the Practice server network. Use is restricted as appropriate to conduct business but not to negatively impact productivity. All e-mail is considered the property of the Practice and is subject to review by management. There is no right to privacy when using the Practice's e-mail system.

PROCEDURES

1. E-mail provides the administrative means to distribute Practice policies and routine notifications (e.g., meeting notifications, seminars, etc.) to employees. While there may be extenuating circumstances that require correspondence in writing, e-mail is considered the Practice's primary method for internal notifications and communications.

2. When conducting business suppliers, vendors and other stakeholders of the Practice, the physicians, advanced practice providers and employees shall utilize their Practice's email address.

3. For vital business communication regarding the administration and long-term issues regarding the Practice, the Administrator or designee shall use a generic email address– "manager@[Practicename].com". This approach allows business communication to be maintained without interruption throughout the operations of the Practice. This generic email address shall be used in any instance where there is a long-term need for stakeholder communication, to include the Centers for Medicare & Medicaid Services, insurers, brokers and so forth. The generic email address shall be routed to the Administrator or designee.

4. Communications with patients and those that may contain patients' protected health information (PHI) shall be performed through the patient portal or other secure electronic communications platform used by the Practice. Email shall *not* be used when transmitting PHI unless the Practice has dedicated bidirectional encrypted capability (see also Policy 8.05). The Practice's patient portal or other secure electronic communications platform, and not email, should be the method of communication of PHI between Practice employees.

5. All employees are expected to check their e-mail at least once each shift they work. Note that some e-mail messages are for notification purposes only, while other e-mail messages require a response back to the sending party.

6. The use of e-mail is restricted to appropriate business only. The use of the e-mail address group that contains all employees' and providers' addresses is restricted to approval by the Administrator.

7. Periodic communication and training about e-mail etiquette is provided to all employees. Employees should not use the "reply all" feature unless the situation warrants it.

8. Employees are prohibited from opening or retrieving emails not addressed or sent to them unless they have been authorized by the Administrator. Any email received that is not addressed to that individual should not be read. A message to the sender should be sent stating the misdirection. The email should be immediately deleted and removed from the account's "trash."

9. The management of the Practice has the authority to access, intercept, and disclose any emails created, received or sent using the Practice's internal network or the Internet from the Practice's software platforms or hardware. All received, drafted and transmitted messages are the property of the Practice and are not confidential.

10. The platform for secure communications with patients should be monitored closely, at that time which is dictated by the Administrator or designee, but no more than three hours. Periodic communication and training about appropriate messaging is provided to employees responsible for these secure patient communications. Communication from employees to patients is considered critical to job performance, and may be reviewed as part of the employee's job evaluation.

11. Failure to abide by guidelines may be grounds for disciplinary actions up to and including termination.

INFORMATION SYSTEMS • POLICY 8.04

Use of Electronic Communication for Protected Health Information

It is the policy of the Practice to maintain protected health information (PHI) in a secure and confidential manner when electronic communication is used. PHI is considered a combination of personally identifying information that renders the information identifiable to an individual patient of the Practice. This includes but is not limited to: patient's name, mailing address, residential address, ZIP code, email address, date of birth, insurance company, insurance member identification, insurance group identification driver's license number, social security number, medical record number, and facial photograph.

PROCEDURES

1. All Practice employees and providers who require the use of e-mail to communicate PHI must do so through a Practice-managed, secure electronic platform.

2. Electronic communication that contains PHI should be used with caution and is subject to the limitations contained in this policy. Email shall *not* be used when transmitting PHI unless the Practice has dedicated bidirectional encrypted capability. The Practice's patient portal or other secure electronic communications platform should be used to communicate regarding patient's care and messages that contain PHI.

3. Practice providers and employees should not transmit electronic communication that contains PHI outside the Practice unless the Practice has a bidirectional encrypted technology.

4. Text, image and video messaging platforms, personal e-mail, social media and instant messaging accounts are not permitted when communicating PHI.

5. Commercial Internet service providers must be approved by the Practice's system administrator. They may be used only to access Practice-managed e-mail systems remotely, and not to send electronic communications containing PHI.

6. All external bi-directionally encrypted electronic communications that contain PHI must include a disclaimer in the message such as: "NOTICE: This email message and/or its attachments may contain information that is confidential or restricted. It is intended only for the individuals named as recipients in the message. If you are NOT an authorized recipient, you are prohibited from using, delivering, distributing, printing, copying, or disclosing the message or content to others and must delete the message from your computer. If you have received this message in error, please notify the sender by return email."

7. All bi-directionally encrypted electronic communications that contain PHI must include a signature, which includes, at minimum, the sender's full name (first and last), title, and position; the Practice telephone number; and an e-mail address.

8. Practice providers and employees should not send group electronic communications containing PHI to distribution lists or multiple recipients, unless they send these communications through the Practice's secure intranet. Even through the secure intranet, these distributions should be kept to a minimum, and performed only when necessary.

9. Users should not use PHI in the header or subject line of an electronic communication. Headers are susceptible to potential viewing by unauthorized individuals.

10. Users should use generic or non-specific phrases such as "patient record request" instead of "Patient John Jones record request" or "patient information" instead of "Patient Jones, SSN 555-55-5555" unless the information is sent via the Practice's bi-directional encrypted platform.

11. Attachments sent electronically are of potentially greater risk due to the volume of information that can be exchanged. Therefore, if it is necessary to attach a document, it should be secured with passwords that are not provided in the same message. Passwords should be distributed in a method that demonstrates double authentication. For example, passwords could be shared by telephone, text or fax. It is highly encouraged to exchange documents with PHI via a secure, encrypted patient portal or other secure electronic communications platform.

    a. If a user needs to transmit files containing large amounts of PHI, a more secure file exchange method must be used.

    b. A user should contact the system administrator for assistance when transmitting files containing large amounts of PHI.

    c. The system administrator will confirm that any system used for transmission or storage of PHI has a current and compliant business associate agreement on file with the Practice when the message is originated by Practice employees.

INFORMATION SYSTEMS • POLICY 8.05

Electronic Communication with Patients

It is the policy of the Practice to establish and maintain a communication platform with patients that allows for secure, two-way electronic messaging. It is the policy of the Practice that all electronic messages are returned in the designated timeframe as defined and periodically assessed by the Practice in order to meet the needs and preferences of patients, families and caregivers.

PROCEDURES

1. The Practice will establish a secure platform for electronic messaging. Although expanding technology and even patient desires may outpace the creation of policies and procedures, text, image and video messaging platforms must be avoided unless the Practice systems administrator has confirmed that communication can be maintained securely and a current and compliant business associate agreement is on file with the Practice.

2. All secure electronic messages will be responded to within three business hours. Electronic messages are responded to electronically or by telephone, as dictated by the nature of the communication and required response. In the event that a message is received after 4:00 p.m., the message will be responded to on the following business morning.

3. Secure electronic messaging is made available to patients who are established with the Practice. Electronic messages are reserved for conditions and situations that do not require immediate medical attention.

4. All secure electronic messages will have a reply acknowledgement and disclaimer that is automatically transmitted to the sender, as such: "Your message has been received by [Practice's name]. We will attempt to process your request within one business day. If you need immediate assistance, please call the office at [Practice's telephone number, which includes access to the after-hours answering service if after hours]. In the event that you are experiencing an emergency, please seek care at the closest emergency room."

5. The Practice assigns responsibility to employees for all inbound electronic messages and requests in writing. Standard workflow is appointment requests being processed by the scheduler, and the triage nurse handling all messages related to clinical advice, and requests for medication renewals and test results notification. In the event of an employee absence, the supervisor must ensure that another employee assumes the role. Inbound messages are checked, at minimum, every 30 minutes.

6. If the event that a patient is messaging about a request that requires communication with a third party (e.g., a medication renewal with communication to the patient's pharmacy), the triage nurse is responsible for sending a confirmation message to the patient within the three-business hour response time.

7. The Practice establishes protocols for messaging etiquette (e.g., do not type a message to a patient in all CAPS) in which all employees and physicians are trained. Reference material is developed about said protocols. As with any form of patient communication and documentation, unprofessional remarks or comments in electronic messages are prohibited. Disciplinary action may be taken in the event of a violation of said protocols.

8. Confidentiality of patient information is maintained at all times to safeguard the integrity of protected health information (PHI).

9. All electronic messages are considered part of the patient's medical record. All electronic messaging is performed and documented in a manner that is consistent with medical and legal prudence.

INFORMATION SYSTEMS • POLICY 8.06

Information System Problems

It is the policy of the Practice that all information system problems are reported to the help desk in the information technology department or the contracted system manager. When system managers are not engaged by the Practice, notify the Administrator or designee. Information system problems are documented and an order for repair or restoration is immediately initiated.

PROCEDURES

1. Physicians, advanced practice providers and employees submit all system help requests to the help desk via the designated internal communication protocols established to report technology issues that require assistance.

2. When issuing a report, the technology user shall have the following information available when contacting the help desk:

    a. His or her full name;

    b. Telephone and/or extension number, if applicable;

    c. Department or office location;

    d. Computer terminal or device number or identification; and

    e. Brief description of the problem or issue, the software application in use and the circumstances associated with the problem, and the impact on patient care or other essential business functions.

3. The help desk documents all requests and requisition assistance.

4. All requests are documented and followed up on within 24 hours in order of the severity of each issue.

5. Depending upon the severity of the problem and the capability of the employee staffing the help desk, the employee may offer directions for problem resolution when the caller is on the phone.

6. The help desk supervisor reports weekly activities based on daily tracking in the problem log. Tracked items include:

    a. Down time;

    b. Type of problems;

    c. User problem frequencies; and

    d. Hardware/software-specific problems.

7. Month-end reports are presented to the Administrator who makes decisions in an effort to decrease the frequency of problems and resolve system challenges.

INFORMATION SYSTEMS • POLICY 8.07

System Administration

It is the policy of the Practice that the system administrator maintains all master files and updates the data in such files.

PROCEDURES

1. All master file changes are made only upon the approval of the system administrator or designee.

2. The system administrator ensures that deletions, additions, or modifications to the system occur only through his or her specific designation. Version control is captured in documentation for all changes to the system and archived in perpetuity.

3. The system administrator assigns levels of security and system access to all users based on job roles and responsibilities.

4. Regular reporting of all system users occurs monthly, to include users, utilization and password assignments for workstations, the practice management system, the electronic health record (EHR) system, and other software used by the Practice.

5. Master file modifications are documented in a log maintained by the information technology department or contract administrator, organized by month. The log is transmitted to the Administrator or designee at the close of each month.

6. The system administrator has the authority to assign hardware availability by user throughout the Practice.

7. Requests for changes to the master files must be submitted in writing to the system administrator.

8. All file maintenance requests are responded to by the system administrator within 24 hours.

9. The system administrator will assure that a Health Insurance Portability and Accountability Act (HIPAA) Security Risk Assessment is conducted annually, and action is taken as a result of any findings. Annual actions include but are not limited to ongoing maintenance to workstation software updates, continuous antivirus and malware sweeps, validation of users, audits of user activities, especially evaluating the access of PHI and its relevance to their job functions, and ongoing upkeep of the system firewall(s).

INFORMATION SYSTEMS • POLICY 8.08

Security Level Designations

It is the policy of the Practice to maintain a secure information system that is fully compliant with all applicable Health Insurance Portability and Accountability Act (HIPAA) of 1996 Security and Privacy requirements and subsequent statutory and regulatory updates. The system administrator assigns levels of security and corresponding passwords to all Practice employees and providers and fully documents all policies, procedures, and employee training.

PROCEDURES

1. The system administrator assigns every physician, advanced practice provider and employee a level of security and data access depending on the individual's level of responsibility and the relative need for information to complete his or her job functions.

2. The system administrator maintains a log of security levels and passwords to be available as needed by the Administrator or designee.

3. Employee changes

    a. The system administrator logs all employee changes in position or levels of security changes.

    b. Supervisors alert the system administrator when such changes occur.

    c. Upon termination of any provider or employee, the system administrator immediately takes steps to terminate future access to the system.

4. Logging on and logging off

    a. All system users are required to log on and log off the system using assigned passwords (or an alternative authentication method, as approved by the system administrator).

b. All users are required to log off their workstations when they leave their areas to avert any misuse of their systems by other individuals. A user should not allow another individual to make entries into the electronic health record (EHR) system or practice management system under his or her login.

INFORMATION SYSTEMS • POLICY 8.09

Passwords

Alert: *Should equipment and training become available for an alternate to passwords, this policy should be replaced with an applicable policy and procedure for the authentication process.*

It is the policy of the Practice that all users are assigned a user name and password and are required to use them to access the Practice's information systems. Users are not allowed to password-protect individual documents with their password without registering the password with the systems administrator.

The password has a very special purpose in the computer environment: it ensures that only authorized individuals access electronic information assets. Each individual system user has the responsibility to protect his or her password and user name.

PROCEDURES

1. Each user is responsible for the security of his or her user name and password(s) and is held responsible for all use or misuse of his or her account; users shall not disclose their user names or passwords.

2. Personal document passwords are registered with the system administrator using the Password Registration Form (see next page). This form is maintained electronically.

3. If a user suspects unauthorized use of his or her password, he or she must contact the system administrator immediately and change the password.

4. Remote access to the Practice network is prohibited unless the system administrator and the Administrator or designee grants permission in writing. Users shall not remotely log on (or otherwise use) any workstations or computers not designated explicitly for public logons over

the Practice network — even if the configuration of the computer permits remote access — unless he or she has explicit, written permission from the Administrator or designee.

5. Users may not use account set up for other users and may not attempt to find out the password of a service for which they have not been authorized, including account set up for other users.

6. Passwords shall expire every 60 days.

7. To ensure the greatest security for their passwords, users are instructed to abide by the following guidelines in selecting a password:

   a. Use a password that is eight or more characters long (recommended 14).

   b. Use a password with a combination of letters (upper and lower case), along with symbols (e.g., @=$) and numbers.

   c. Use a password with word combinations instead of just one word.

   d. Don't use a password that contains the employee's user identification, user account, or any family member names, pet names, or easily identifiable dates or other information as part of the password. Passwords used for other public systems should not be the same as those for Practice workstations or software.

   e. Don't repeat the same letter or number more than twice.

   f. Don't use the employee's first or last name in any form.

   g. Don't use any information easily obtained about the employee, such as your Social Security number.

8. Failure to abide by password guidelines may be grounds for disciplinary actions up to and including termination.

PASSWORD REGISTRATION FORM

Name: _____

Date created: _____

Password: _____

Date changed: _____

Electronic signature of user: _____

INFORMATION SYSTEMS • POLICY 8.10

Copyright Infringement

It is the policy of the Practice to comply with all copyright regulations pertaining to intellectual property rights. Many software programs, computer data, music, books (printed, audio and electronic), and related materials, such as documentation owned by individual users or other companies, are protected by copyright and other laws, together with licenses and other contractual arrangements.

PROCEDURES

1. All software loaded on Practice workstations is duly licensed and authorized by the software developer and/or third-party re-seller.

2. Any physician, advanced practice provider or employee obtaining electronic access to another company's or individual's materials must respect all rights (including copyrights) and may not copy, retrieve, modify, disclose, examine, rename, or forward such materials except as permitted by the person owning the data, software programs, or other materials. Such restrictions include:

   a. Copying programs or data;

   b. Reselling programs or data;

   c. Using programs or data for non-Practice business purposes;

   d. Using programs or data for personal financial gain;

   e. Using programs or data without being one of the licensed individuals or groups; and

   f. Publicly disclosing information about software programs without the owner's permission.

3. Failure to abide by these restrictions may subject providers and employees to civil and/or criminal prosecution as well as disciplinary action up to and including termination.

INFORMATION SYSTEMS • POLICY 8.11

Employee Computer Usage

It is the policy of the Practice that employees may not use the Practice's computers for their personal use. The intent of this policy is to establish guidelines for the use and access to the Practice's information systems so as to protect the Practice and its employees from the misuse of company time and property.

PROCEDURES

1. This policy is in force at all times to include in advance of work, during work hours, after work, or during lunch or breaks.

2. All computer equipment, as well as the information that it contains or transmits to approved third party vendors, is the Practice's property. Users should have no expectation of their privacy related to their usage of any Practice system.

3. The Practice reserves the right to monitor, measure, and track the use and performance of its systems for technical or other reasons at any time, and may access any information contained in its systems. When routine maintenance and monitoring of the network and its performance reveal violations of this policy by specific users, individual investigations may be conducted without advance warning.

4. Physicians and employees will not upload or use any program that is not authorized by the Practice and licensed for work purposes as dictated by the Practice.

5. Physicians and employees will not use the Practice's information systems to damage, disable or illegally monitor the property of another person or organization. This prohibition includes, but is not limited to, deliberate attempts to degrade or disrupt equipment, software or system performance by spreading computer viruses or by any other means; tampering with, modifying or changing the Practice's information systems in violation of applicable user agreements; or using hardware, wiring or taking any other type of action that would compromise the security of the Practice's computer systems.

6. Physicians and employees will not use the Practice's information system to transmit, receive, access, review, upload, download, store, print, post, or distribute pornographic, obscene, abusive, profane, lewd, vulgar, rude, inflammatory, threatening, disrespectful, or sexually explicit material or materials that use language or images that advocate violence or discrimination toward other people or that may constitute harassment or discrimination. This prohibition applies regardless of whether or not such materials are actually seen by another party.

7. Physicians and employees will not use the Practice's information systems for campaigning, fundraising or any other local, state or federal advocacy that is not sanctioned and approved in writing by the manager.

8. Physicians and employees will not use the Practice's information systems to access, review, upload, download, store, print, post, or distribute materials that use language or images that are inappropriate to the work setting or disruptive to the work environment nor may post information or materials to the Practice's systems (internal or website) or to external computer systems, bulletin boards, forums, etc., that could cause damage, danger of disruption or intentional loss of reputation to the Practice. If an employee inadvertently accesses unacceptable materials or an unacceptable Internet site, the physician or employee shall immediately disclose the inadvertent access to the manager. This disclosure may serve as a defense against an allegation that the employee has intentionally violated this policy.

9. Physicians and employees will not use the Practice's information systems to knowingly or recklessly post false or defamatory information about a person or organization, or to harass another person, or to engage in personal attacks, including prejudicial or discriminatory attacks.

10. Physicians and employees will not use the Practice's information systems to engage in any illegal act or violate any local, provincial or government regulation, statute or law.

11. Physicians and employees will not use the Practice's information systems to gain unauthorized access to information, material or files or to access another person's materials, information or files without the implied or direct permission of that person.

12. Physicians and employees will not use the Practice's information systems to post private information about another person, protected health information about a patient, or personal contact information about themselves or other persons including, but not limited to, addresses, telephone numbers, work addresses, identification numbers, account numbers, access codes or passwords.

13. Physicians and employees will not attempt to gain unauthorized access to the Practice's information systems or any other system through the Practice's information system, attempt to log in through another person's account, or use computer accounts, access codes or network identification codes other than those assigned to the user.

14. Physicians and employees will not use the Practice's information systems to violate copyright laws or usage licensing agreements, or otherwise to use another person's property without the person's prior approval or proper citation, including the downloading or exchanging of music, books (printed, audio or electronic), pirated software or copying software to or from any Practice computer.

15. Physicians and employees will not use the Practice's information systems for unauthorized commercial purposes or for financial gain unrelated to the official business of the Practice. Users will not use the Practice's information systems to offer or provide goods or services or for product advertisement, other than for work purposes. Users will not use the Practice's system to purchase goods or services for personal use without authorization from the manager.

16. Although a certain amount of incidental private use[15] of its computer systems by employees is allowed, this usage must not exceed what would be regarded by any reasonable person as fair and just, and is subject to the terms and conditions of this policy. Private use of the system is a privilege and not a right, and what would be considered suitable use on a private account on another system will not necessarily be suitable for the Practice's system.

17. **EMPLOYEES AND PROVIDERS WILL BE PRESENTED WITH THE APPROPRIATE USE OF INFORMATION** and Confidentiality Agreement upon hiring; all employees and providers are expected to review, acknowledge and sign the agreement, which will be maintained on file at the Practice.

[15] *Incidental private use can include accessing (but not downloading from) personal email accounts, social media and streaming music that does not interfere with the work environment or job duties.*

APPROPRIATE USE OF INFORMATION AND CONFIDENTIALITY AGREEMENT

I, the undersigned, have been provided access to certain information systems in order to efficiently provide medical services to patients of the Practice. Confidential patient and sensitive business information is this Practice's most valuable asset residing on its computer systems. The privacy of the Practice's confidential patient and sensitive business information depends on the protection of this information against theft, destruction, or unauthorized disclosure to outside interests.

In order to be granted access, I acknowledge that I have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of the patients' health information. I understand and agree to be bound by the information security policies in effect for the Practice.

Therefore, in consideration of being allowed access to one or more of the Practice's software systems, I, the undersigned, hereby agree to the following provisions:

- I will only access patient's protected health information (PHI) when I have a need to know and it is appropriate to support patient medical care.
- I will not divulge, copy, release, sell, loan, alter or destroy any confidential information regarding patients or employees without proper authorization and authority.
- I will abide by the policies and procedures set forth by the Practice regarding the use of all electronic media and transmission of data.
- I will maintain assigned passwords and/or access methods that allow access to computer systems and equipment in strictest confidence and will not disclose a password or access method to anyone at any time for any reason, as I acknowledge this increases the possibility of accidental disclosure.
- I will practice good workstation security measures such as locking up electronic storage devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
- I will contact the Administrator or designee immediately and request a new password if mine is accidentally revealed.
- I will not disclose any portion of the Practice's computerized system to any unauthorized individual, including friends or family, who do not have a need to know.
- I will not access my own or a family member's medical record or account information without a job-related reason.
- I will not disclose any portion of a patient's PHI except to a recipient authorized by the patient to receive that information.
- I will report activity that is contrary to the provisions of this agreement to the Administrator immediately.

I understand that failure to comply with the terms of this agreement and the authorization to access the Practice's information systems and the above-referenced policies may result in formal disciplinary action up to and possibly including termination and potential civil and criminal penalties for wrongful disclosures of PHI.

Employee signature: _____ Date: _____

Employee printed name: _____

INFORMATION SYSTEMS • POLICY 8.12

Mobile Device Security

Alert: *Additional information regarding security requirements is provided in Chapter 16. Refer to related policy 16.07 on Security of Electronic Medical Records.*

It is the policy of the Practice to securely maintain all mobile devices that store, access or transmit protected health information (PHI) electronically. It is the policy of the Practice to comply with the Health Insurance Portability and Accountability Act of 1996 in its usage of mobile devices.

The purpose of the policy is to mitigate the threat of data loss, data theft, and the introduction of viruses, spyware, trojans, worms, and other malware which can impact the security of the practice systems. Practice appreciates that the rapid growth and use of various devices and applications cannot be covered by policies and procedures alone. All employees are reminded and encouraged to exercise good judgment in securing devices and communication at all times.

PROCEDURES

1. All mobile devices that physicians and employees use for approved business functions (such as viewing the appointment schedule, entering charges, and accessing the electronic health record system) must be registered with the Practice (regardless of who purchased or owns the device). The registration process includes the person who uses the device, the beginning date of usage, serial number, cellular carrier, device identification (ID), and user name/password.

2. Physicians and employees are expressly forbidden to use non-registered devices for any business function of the Practice or to access the PHI of its patients. Violation of this procedure will be considered an action requiring disciplinary action.

3. All mobile devices used for approved business functions employ, at a minimum, the requirement for passwords or other appropriate authentication to power on the device and to access the device after defined period of inactivity.

4. All wireless communications between mobile devices for approved business requirements will use contemporary wireless encryption standards that are defined by the practice's system administrator or designee.

5. If applicable, all mobile devices used for approved business functions will complete daily data backup or synchronization operations to a secure server maintained by the Practice.

6. All PHI must be adequately removed from mobile devices prior their repair by a vendor, destruction or replacement, in compliance with HIPAA.

7. In the event that a mobile device is lost or stolen (regardless of who purchased or owned the device), the device will be immediately locked remotely. If a reasonable period of time has been consumed to locate the device without success, the device will be remotely erased.

INFORMATION SYSTEMS • POLICY 8.13

Data Backup Procedures

It is the policy of the Practice that the computer system is backed up on a daily basis.

PROCEDURES

1. The information technology department or system administrator ensures the automatic backup of the entire computer system on a daily basis utilizing the method best suited to the storage needs of the Practice.

2. The backup process occurs during off-office hours each evening from approximately 1 a.m. to 3 a.m.

3. The systems administrator maintains a backup log and designates the appropriate person in each department to facilitate any follow-through necessary to accomplish these procedures.

INFORMATION SYSTEMS • POLICY 8.14

Daily System Shutdown

It is the policy of the Practice that each user workstation and monitor is shut down daily to prevent data degradation, system lockup, and early demise of monitors.

PROCEDURES

1. Each workstation is programmed to completely shut down when the user carries out the shutdown commands that are defined by the system administrator.

2. In most networked environments, the system administrator will program the workstation to log the user off the network and time out after a predetermined time has elapsed. Monitors may be set to go into a power-saving mode where they go inactive after a period of inactivity. When this is not set, monitors will need to be shut down by each user.

3. The system administrator sets all workstations to log users off after a predetermined time, typically 5 to 20 minutes after inactivity. This requires the user to log back in and protect private data from being accessed by casual observers. (See related policy 8.01 on Workstations.)

INFORMATION SYSTEMS • POLICY 8.15

End-of-Day Closing

It is the policy of the Practice that the business office initiates and completes the end-of-day closing of the practice management system.

PROCEDURES

1. The business office accomplishes the end-of-day closing of the practice management system on the day following each business day. (See also Policy 9.01 in Financial Management)

2. Every employee closes his or her batches and prepares a summary report that shows all items are balanced.

3. If applicable, a designated employee in each office ensures that a clear audit trail of all charges, payments, and adjustments is completed prior to closing of the day's activities. This employee is responsible for resolving any conflicts.

4. Any hard-copy documents generated from the closing process are saved and stored electronically either by generating them in an electronic document or scanning them.

5. Reports that record the day's activities are generated and submitted to the business office for distribution and electronic storage. Distribution may include the use of electronic file folders with user-designated access.

6. The designated employee in the office matches deposits to the closing summaries.

INFORMATION SYSTEMS • POLICY 8.16

Report Generation and Distribution

It is the policy of the Practice that the manager of the business office is responsible for producing daily, monthly, and annual reports and for distributing the reports to the appropriate individuals based upon the Practice's report schedule.

PROCEDURES

1. The Report Distribution Protocol is defined and maintained by the Practice (see below).

2. The Practice makes data available on its secure, firewalled intranet for customization and reporting by internal users. Training is provided to all physicians, advanced practice providers, managers, and any other designated employee with a need for management reports.

3. Custom reports may be produced upon completion of a written request. Custom reports require a minimum of five business days to complete and must be approved by the Administrator or designee. Custom reports require time for report writing and data extraction. Notification of any time delay is communicated to the requestor and the Administrator or designee.

4. Reports are stored for access using uniquely identified shared file folders on the network server. Access is provided on a need-to-know basis determined by the Administrator or designee.

REPORT DISTRIBUTION PROTOCOL

Frequency	Report Type	Report Recipient
Daily and Monthly	End-of-day/month balance	
	Collections by category (time of service, electronic remittance and funds transfer, online payment, etc.)	
	Arrived encounters, charges and work relative value units (wRVUs) by physician and advanced practice provider	
	Charge report showing charges, corrections, and transfers	
	Payment batch report	
	Transaction journal showing payments and adjustments by category	
	Scheduled but not arrived patients, by category (no-show, cancel, bump, other)	
	Missing charges	
Monthly (in addition to above) and Annually	Aged trial balance (ATB) by payer category (e.g., Medicare, Medicaid, Self, Workers' Compensation, Blue Cross Blue Shield); includes total current receivables (also called "aged accounts receivable by payer"), etc.	
	Bad debt	
	Credit balance by payer category (see above)	
	Payment variance report (actual versus expected per contracted fee schedule)	
	Reimbursement performance by payer (net collection ratio by payer)	
	Utilization report	
	Referrals (referral source, patient, service, diagnosis, charges, revenue)	
	Payer mix (by charges, revenue, encounters or active patients)	
Annually (in addition to the above)	All year-to-date activity by physician, advanced practice provider and office, with comparisons to previous year-to-date	

CHAPTER 9

Financial Management

POLICY 9.01 • Time-of-Service Payment Controls and Daily Close

POLICY 9.02 • Deposit of Patient Receipts

POLICY 9.03 • Bank Statement Reconciliation

POLICY 9.04 • Month-End and Year-End Closing

POLICY 9.05 • Authorized Check Signing

POLICY 9.06 • Reimbursed Expenses

POLICY 9.07 • Check Requests

POLICY 9.08 • Check Processing Cycle

POLICY 9.09 • Petty Cash Transactions

POLICY 9.10 • Internal Controls

POLICY 9.11 • Online Banking

POLICY 9.12 • Operating Budget

POLICY 9.13 • Payroll Expenses

FINANCIAL MANAGEMENT • POLICY 9.01

Time-of-Service Payment Controls and Daily Close

It is the policy of the Practice to ensure timely and accurate tracking, reconciliation, and deposits of all payments received at the time of service.

PROCEDURES

1. Each employee logs into the practice management system using his or her personal user identification. No charges and payments will be entered by an employee under or using another employee's workstation or login credentials. Each employee is responsible for all transactions occurring at his or her workstation and under his or her login credentials.

2. All charges and payments are entered into the practice management system at the time of patient check-out, unless otherwise designated to be the responsibility of the business office.

3. All payments are linked to the appropriate charges at check-out. All unassigned payments will be resolved by the end of the business day.

4. Every check received by the patient at time of service is endorsed with the Practice's bank endorsement stamp at the time of check-out. Alternately, the Practice may process checks at the time of service utilizing automated check handling (ACH), in which case employees are provided training and instructions regarding ACH protocols. The payment is posted and a statement reflecting the application of the payment is given to the patient.

5. Credit and debit card payments are transmitted immediately or, at maximum, daily in accordance with the service procedure found at each credit card terminal or online merchant processor.

6. At the end of the shift, each employee entering charges and/or time-of-service payments runs a daily system summary in the practice management system, showing all patient charges and payments (cash, check, debit card and credit card) by user identification. This report is balanced against the practice management system, and reported as part of the daily close.

7. Each employee responsible for charge and/or payment entry must balance patient charges as well as receipts for his or her allotted shift under his or her user identification.

8. At the daily close of business, the manager or designed employee prepares and signs a daily close sheet that records credit/debit card payments, cash and personal checks received at the Practice. If using ACH or another automated transmission process, the daily close may incorporate an automated deposit in accordance with the protocols provided by the vendor used for the purpose of financial transactions at the time of service.

    a. The employee reconciles the totals posted to the practice management system to the totals indicated on the daily close sheet. The totals posted to the practice management system are printed, and attached to the daily close sheet.

    b. The record of the credit/debit card payments is attached.

9. The designated employee prepares the daily close deposit as follows:

    a. Dates the deposit slip with the date of service.

    b. Totals all cash and write the amount in the cash area on the deposit slip.

    c. Lists each check by check number on the deposit slip.

    d. Writes the total of cash and checks to be deposited in the appropriate space on the deposit slip.

    e. The deposit slip should only be used for monies received "over the counter." Any other monies to be deposited (e.g. rebate checks, payments for items not recorded in the practice management system) should be prepared on a separate and unique deposit slip. Any insurance or other payments received by mail, recorded and prepared for deposit should be recorded on a separate, unique deposit slip.

10. The daily close sheet is delivered to the business office along with the supporting documentation.

11. The manager or designee confirms that the deposit total plus the credit card charges balances to the daily close summary. The business office or accounting staff is responsible for confirming the daily close summary matches the bank account. The duties of preparing the deposit and confirming the deposit matches the bank account must be performed by different persons so as to ensure appropriate internal controls.

12. The business office manager verifies the daily close sheet to the practice management system. When these are confirmed to be in balance, the day is closed and the system date is advanced.

13. The manager or designee shall enclose checks, cash, and the deposit slip for a single date of service in an envelope stamped with the date of service, the total of the deposit, and the name of the Practice. The manager shall place all the deposit in the site-specific, numbered bank pouch, and lock the pouch.

14. Each individual credit card total (MasterCard, Visa, Discover and American Express) is noted daily as a line item under the cash/check deposit for the day on the calculator tape or documented electronically to ensure balancing to the transmitted credit card charges.

15. A copy of this tape is marked "Total Credit Card Charges," dated with the date of receipt and attached to the daily close form along with the cash/check deposit slip for the day. Alternately, an electronic format can be saved using the file name for the date of the deposit.

16. The daily close sheet and supporting documentation are given to the Practice's accounting department for reconciliation against the actual deposits made.

17. Discrepancies are addressed immediately and errors corrected by making the appropriate adjustment entries.

18. All deposits should be made promptly. Any monies held overnight should be placed in a secure safe. (See Policy 9.02, Deposit of Patient Receipts.)

19. All monies received during the month period where the detail for posting is available are to be posted to the system prior to closing of the last day of the respective month.

20. Accounting and the business office reconcile any carryover of electronic funds and/or checks that cannot be posted prior to the closing of the month.

SAMPLE DAILY DEPOSIT LOG

Practice site: _____

Date	**Deposit total**	**Prepared By**
12/1/17	$500.00	EWW
12/1/17	MC $350.00	EWW
12/1/17	VISA $750.00	EWW
12/1/17	Discover $235.00	EWW
12/1/17	American Express $175.00	EWW

REQUEST FOR EDIT/CORRECTION/VOID

Account number: _____

Patient name: _____

Date of service to be edited: _____

Description of issues:_____

_____

Requester: _____

Date:_____

Approval granted by: _____

Date: _____

Notes of approval not granted: _____

_____

Please attach any available, appropriate documentation.

FINANCIAL MANAGEMENT • POLICY 9.02

Deposit of Patient Receipts

It is the policy of the Practice that all employees follow appropriate and consistent procedures for handling and depositing patient receipts.

PROCEDURES

1. For all funds collected directly from patients, the following guidelines should be followed:

    a. During operating hours, all cash funds are maintained in a locked drawer that is inaccessible to patients, as well as unauthorized employees. The drawer is always locked when unattended.

    b. At the end of the business day, a reconciliation of the cash drawer is prepared to ensure accuracy.

    c. As part of the reconciliation process, all checks and cash in excess of the cash fund balance are prepared for deposit into the bank.

    d. A deposit slip is prepared and checks are properly endorsed with a stamp.

        1) If the bank is still open, the deposit is taken into the bank for inclusion in the nightly sweep account for daily reconciliation and consolidation of practice accounts.

        2) If the bank is closed, the deposit is placed in the night drop box at the bank.

    e. The Practice bank account(s) should reflect the deposit the next day.

    f. An alternate deposit procedure is to prepare a daily deposit by 3 p.m.

        1) This ensures that the deposit is included in the consolidation of accounts (nightly sweep), which enhances cash flow.

g. Any money collected after 3 p.m. is securely stored overnight and deposited the following day by 3 p.m.

2. For satellite offices or that which is other designated by the Administrator, the same procedures are followed; however, deposits are made when there is greater than $500 on hand for deposit, or at the business weekend, whichever is sooner.

   a. At the end of the business day, the money must be maintained in a locked, fireproof safe for security purposes.

   b. At the end of the business day, copies of the receipts are submitted to Practice employees assigned to post payments or to the business office for posting to patient accounts if not previously posted at the time of the visit.

FINANCIAL MANAGEMENT • POLICY 9.03

Bank Statement Reconciliation

It is the policy of the Practice to reconcile bank statements as part of month-end closing procedures. The purpose of this policy is to ensure the timely performance of month-end closing.

PROCEDURES

1. Bank statements

   a. Bank statements must be reconciled as part of the month-end closing procedures.

   b. This procedure is completed for each bank account.

   c. The following is an example of the recommended reconciliation format:

   - Bank balance at month end $ xxxx
   - Plus deposits in transit to bank xxx
   - Less outstanding checks (xxx)
   - Plus/minus other reconciling items xxx
   - Balance $xxxxx
   - Balance on general ledger (G/L) $xxxxx

2. Deposits in transit (DIT)

   A review of the detail is essential to determine whether there have been any lost or misapplied deposits. Any DIT greater than five days old should be investigated immediately.

3. Outstanding checks

    a. A detailed list of outstanding (uncashed) checks should be maintained.

    b. All outstanding checks over 30 days old with a balance of $100 or more should be reviewed.

    c. A stop-payment should be issued on any outstanding checks older than three months.

        1) These checks should be investigated as to why they have not been cashed.

        2) A new check is reissued, if applicable.

4. Other reconciling items

    a. The detail is reviewed monthly to determine appropriateness and a method of resolution (e.g., general ledger journal entry).

    b. There should be no difference between the reconciled bank balance and the general ledger balance.

    c. If the balances do not match, then there may be more reconciling items than originally identified.

    d. Daily reconciliation should be logged (see related policy 9.01 on Time-of-Service Payment Controls).

    e. The individual reconciling the bank account should be different than the person assigned responsibility for writing checks (see related policy 9.10 on Internal Controls).

        1) A designated individual who is not responsible for writing checks should open all bank statements.

        2) If bank statements are provided electronically, a designated individual separate from the one responsible for writing checks should obtain and review the bank statement as well as images of checks.

FINANCIAL MANAGEMENT • POLICY 9.04

Month-End and Year-End Closing

***Alert**: The following procedures may require modification if the Practice utilizes the accrual based accounting method of financial reporting. Consult your accounting professional for guidance on proper entry of revenues, adjustments to revenues, and expenses.*

It is the policy of the Practice to establish procedures for month-end and year-end closes. Month- and year-end closing procedures are necessary for purposes of reconciling the bank statement(s), accounts receivable, and accounts payable and for making timely business decisions based on current operating results. The purpose of this policy is to ensure closing procedures are performed in a consistent and timely manner.

PROCEDURES

The following outlines the month-end closing process:

1. At mid-month and prior to the end of month, the information technology (IT) department/employee will run an exception report to identify any transactions that did not post properly or completely to the practice management system. These transactions are repaired by the business office, in conjunction with accounting.

2. All charge tickets for the last business day of the month must be posted manually or electronically on the first day of the following month.

3. Once the last business day of the month is closed, the month-end procedure per the practice management system is run, the month closed and the system date advanced.

4. The lockbox contents from the last business day of the month must be posted as soon as they are received from the bank, which is usually one day after the deposit date, but no more than two.

5. When all charges and receipts are posted for the month, the interface reconciliation between the practice management system and general ledger must occur.

    a. This "interface" usually happens the night of the second business day of the following month, but no later than the third business day.

    b. During the first two business days, all standard journal entries are prepared and entered.

6. The reconciliation between the accounts payable and general ledger/accounting systems should also occur.

7. All accounts payable for the month must be entered into the system by the second business day.

8. On the third business day of the month, the preliminary general ledger can be reviewed for accuracy and reasonableness.

9. On the third business day of the month, a final reconciliation of the Practice's previous month's balance sheet is made to the bank account.

10. The Administrator or designee reviews and signs off on the balance sheet reconciliations when they are completed.

11. Any subsequent journal entries that result from these reviews are made so that a final trial balance is run on the fourth business day of the month.

12. Management reports, site income statements, provider productivity, and any other monthly management reports can be developed for distribution when the Administrator reviews and signs off on the final trial balance.

The month-end close will occur no later than four business days after the last calendar day of the month.

The Closing Calendar (see next page) outlines the year-end closing process:

1. Procedures for year-end closing are similar to month-end closing procedures, except that accounts payable stays open for a maximum of two weeks subsequent to the year-end close.

2. After all transactions are posted to the practice management system to reflect gross charges and revenue collected for the year, the exception report, daily close, monthly close and annual close are performed to produce totals for the year.

3. As a result, preliminary financial statements are not issued until about the third week of January or the month following the Practice's fiscal year-end.

CLOSING CALENDAR

1. Financial statement preparation is as follows:

Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**
Post all charge tickets	Post all lockbox receipts	Review preliminary general ledger	Review final general ledger	Issue site income statements, management reports, and provider productivity
Post all cash receipts	Prepare and post all journal entries	Make any necessary journal entries (adjustments)	Receive Administrator or designee's sign-off on final trial balance	
Prepare and post all journal entries	Run interface between billing system and general ledger	Reconcile balance sheet to bank account		
	Run interface between the account payable system and general ledger	Run final trial balance		
	Run preliminary general ledger			

2. Post-financial statement preparation is as follows:

Day 6	**Day 7**	**Day 8**	**Day 9**	**Day 10**
		Perform reconciliations on all balance sheet accounts		
		Prepare any subsequent journal entries that result		

FINANCIAL MANAGEMENT • POLICY 9.05

Authorized Check Signing

It is the policy of the Practice that all accounts payable, manual, and payroll checks require authorized signatures. The purpose of this policy is to provide control over the signing of these checks.

PROCEDURES

1. The Practice maintains guidelines for the type of signature needed based on the nature of the check. The following is a matrix of check-signing guidelines:

Type of checks	**Type of signature**	**Exceptions**
Accounts payable	Signature machine (pre-printed) or original signature	Amounts >$1,000 must have an *original* signature. Amounts greater than $10,000 require two signatures.
Payroll checks (not issued by third party vendor)	Signature machine (pre-printed) or original signature	Bonus checks must have an *original* signature
Manual checks	Signature machine (pre-printed), when the check and documentation have been approved and signed off with original signature	Amounts >$1,000 must have an *original* signature. Amounts greater than $10,000 require two signatures.

2. The Practice establishes levels of authorizations regarding check-signing authority.

    a. The Administrator may approve as much as $500.

    b. A provider owner may approve as much as $1,000.

    c. The president of the Practice or two provider owners may approve as much as $10,000.

    d. Orders for more than $10,000 require the approval of the Practice's executive committee or a majority vote of the board of directors, unless approved in advance by resolution for certain recurring, high cost items (e.g., medications).

    e. See the related policy 9.07 on Check Requests.

3. The Practice may choose to use pre-printed signatures for limited purposes only.

4. The Practice uses pre-numbered checks.

    a. Accounts payable must account for proper sequence of checks.

    b. Any discrepancies must be reported to the Administrator and/or Practice accountant.

5. The Practice clearly identifies voided checks.

    a. All voided checks must clearly state "VOID" on the face of the check.

    b. The purpose of the void should also be clearly stated and reviewed with the Administrator or designee prior to voiding.

    c. Copies of all voided checks are be maintained to account for check sequencing.

6. All blank checks, bank statements, cancelled checks, and debit/credit memos are locked up with access only to designated individuals who need access to perform their assigned functions.

7. All Practice physicians, advanced practice providers, and employees, to include the Administrator, are expressly prohibited from signing blank checks or checks with incomplete supporting documentation. Blank checks are never signed prior to completing the payee, date, and amount.

8. All unused checks not intended to be used in the future will be destroyed via the secure document destruction service with which the Practice contracts.

9. The bank is notified if any unused checks are missing or there is a discrepancy during reconciliation.

10. The bank is notified immediately if any checks are lost, damaged or stolen.

11. The bank is notified to inactivate employees with financial authority who have left the Practice employment immediately upon termination.

12. The Practice designates an external accountant to receive and/or periodically audit checks. The audit reviews returned checks, and must be conducted by the accountant or someone other than the preparer after they are signed.

13. The check-signing procedures are reviewed, at minimum, annually by the Practice's accountant to ensure appropriate compliance with financial controls.

FINANCIAL MANAGEMENT • POLICY 9.06

Reimbursed Expenses

It is the policy of the Practice that all reimbursable business expenses of every employee are submitted using the appropriate form and with sufficient documentation as defined and required by the Internal Revenue Service.

PROCEDURES

1. Documentation

    a. The following must be substantiated for all business expenses submitted for reimbursement:

        1) Amount;

        2) Date and place;

        3) Business purpose; and

        4) Business relationship (entertainment and gifts).

    b. Receipts, paid invoices, and a contemporaneous log are all deemed sufficient documentary evidence.

2. Expense report form

    a. All expenses are detailed on the Expense Report Form (see below).

        1) The following information is required:

            a) Date — Indicate the date when expenses occurred.

            b) Receipt(s) — Receipts must accompany all expenses greater than $25 and must be attached to the expense report. Copies of credit card statements or non-itemized credit card receipts are not acceptable documentation.

c) Purpose — Indicate the business purpose of the event. Note that for tax purposes, deduction for "goodwill" entertainment is not allowed. The entertainment must have a specific purpose.

d) Approval — The signature of requestor's supervisor is required.

b. An explanation of each category of expense is provided:

1) Cellular telephone — An itemized copy of the bill showing the total business minutes as a percentage of the total minutes as contracted based on the monthly or annual agreement with the cellular phone company.

2) Seminars — Tuition, seminar fees for continuing medical education (CME), or Practice-related course work, in accordance with related policies.

3) Office expense — Cost incurred related to the office administration or project completion resulting from extenuating circumstances. (Office supplies should be routinely ordered through the Practice purchasing process and office supply vendor.)

4) Travel — All travel expenses, such as lodging and transportation, incurred during out-of-town business travel. This also includes routine business mileage, parking, and tolls (not including normal commute to and from the provider or employee's Practice work location). All mileage must be shown on a separate mileage form or indicated in detail on the reverse side of the expense report, totaled, and transferred to the front page. All mileage is reimbursed at the current IRS mileage rate at the time that the mileage was incurred. Routine business mileage may include travel between Practice locations if required for business purposes during the business day; however, mileage to and from the provider or employee's home and individual practice locations is considered a part of the normal commute.

5) Meals — Includes all expenses related to meals associated with the Practice for business purposes. (Note that entertainment and meals are only 50% deductible for income tax purposes. Thus, this amount is separately coded into the Practice's general ledger and accumulated for tax purposes.) Meals are limited to $75 per provider or employee per day. Spouses and/or guests may not be included.

6) Other — For all expenditures not noted above, the appropriate account number must be assigned to the expense from the Practice's chart of accounts.

7) Total — The total amount when all expenses for a particular date are added.

8) Purpose — Indicate the business purpose of the event.

c. Completed expense reports must be submitted for reimbursement within 30 days of expenditure. Submissions may be submitted online to accounting or the business office with legible receipts scanned and transmitted, faxed or presented in hard copy.

d. Each Practice provider or employee must sign and date his or her expense report form.

e. Expense report forms are submitted to the Administrator or designee.

f. A copy of the expense report form is made for the employee's personal records.

3. Check requests

a. A check request (see related policy 9.07 on Check Requests) must be completed and accompany the expense report.

b. Include the address to which the check should be mailed.

EXPENSE REPORT FORM

Name: _____

Practice office: _____

Time period: From_____ to _____

Date	Cell phone	Seminars	Office expense	Travel (by type)	Meals	Other	TOTAL	Purpose

Total reimbursement requested: _____

Employee signature: _____

Date: _____

Approval: _____

Date: _____

FINANCIAL MANAGEMENT • POLICY 9.07

Check Requests

It is the policy of the Practice that check requests are submitted after purchasing goods and services required by the Practice to serve patients' needs. Check requests are used only when goods and services must be prepaid, and when the vendor cannot invoice the Practice.

Some examples of purchases that the Practice reimburses after receiving a check request are:

- Seminars
- New subscriptions or periodicals
- Prepayment for any service or good

PROCEDURES

1. When goods and services are needed for the Practice and must be prepaid, follow the steps listed below for completing a Check Request Form (see below):

    a. Accounting writes checks on Wednesday by 5:00 p.m. for all requests received by 4:00 p.m. the previous Friday. Only emergency checks are written out of cycle. Any emergency requests should be delivered directly to accounts payable to ensure proper processing.

    b. The requester shall enter a reason for the check request.

    c. The requester shall enter the department and/or office location for which the purchase was made. If it is for the entire Practice, please write "Entire Practice."

    d. If applicable, the requester shall enter the provider for which the purchase was made. If it is not for a specific provider(s), the requester shall write "None."

e. The requester shall enter the amount of the check.

f. The requester shall enter the information about the recipient of the check.

g. The requester shall sign his or her name as the requester.

h. The requester shall date the check request form.

2. Approval of check requests.

a. All check requests must have proper authorization before a check is generated.

b. The Administrator may approve as much as $500 [or insert alternative amount].

c. A provider owner may approve as much as $1,000 [or insert alternative amount].

d. The president of the Practice or two provider owners may approve as much as $10,000 [or insert alternative amount].

e. Orders for more than $10,000 [or insert alternative amount] require the approval of the Practice's executive committee or a majority vote of the board of directors, unless approved in advance by resolution for certain recurring, high cost items (e.g., medications unless a recurring expense is approved ahead of time.

3. Submit approved check requests to accounts payable.

a. The requester shall place or transmit electronically his or her request in the accounts payable mailbox.

b. All received requests are processed within the next cycle unless noted in the date required field.

c. All requests are processed no later than 10 business days.

4. When the check is cut, it is delivered to the requester or the reimbursement may be made through direct deposit to the requester's account.

5. Accounts payable retains all documentation submitted with the check request; the requestor is advised to keep what he or she needs for his or her records.

CHECK REQUEST FORM

Please print information or submit the completed form to Accounts Payable electronically.

Date: _____ Payable to: _____

Address: _____

City: _____ State: _____ ZIP: _____

Return to: _____ Mail: _____

Office, Department or Physician/Advanced Practice Provider to which or whom the expense should be allocated: _____

Requested by: _____ Approved by: _____

Amount: $_____ Account code: _____ Description: _____

TOTAL

Reason for payment:

Please note: Original invoices or expense form(s) must be attached to this request.

FINANCIAL MANAGEMENT • POLICY 9.08

Check Processing Cycle

It is the policy of the Practice to provide a timeline for Practice employees regarding the processing of invoices, check requests, and expense reimbursements.

PROCEDURES

1. When received by Friday at 4:00 p.m., accounts payable processes and pays all invoices, check requests, and expense reimbursements by 5:00 p.m. on the following Wednesday, unless circumstances prohibit this.

2. When a written request is submitted and a delay in processing or payment is anticipated, accounts payable notifies the requesting party.

3. Requesters must submit all requests for reimbursement for Practice-related activities on the appropriate Check Request Form. (See related policy 9.07 on Check Requests.)

FINANCIAL MANAGEMENT • POLICY 9.09

Petty Cash Transactions

It is the policy of the Practice to maintain a petty cash fund of $200 at each Practice site to cover small local purchases, expenditures, and reimbursement amounts of less than $25. The Administrator or designee approves the total dollar amount of the fund. Whenever possible, any purchase over $25 should be made with a check request.

PROCEDURES

1. The petty cash is kept in a designated locked box, safe, and/or locked area (e.g., locked drawer).

2. A Petty Cash Transactions Log (see below) is kept with the petty cash.

3. The Administrator or designee approves and executes all withdrawals.

4. Each withdrawal is recorded on the Petty Cash Transactions Log (see below) with the appropriate account number from the Practice-approved chart of accounts.

5. Receipts or invoices from each purchase must be kept in the envelope.

6. Balancing petty cash

    a. A continuous balance of the remaining petty cash is maintained and must match the petty cash remaining in the locked location.

    b. The invoices/receipts and remaining petty cash must be balanced on a daily basis on the Petty Cash Transactions Log (see below).

    c. The total must equal the starting fund amount.

    d. Any variance must be reported to the Administrator, combined with a written explanation of the variance.

7. Check request form

    a. When requesting a check to replenish the petty cash fund, the Practice employee shall complete a Practice Check Request Form (see related policy 9.07 on Check Requests).

    b. The Practice employee shall attach the Petty Cash Transactions Log (see next page) and all receipts and invoices to the Check Request Form and forward the form to accounts payable.

8. Petty cash replacement

    a. Petty cash replacement requests are returned to the Practice site if the log is missing expense account numbers.

    b. Petty cash replacement checks may require as much as two weeks processing time from the time of receipt in administration.

    c. The petty cash replacement check is made payable to the office manager of the Practice site and "petty cash."

9. Mileage or other travel expenses totaling more than $25 are recorded on the approved expense report and may not be removed from the petty cash drawer.

10. Under no circumstances is petty cash to be utilized for cash advances nor is any employee authorized to borrow money from petty cash.

PETTY CASH TRANSACTIONS LOG

Practice site: _____

Beginning balance (A): _____

Date	Transactions/item	Account #	Amount ($)	Petty cash balance
	Total		(C)	(B)

PETTY CASH REPLACEMENT

Remaining petty cash balance (B) _____

Check request replenishing amount (C) _____

Note: B plus C must equal A for processing.

Signature of Administrator (or designee) _____

FINANCIAL MANAGEMENT • POLICY 9.10

Internal Controls

It is the policy of the Practice to maintain financial controls to protect the integrity of the business. It is the goal of the Practice to provide for individual accountability, exceptional record keeping (especially pertaining to cash or to cash equivalents), protection of assets, and discouragement of theft, fraud, embezzlement, and other improper use of assets.

PROCEDURES

1. Background checks are conducted on all employees prior to hiring. (See related policy 2.15 Background Check.)

2. Employees with negative reports that include, but are not limited to, theft and/or fraud and abuse violations are not eligible for hire.

3. The Practice bonds all employees who have direct responsibility for accounting and bookkeeping.

4. All accounting systems are electronic and user names and passwords are assigned to each and every user.

5. Entries into the accounting system, to include the general ledger, are reviewed on a quarterly basis per user by the Administrator or designee.

6. Bookkeeping tasks are divided and assigned among several employees. The person who receives cash and checks is not the same person who makes the deposit and posts the transaction to the accounting system, and yet another individual is responsible for reconciling the bank account.

   Any individual handling cash should not post payments, write-offs or adjustments, and the person who reconciles the bank account should not perform these functions.

7. Certain tasks in the cash management system are assigned to employees on a rotating basis, rotating quarterly or that which is recommended by the Practice's accountant.

8. The practice management system and accounting system are set with restrictions on who can post charges and payments to the systems. Administrative rights are assigned by the management.

    a. Under no circumstance can anyone delete charges or payments posted to the systems.

    b. Corrections to incorrect entries are made using a separate transaction to create an audit trail to trace entries, including all charge corrections and posting errors.

9. Monthly reports are generated to track write-offs and their explanations. When suspicious adjustments are noted, the Administrator conducts thorough investigations of the transactions.

10. To ensure that all patient visits are documented and all claims are billed, daily audits are conducted that compare patients who arrived for their appointments against billed charges. A missing charge report is generated daily if the function is available in the practice management system.

11. Income statements and balance sheet reports are monitored monthly to control overhead expenses and monitor significant changes.

12. An external accountant conducts periodic accounting reviews of the Practice's accounting system financial reports and the practice management system financial reports. A review of unauthorized entry, unsubstantiated adjustments and systemic write-offs should be included.

13. A monthly financial meeting is conducted to review in detail the prior month's financial reports and activities with the provider board members or finance committee, or those persons which are designated by the Practice for the review process (e.g., a subgroup of the executive committee).

14. A Practice owner is asked to periodically perform random accounting duties to have an objective review of processes and to deter embezzlers.

FINANCIAL MANAGEMENT • POLICY 9.11

Online Banking

It is the policy of the Practice to utilize the most secure methods of conducting its business to protect itself from fraud and identity theft. Online banking provides such measures when used appropriately. Procedures are implemented to assure this privacy and security while conducting online banking.

PROCEDURES

1. Electronic payments for expenses incurred for the business are used where vendors have this capability such as online bill payment and electronic fund transfers.

2. Online statements are used to eliminate paper statements, expedite delivery, and reduce potential unauthorized access to confidential information.

3. Access to banking information is determined by the Administrator and levels of security are determined based upon a need-to-know basis by job responsibility.

4. Passwords are periodically changed and maintained securely. It is recommended that one of the practice owners have access to passwords to assure the Administrator is not the only person with knowledge.

5. Bank information is never provided to anyone initiating the inquiry without proper identification and authorization.

6. The Administrator or designee with no conflicting duties reviews deposits to look for unexpected fluctuations in average cash deposits. Large fluctuations may indicate embezzlement.

7. The Administrator or designee with no conflicting duties watches for checks cashed out of sequence and checks made out to "cash." These are red flags for embezzlement. This individual also watches for wire transfers and other electronic payments to ensure that these were properly authorized.

8. Changes to pay rates, duplicate or extra checks should only be authorized by the Administrator or practice owner. Alternately, the Practice may require two authentications before execution or that which is recommended by the Practice's accountant.

9. The Administrator or designee does not leave his or her computer unattended while accessing payroll or bank accounts. He or she completely logs out of the online session without letting the session time out. Public computers are not to be used when accessing the Practice's bank or payroll accounts.

10. No person responds to an unsolicited e-mail that requests an account number and personal identification number (PIN), no matter how authentic the request appears.

11. When possible, the accounting system should import transactions, including deposits, from the bank.

FINANCIAL MANAGEMENT • POLICY 9.12

Operating Budget

It is the policy of the Practice that an operating budget is developed every year for the purposes of communicating short-term operating plans, approving staffing or monetary requests, and monitoring performance. The purpose of this policy is to outline the annual operating budget process for the Practice.

PROCEDURES

1. The Administrator or designee is responsible for preparing and adopting an annual operating budget by December 1 of each year (or one month prior to the start of the fiscal year if it does not conform to the calendar year). If applicable, the Administrator appoints individuals to a budget team, which is composed of a physician or advanced practice provider, a clinical supervisor, the front office supervisor, the business office manager, as well as the Administrator. The budget team is responsible for the following:

    a. Devising a revenue budget based on the following factors:

        - Productivity;
        - New or discontinued services, such as ancillaries;
        - Payer mix;
        - Coding; and
        - Regulatory and/or payer-specific issues impacting reimbursement.

    b. Devising a budget for all expenses, including:

        - Compensation and benefits;
        - Supplies and equipment;

- Operating expenses;
- Capital expenditures; and
- Other significant or one-time expenses.

c. Generating a preliminary budget for review.

d. Conducting budget meetings with stakeholders, if applicable.

e. Finalizing the budget process.

2. The budget must be submitted to the Practice's board of directors a minimum of 30 days prior to the close of the fiscal year.

3. The board of directors must review and approve the budget.

4. During the year, the Administrator uses the variance report as an analytical tool to compare actual results to budgeted expectations. The manager prepares a summary of the variances and presents the summary to the board of directors every month or quarter as designated by the Practice's bylaws.

5. Any expenditure that is more than 10% of the budgeted expense requires the written approval of the Administrator, and the majority vote of the board of directors or finance and audit committee.

FINANCIAL MANAGEMENT • POLICY 9.13

Payroll Expenses

Alert: *This policy is established in the event that the Practice does not utilize a third party payroll processing organization.*

It is the policy of the Practice that all payroll related expenses be managed in a way to assure proper transfer of funds to employees and payment of state and federal taxes.

PROCEDURES

1. A separate bank account, ideally at the same institution where the primary checking account is maintained, will be established for the payroll related payments.

2. Funds sufficient to meet the payroll amount plus related state and federal tax obligations should be transferred to the account at least one business day prior to the date paychecks are issued.

3. Payments for state and federal tax obligations, including amounts withheld, should be issued to proper state and federal authorities within two business days of the date paychecks are issued, or sooner if required by law.

4. Payments for deposit in retirement accounts, including amounts withheld from employees, should be transferred to the proper account within two business days of the date paychecks are issued, or sooner if required by law.

CHAPTER 10

Materials Management

POLICY 10.01 • Budgeted Purchases

POLICY 10.02 • Purchasing Control

POLICY 10.03 • Pricing Discounts

POLICY 10.04 • Vendor Selection

POLICY 10.05 • Maintenance/Leasing Contracts

POLICY 10.06 • Capital Equipment

POLICY 10.07 • Equipment and Service Requests

POLICY 10.08 • Forms and Stationery

MATERIALS MANAGEMENT • POLICY 10.01

Budgeted Purchases

It is the policy of the Practice that purchases are made according to consistent approval, purchasing, and receiving procedures.

PROCEDURES

1. Approval

    a. A supervisor must approve all purchases.

    b. The Administrator may approve as much as [x].

    c. A provider owner may approve as much as [x].

    d. The president of the Practice or two provider owners may approve as much as [x].

    e. Orders for more than [x] require the approval of the Practice's executive committee.

2. Purchasing

    a. The Administrator or designee places orders directly from the vendor and forwards a copy of the Purchase Requisition Form (see below) to accounts payable.

    b. The vendor ships the ordered merchandise to the Practice site.

3. Receiving (see also related policy 10.02)

    a. Upon receipt, the supervisor signs the packing slip and forwards it, along with a Check Request Form (see related policy 9.07 on Check Requests) to accounts payable for payment.

    b. If the vendor invoices the Practice, the delivery site must be identified. Accounts payable matches receiving documents to purchase order (if utilized) and codes the invoice for check preparation.

PURCHASE REQUISITION FORM

Practice name:

Street:

City/State/ZIP:

Phone #:

Purchase order #:

Department:

Physician or APP:

Vendor Information

Name:

Attn:

Street:

City/State/ZIP:

Phone #:

Fax #:

Tax identification #:

Ship to

Practice name:

Street:

City/State/ZIP:

Phone #:

Qty	Units	Description	Unit Price	TOTAL
			Subtotal	
			Shipping & handling	
			Sales Tax	
			TOTAL	

Requested by:

Date requested:

Approved by:

Date approved:

Second approval (if necessary):

Date approved:

Notes/comments:

Practice is not responsible for unauthorized orders.

MATERIALS MANAGEMENT • POLICY 10.02

Purchasing Control

It is the policy of the Practice to provide internal control over the purchasing, authorization, and payment processes.

PROCEDURES

1. Purchase requisitions

    a. The employee requesting goods or services completes a Purchase Requisition Form (see related policy 10.01 on Budgeted Purchases).

    b. The requisition form includes the following information:

        1) Appropriate general ledger coding;

        2) Practice office or site;

        3) Department; and

        4) General ledger expense classification.

    c. The requisition is sent through the approval process.

        1) The following individuals have approval authority:

            a) The Administrator may approve as much as [x].

            b) A provider owner may approve as much as [x].

            c) The president of the Practice or two provider owners may approve as much as [x].

            d) Orders for more than [x] require the approval of the Practice's executive committee.

d. The Administrator approves all capital asset purchase requisitions, regardless of dollar value, prior to equipment being ordered.

e. The Administrator or designee evaluates and approves leasing arrangements prior to entering into a contract.

f. A spreadsheet is maintained that details the type of product/service or the general ledger accounts on which each authorized individual is allowed to sign off.

1) Signatures are documented and maintained on the signature log for all employees authorized to approve purchases. (See related policy 5.08 on Signature Log.)

2) All requisition signatures are compared against authorization limits and the signature log.

2. Purchase order number

a. When the requisition is properly authorized, the Practice employee responsible for purchasing assigns a purchase order (PO) number to the requisition.

b. This PO number is communicated to the vendor when the goods or services are ordered.

c. All invoices submitted to accounts payable should reference an applicable PO number, which provides the Practice with an appropriate reference number for the order and ensures proper authorization of the purchase.

d. If the Practice uses a manual system, a copy of the PO (see below) must be sent to the accounts payable when a PO is issued.

e. If the PO system is automated and linked to the accounts payable system, the details of the PO are entered into the system. These details include the description of items ordered, quantity (unit specific), price per unit, and vendor.

3. Receiving

a. Upon receipt of goods, the packing slip is reviewed and checked against the items received to ensure appropriateness of products ordered, the product condition is satisfactory and the correct quantity was received.

b. When the packing slip is reconciled, it is sent to accounts payable.

c. A Practice employee other than the person responsible for creating the accounts payable checks or matching the accounts payable documentation records the receipt of goods and services in the accounts payable system.

4. Invoices

    a. When the vendor invoice is received, the related packing slip and a copy of the PO are attached or logged if the PO system is automated..

    b. The invoice is compared to the PO to determine adequate pricing, quantity, and product or service.

    c. An invoice is not paid without a supporting PO.

    d. If an invoice is received without a PO issued, it is sent to the employee responsible for purchasing for resolution.

    e. When accounts payable has confirmed receipt and compared items ordered, quantity, and pricing on the invoice and the PO, accounts payable establishes payment according to predetermined payment terms.

    f. Any discrepancies between the PO information and the vendor invoice are sent to the employee responsible for purchasing for resolution.

    g. If an automated purchasing and accounts payable system is in place, accounts payable must indicate on the PO system that the PO has been paid.

    h. A record of the invoice transaction, including the vendor invoice, packing slip, and the PO are retained as electronic records for seven years for tax purposes.

5. Emergency orders

    a. If a Practice needs to issue an emergency order, the employee requisitioning the goods or services must contact accounts payable.

    b. The order is placed or filled without the related paperwork. However, the appropriate paperwork with authorized signatures must be filed with accounts payable within the next business day.

    c. The paperwork indicates that the purchase has been made and identifies the assigned PO number.

    d. If this policy is not followed and individuals abuse emergency order guidelines, the Administrator or designee is responsible for resolving the issue.

6. Maintenance orders

    a. Because maintenance needs and repairs are usually unplanned, a blanket PO is used for frequently used maintenance vendors.

b. Blanket POs are used for purchases up to a specific dollar amount, as determined by the board of directors, and reviewed annually.

c. The Administrator or designee must authorize blanket POs and place a specific dollar amount on the blanket PO.

d. The vendor is notified of the blanket PO number and must reference that PO on any invoice relating to associated purchases.

e. These purchases at these particular vendors can then be made without prior authorization.

f. When a blanket PO has reached its predetermined limit, a new blanket PO with proper authorization is issued before subsequent purchasing continues.

7. Blanket purchase orders

a. To vendors that are used frequently for routine services (e.g., lab, housekeeping, laundry), blanket POs can be issued.

b. These POs identify a predetermined dollar limit and are authorized by the Administrator or designee.

c. Purchases are made on the same PO number until the limit has been reached.

d. A mechanism is in place for tracking the purchases against the limits of the blanket PO.

8. Follow-up

a. A search for "old" (more than 30 days), unfilled POs is performed quarterly. This ensures there are no unpaid POs and all orders are being filled on a timely basis.

b. An audit of the authorization policy is performed on a periodic basis.

1) A sample of purchase requisitions is chosen and authorization of the requisitions is compared to the signature log, as well as the authorization limits established.

c. Occasionally, an audit of invoice payments is performed to ensure that invoices are being paid according to the payment terms and appropriate discounts are being applied.

PURCHASE ORDER

Attn:

Name:

City/State/ZIP:

Phone #:

Fax #:

Purchase Order #:

Department:

Expense assignment to:

Order #:

Vendor Information

Name:

Attn:

Street:

City/State/ZIP:

Phone #:

Fax #:

Tax identification #:

Ship to

Name:

Attn:

Street:

City/State/ZIP:

Phone #:

Fax #:

Qty	Units	Description	Unit Price	TOTAL

Subtotal

Shipping & handling

Sales tax

TOTAL

Requested by:

Date requested:

Approved by:

Date approved:

Second approval (if necessary):

Date approved:

Notes/comments:

Practice is not responsible for unauthorized orders.

MATERIALS MANAGEMENT • POLICY 10.03

Pricing Discounts

It is the policy of the Practice to take advantage of pricing discounts for biologicals (pharmaceuticals and immunizations), office supplies, medical supplies, malpractice insurance, and other items. The discounts may be the result of a membership-based group purchasing organization, an Internet-based discount store, a bulk order, or other means.

PROCEDURES

1. The Administrator or designee identifies, negotiates, and secures discounts.

2. The Administrator identifies appropriate employees of discounts, and vendors deal directly with Practice supervisors or managers.

3. Invoices are sent to accounts payable in accordance with policy 10.01 on Budgeted Purchases.

MATERIALS MANAGEMENT • POLICY 10.04

Vendor Selection

It is the policy of the Practice to identify and select vendors of goods and services in a consistent manner based on quality, service, and cost.

PROCEDURES

1. List of services

    a. The Administrator or designee creates a list of services and products to be purchased from vendors.

    b. This list is reviewed at least annually, and vendors are contacted for estimates as shown in the Common Services and Supplies for Future Group Purchase Form (see below.

2. Analysis

    a. The Administrator or designee carries out a comparative analysis of services for each potential vendor.

    b. This detailed assessment includes current costs and services and the cost and service estimates of each vendor.

3. Evaluation

    a. When selecting vendors for contracted services, the Administrator or designee receives at least two proposals from potential vendors.

        1) When the proposals are received, the Administrator or designee, in consultation with Practice physicians, advanced practice providers, and employees affected by the decision, make the final selection.

2) For vendors providing services totaling more than $10,000 per annum, the board of directors makes the final selection by a majority vote.

3) The selection criteria for contracted services include:

   a) Price;

   b) Quality;

   c) Reputation;

   d) Response time;

   e) Volume and other discounts (e.g., purchase discounts, loyal customer discounts);

   f) Training; and

   g) Customer service.

Alternate vendors who would be acceptable are recorded in case of the primary vendor's inability to deliver the product or services upon award of the contract.

Documentation of the decision criteria is recorded along with the bid responses and award decision for reference in case of disputes, failure to deliver, or repeat requests for proposal or bids.

COMMON SERVICES AND SUPPLIES FOR FUTURE GROUP PURCHASE FORM

Services

Examples:

- Information technology support
- Housekeeping
- Laboratory services
- Grounds maintenance
- Laundry
- Mailing service for statements

Vendor bid	Covered services	Covered locations	Current cost by location	Date
1.				
2.				
3.				

Supplies

Examples:

- Laboratory supplies
- Medical supplies
- Imaging supplies
- Immunizations

Vendor bid	Covered services	Covered locations	Current cost by location	Date
1.				
2.				
3.				

MATERIALS MANAGEMENT • POLICY 10.05

Maintenance/Leasing Contracts

It is the policy of the Practice to track maintenance and leasing contracts in order to update them as necessary.

PROCEDURES

1. The Administrator or designee is responsible for creating and maintaining an electronic tickler file of all maintenance, service and leasing contracts.

2. Prior to contracts expiring, the Administrator or designee researches the current market to determine if the contract should be renewed.

3. During the review, the Administrator or designee assesses the Practice's capability to offer services internally or purchase equipment in a cost-effective manner.

4. The Practice's accountant should be consulted for financial advice to determine the impact and value of leasing versus purchasing for tax purposes.

MATERIALS MANAGEMENT • POLICY 10.06

Capital Equipment

It is the policy of the Practice that all capital equipment (fixed assets) are listed, maintained, and distributed by the Administrator or designee. A capital equipment schedule is maintained, reviewed for accuracy, and updated annually.

PROCEDURES

1. General office equipment is managed through materials requisition and inventory systems.
2. As assets are received, accounts payable maintains an order entry and control schedule and materials management is responsible for assuring the asset is delivered to the appropriate
3. Capital equipment is purchased through the process outlined in policy 10.01 on Budgeted Purchases.
4. By the time the equipment is delivered, each piece is logged on a spreadsheet featuring receiving and inventory control with the following information:
    a. Vendor name;
    b. Date received;
    c. Asset description;
    d. Location/site code; and
    e. Inventory control number.
5. The Administrator or designee properly manages capital equipment for:
    a. Cost effectiveness;
    b. Quality control;

c. Service;

d. Depreciation schedule (asset life);

e. Timely delivery; and

f. Inventory control.

MATERIALS MANAGEMENT • POLICY 10.07

Equipment and Service Requests

It is the policy of the Practice to provide certain services and deploy office equipment to the offices of the Practice as necessary.

PROCEDURES

1. Practice physicians, advanced practice providers and employees may request equipment and/or services (to include maintenance) from the Administrator or designee.

2. The Administrator or designee reviews the request, which must comply with related policy 10.01 on Budgeted Purchases. The Administrator must approve the request to proceed with ordering.

3. The Administrator or designee attempts to order the equipment and/or service in a timely manner.

If replacement is needed, the Administrator or designee will activate the purchasing process.

MATERIALS MANAGEMENT • POLICY 10.08

Forms and Stationery

It is the policy of the Practice to maintain standard forms and stationery for any paper-based correspondence. The Practice's name, brand and logo shall be used consistently in any electronic communications.

PROCEDURES

1. All offices of the Practice shall use standard forms and stationery for paper-based correspondence, with the name, brand and logo being used in its complete and accurate form in any electronic communications.

2. The Administrator or designee reviews and approves all new forms, stationery, business cards, branding and logos that are created to ensure a standard and consistent format in all forms of communication.

CHAPTER 11

Facilities

POLICY 11.01 • Ergonomics

POLICY 11.02 • Clean Practice Environment

POLICY 11.03 • Facility Cleaning Schedule

POLICY 11.04 • Safety Committee

POLICY 11.05 • Secure Facility

POLICY 11.06 • Fire Control and Evacuation

POLICY 11.07 • Waste Disposal

POLICY 11.08 • Indoor Air Quality

FACILITIES • POLICY 11.01

Ergonomics

It is the policy of the Practice to comply with all federal, state, and other entity rules and regulations concerning the safety and health of its employees. The Practice is committed to reducing the risks of injuries and illnesses to its employees who work at computers or at other tasks that require repetitive motions. Therefore, all workstations, equipment and other items (including computers) shall be kept in good repair by the Practice. The procedures incorporated herein will be followed to apply ergonomic principles in the workplace.

PROCEDURES

1. Employees are responsible to:

    a. Inform the manager or designee about potential ergonomic issues.

    b. Follow guidelines the Practice provides for proper ergonomic posture.

    c. Promptly report equipment maintenance or repair issues related to tools or equipment used.

    d. Promptly report physical discomfort with their workstations and duties, as well as any injuries received in the workplace.

2. The Practice will provide proper furnishings, equipment and tools for workstations. No employee shall be required to provide items necessary to work safely at his or her personal expense. The Practice shall use design principles mindful of ergonomics to create, position and provision its workstations for employees, as available and cost-effective. The Practice provides specialty items (special keyboards, keyboard trays, telephone headsets, computer mouse, etc.) to reduce risks of injury to employees based on the individual employee's dub duties and his or her needs.

3. Computer monitors will be properly sized for the work performed, mounted on a stand that allows height and angle to be easily adjusted by the employee, and positioned to avoid glare or eyestrain.

4. Keyboards will be full-sized and made available with options (such as a split keyboard) as needed for the individual employee's needs.

5. Chairs will have adjustable seats, backrests and armrests as required for the employee to work in a comfort and ergonomically correct position in relation to the keyboard and other machines or materials with which he or she frequently interacts.

6. Lighting will be appropriate to the job functions of the employee and to the employee's needs. Natural lighting will be provided when feasible, supplemented by artificial lighting that is adequate to for overall illumination and to illuminate the task(s) being performed. The employee should be able to control both the amount and angle of task lighting provided.

7. The Practice will provide ergonomic awareness training to all staff, and make onsite consultation available for individual employees based on job duties, individual employee need and when requested by the manager or designee. These consultations will be provided by individuals who have completed training in basic ergonomic functionality from a third party with recognized experience in risk management and safety.

8. The Practice's ergonomic policy shall be reviewed annually to assure that it complies with the regulations and recommendations of the state and federal government, including the Occupational Safety and Health Administration (OSHA) and other applicable regulations related to safety in the workplace.

9. The Practice will document and respond to employees' ergonomic issues in the same manner and with the same attention as it would give any other potential cause of injury in the workplace.

10. The Practice reserves the right to make all final decisions regarding employees' workstations, supplies and equipment.

FACILITIES • POLICY 11.02

Clean Practice Environment

It is the policy of the Practice to provide clean, well-maintained, and professional Practice facilities and equipment.

PROCEDURES

1. The Administrator or designee is responsible for overseeing the maintenance of all facilities and equipment.

2. The Administrator or designee is responsible for contracting for housekeeping services five days a week, and additionally as needed. (See related policy 11.02 on Facility Cleaning Schedule.)

3. The Administrator or designee is responsible for contracting with grounds maintenance services once or twice a week, and additionally as needed.

4. Physicians, advanced practice providers and employees are responsible to report any unsafe or unsanitary situations to management. Parking areas, restrooms, reception, and exam rooms should be clean and well maintained.

FACILITIES • POLICY 11.03

Facility Cleaning Schedule

It is the policy of the Practice that each office maintains its facility in a clean and tidy manner. It is the responsibility of all employees to ensure that the facility remains clean and tidy to the best of their ability during operating hours.

PROCEDURES

1. A cleaning service is scheduled to clean the office based on the following list of specific responsibilities.

    a. The cleaning schedule for the main office space (hallways, reception area, nursing stations) includes the following responsibilities:

        1) Daily responsibilities

            a) Spot vacuum carpet traffic lanes;

            b) Dust mop hard floor surfaces;

            c) Wet mop hard floor surfaces as dictated by weather/spillage;

            d) Empty and re-line waste containers daily;

            e) Remove waste to designated area;

            f) Brush away foreign particles from furniture/upholstery; and

            g) Clean and sanitize drinking fountain.

        2) Weekly responsibilities

            a) Vacuum carpet completely wall to wall;

            b) Spot clean carpets as needed;

c) Damp mop hard floor surfaces;

d) Dust furniture and vertical surfaces;

e) Dust pictures, clocks, vents, window sills, and moldings;

f) Clean and sanitize telephones and door handles;

g) Spot clean walls and switch plates; and

h) Spot clean glass, windows, interior doors, and partitions.

3) Monthly responsibilities

a) Dust blinds;

b) Dust low-level sills, baseboards, and moldings;

c) Vacuum carpet edges;

d) Vacuum furniture; and

e) Buff hard surface floors.

4) Biannual responsibilities

a) Scrub and refinish hard surface floors; and

b) Shampoo all carpets.

b. The cleaning schedule for the restrooms (employees and public) includes the following responsibilities:

1) Daily responsibilities

a) Empty trash (including sanitary napkin receptacles) and re-line;

b) Clean and sanitize sinks and counters;

c) Damp wipe fixtures and chrome;

d) Clean and refill dispensers;

e) Clean mirrors completely;

f) Descale and sanitize toilet bowls;

g) Clean and sanitize toilet seats and lids;

h) Descale and sanitize urinals;

i) Spot clean partitions;

j) Clean napkin holder and door handles;

k) Spot clean doors, walls, switch plates, etc.; and

l) Damp mop floors with disinfectant.

2) Weekly responsibilities

a) Clean doors completely;

b) Dust all ledges;

c) Clean partitions completely;

d) Damp wipe and dry all chrome pipes under sinks; and

e) Clean vents.

3) Monthly responsibilities

a) Wash walls and

b) Scrub floors.

c. The cleaning schedule for the exam rooms includes the following responsibilities:

1) Daily responsibilities

a) Empty trash and re-line;

b) Damp wipe counter top;

c) Clean and sanitize telephone and computer keyboard; Wipe computer screen;

d) Clean horizontal surfaces;

e) Clean and disinfect all surfaces of exam tables;

f) Clean step of exam tables;

g) Damp wipe vinyl and upholstered furniture;

h) Spot vacuum carpets;

i) Dust mop hard floor surfaces;

j) Wet mop hard floor surfaces using disinfectant;

k) Damp wipe and restock dispensers (e.g., soap, paper towel);

l) Clean and disinfect cleared counters and sinks;

m) Dust/damp mop scales; and

n) For procedure room, damp wipe all cabinets, splash guard, walls, switch plates, doors, and door handles with disinfectant solution.

2) Weekly responsibilities

a) Damp wipe all scales;

b) Clean entire exam table;

c) Spot clean walls, fixtures, and doors;

d) Dust pictures, clocks, vents, etc.; and

e) Vacuum carpet wall to wall.

3) Monthly responsibilities

a) Buff hard surface floors;

b) Dust blinds and window sills; and

c) Damp wipe all trash containers inside and out.

4) Biannual responsibilities

a) Shampoo all carpets and

b) Scrub and refinish all hard surface floors.

d. The cleaning schedule for the administrative offices, corridors, stairwells, and elevators includes the following responsibilities:

1) Daily responsibilities

a) Spot vacuum carpets and walk-off mats;

b) Spot clean elevators and mop daily;

c) Spot clean elevator thresholds and tracks;

d) Dust mop hard surface floors;

e) Wet mop hard surface floors;

f) Spot clean glass doors and windows;

g) Brush away foreign particles from furniture; and

h) Police, sweep, and mop stairways and landings.

2) Weekly responsibilities

a) Spot clean/extract mats as needed;

b) Spot clean carpets;

c) Spot clean elevator thresholds and tracks;

d) Vacuum all carpets completely wall to wall;

e) Vacuum/wipe all furniture top to bottom;

f) Dust high pictures, clocks, ledges, vents, and moldings; and

g) Dust low sills, ledges, and moldings.

3) Monthly responsibilities

a) Bonnet clean all traffic lanes of carpeting and

b) Buff elevators and/or hard surface floors.

4) Quarterly responsibilities

a) Scrub stairwells and handrails as needed and

b) Shampoo carpets of all center corridor areas.

5) Biannual responsibilities

a) Scrub lobby hard surface tile;

b) Shampoo all carpets and/or corridors; and

c) Scrub and refinish all elevators and hard surface floors.

FACILITIES • POLICY 11.04

Safety Committee

It the policy of the Practice to maintain a multidisciplinary safety committee. It is composed of individuals qualified by training and experience to develop, implement, maintain, and monitor a comprehensive safety program.

PROCEDURES

1. The Safety Committee includes:

    a. A chairperson who coordinates and facilitates the function of the committee;

    b. Representative members from each functional area and/or Practice site who are instrumental in developing the safety programs, as well as analyzing safety management issues and developing recommendations for resolution; and

    c. A director of quality and risk management.

2. The committee meets at least monthly to discuss Practice-wide safety issues, safety incident reports and challenges brought to their attention.

3. The committee is responsible for developing Practice safety policies and standards, creating safety plans and programs, and initiating the training programs for physicians, advanced practice providers and employees.

4. The safety committee produces written minutes of each meeting, recording specific conclusions, recommendations, and actions in such a manner that the appropriate personnel can evaluate them.

5. The conclusions, recommendations, and actions of the safety committee are reported to each site manager for any necessary action, and to the Administrator or designee and board of directors via quality management reporting systems.

6. The safety committee is kept informed of the safety activities and programs of each practice site by monitoring the following:

    a. All injuries/accidents occurring at the Practice;

    b. Office safety education;

    c. Emergency preparedness, including natural disasters;

    d. Hazardous and toxic material procedures;

    e. The exposure control plan; and

    f. The fire safety program.

7. See Chapter on Exposure Control for more details.

FACILITIES • POLICY 11.05

Secure Facility

It is the policy of the Practice to maintain a secure facility for the safety of employees, patients, and Practice assets.

PROCEDURES

1. The Administrator or designee manages the electronic security system to ensure that the system is working correctly.
2. Facility keys or proximity cards
    a. The Administrator or designee maintains the keys and cards to the facility.
    b. A log is kept, which lists each key or proximity card holder and a signature verifying receipt of the key or card.
    c. All keys or cards that are issued must be returned to the Administrator or designee upon request and upon termination of employment.
3. Codes
    a. One "master door code" is maintained for management and control of the security of the facility.
    b. Each employee is given a unique door code for use during employment.
    c. A secure log is kept which lists each code assigned.
    d. At the time of an employee's termination, the Administrator facilitates deactivation of the terminated employee's code.

FACILITIES • POLICY 11.06

Fire Control and Evacuation

It is the policy of the Practice to conduct a fire drill or handle a fire in a manner that saves lives, prevents undue panic, and prevents the spread of fire. Each employee is aware of fire exits, fire extinguishers, fire zones, and the proper procedures for ensuring fire safety. All employees are aware of the proper steps to be taken in the event of a fire. No employee should take any chance or action that may endanger his or her life; rather, the intent of this policy is to ensure the safety of patients, physicians, advanced practice providers and employees.

PROCEDURES

1. Training procedures and responsibilities

    a. Providers and employees are thoroughly trained in the responsibilities and duties that could be required of them.

        1) The Administrator or designee is responsible for ensuring that proper training of providers and employees takes place and is documented properly.

        2) Fire drills take place to simulate possible conditions and to evaluate the response of personnel.

        3) Fire drills take place at least quarterly each year.

        4) Appropriate in-services are held pertaining to fire safety.

    b. Providers and employees are also trained to operate all firefighting equipment present in the office.

        1) This training occurs during each provider's and employee's initial orientation and at least annually thereafter.

2) Alarm and notification systems present in the Practice are also part of this training process, with instruction occurring at initial orientation and each annual reorientation.

2. General procedures and responsibilities

a. A fire is considered an uncontrolled flame and/or smoke.

1) In the event that a fire is discovered, employees shall be instructed to not shout "fire!"

2) Employees shall be instructed to stay calm and act quickly, following these "R-A-C-E" steps as simultaneously as possible:

a) R — RESCUE

- Remove any patients or visitors from the immediate area.

b) A — ALERT

- Activate the appropriate fire alarm.
- Notify the supervisor and/or Administrator or designee immediately.
- Be prepared to name the location of the fire.
- If unable to leave the vicinity of the fire, designate someone to make appropriate notifications.
- Call 911 (or have the designee call 911) outlining:

(i) Location;

(ii) Extent of fire; and

(iii) Type of fire.

- Notify the Administrator or designee immediately.

(i) The Administrator or designee determines the need to evacuate the entire office and to notify the medical staff.

(ii) If the need to evacuate exists, the Administrator or designee announces a designated code (e.g., RED) for a fire three times consecutively over the public address system (if available), giving the location of the fire: "Code red, code red, code red."

c) C — CONFINE

- If possible, close all doors and windows in the area of the fire and in successive areas leading out of the office, and shut off electricity to the area.
- Confine the area.
- Have personnel not involved directly with fighting the fire evacuate patients and visitors from the immediate vicinity according to the fire escape plan map, which shows locations of fire extinguishers and fire evacuation exits and is located throughout the facility.

d) E — EXTINGUISH

- If possible, and if it is safe to do so, attempt to extinguish or contain the fire using the appropriate equipment until the fire department arrives.

3. Specific procedures and responsibilities

a. The Administrator or designee does the following:

1) Acts as the coordinator for fire procedures, evaluates evacuation needs, and supervises evacuation if necessary.

2) Coordinates the closing of doors and windows.

3) Disconnects utilities to the fire.

4) Assists the fire department if needed.

5) Checks mechanical equipment.

6) Secures elevators if applicable.

7) Assumes responsibility for:

a) Safety of patients in the area;

b) Sending personnel to area of need; and

c) Keeping corridors and doorways clear.

8) Secures the office.

9) Designates the individual to report to alarm zone until the fire department arrives.

10) Notifies appropriate supervisory personnel.

11) Secures business, personnel, and medical records, if possible.

12) After the fire is extinguished, completes an incident report and forwards it to the Administrator.

b. Other personnel perform the following:

1) Report to the designated area for instruction.

2) Close doors and windows.

3) Designate one employee to monitor the front entrance and ask visitors to remain in waiting areas.

4) Reassure patients and family members.

5) Evacuate as directed.

6) Remain calm.

7) Secure business, personnel, and medical records, if possible.

8) A designated employee announces three times, after receiving notification from the Administrator or designee, that the fire is under control: "All clear, code red, all clear, code red, all clear, code red."

4. Evacuation procedures, responsibilities, and duties

a. The following list sets forth responsibilities and duties for the evacuation of personnel from the office in the event of fire or similar disaster.

1) The Administrator or designee:

a) Orders the evacuation of the office;

b) Personally directs or appoints an individual to direct the evacuation process;

c) Conducts an accurate head count of all staff and patients in the designated assembly area;

d) Ensures that at all times the safety of the providers, employees and patients comes first in any decision-making process;

e) Organizes available personnel and volunteers not already involved with other duties;

f) Ensures that ambulatory patients are assisted to the degree warranted by a provider or employee to the designated assembly area; and

g) Ensures that a provider or employee transports non-ambulatory patients using the appropriate transportation equipment to the designated assembly area.

2) Other personnel:

a) Perform transportation or give assistance to patients or visitors as instructed;

b) Keep patients and visitors being assisted moving quickly, but calmly; and

c) Stay with evacuated individuals in the designated assembly area unless instructed to assist with other responsibilities or procedures of containment.

b. When outside, everyone congregates in the designated assembly area in order to take account of all persons. Sign-in and checkout sheets are compared at this time to track patient numbers. No person is allowed to re-enter the facility until the fire officials have deemed it safe.

FACILITIES • POLICY 11.07

Waste Disposal

It is the policy of the Practice to maintain a safe facility for the staff, patients, and guests. Sharps and biomedical wastes are disposed according to state and local rules and regulations.

PROCEDURES

1. Documents containing patient identifiable information are disposed of by shredding. This includes notes, medical records, reports and images. The Practice maintains a contract with a document-management company for disposal and provides secure barrels and cross shredders in areas too remote from secure storage.

2. Trash bins are provided in staff break rooms and lunch rooms for discarding food items.

3. Boxes from deliveries and supplies are collapsed and stored away from traffic areas. Oversized waste items and boxes are removed daily by the housekeeping staff.

4. See Chapter 14 on Exposure Control for more details.

FACILITIES • POLICY 11.07

Indoor Air Quality

It is the policy of the Practice to ensure a healthy work environment for staff, patients and guests. The quality of the air contributes to the safety and health of all.

PROCEDURES

1. All must comply with the smoking policies of the practice and the building.
2. Spills must be immediately cleaned up when possible. Hazardous materials or large spills should be cordoned off and housekeeping staff notified to prevent slips and falls.
3. Garbage and perishable food products must be disposed of properly in the appropriate containers which are emptied daily.
4. Whenever possible, odors should be prevented during office hours. This includes food preparation and disposal and products such as cleaning solutions, pesticides, paint, solvents and adhesives which can give off pollutants and offensive odors.
5. Personal work spaces, kitchen areas and refrigerators should be kept clean and sanitized to maintain hygiene and prevent pests.
6. Management should be notified if the indoor temperature or air-quality problems are detected.
7. See Chapter on Exposure Control for more details.

CHAPTER 12

Business Office

POLICY 12.01 • Financial Policy

POLICY 12.02 • Time-of-Service Payment

POLICY 12.03 • Time-of-Service Payment Controls

POLICY 12.04 • Waiver of Patient Financial Responsibility

POLICY 12.05 • Fee Schedules

POLICY 12.06 • Billing Inquiries

POLICY 12.07 • Workers' Compensation

POLICY 12.08 • Financial Agreement for Surgeries and Procedures

POLICY 12.09 • Medicare Noncovered Services — Advance Beneficiary Notification of Non-coverage (ABN)

POLICY 12.10 • Charge Accuracy and Completeness

POLICY 12.11 • Charge Reconciliation — Office Outpatient Services

POLICY 12.12 • Charge Reconciliation — Non-Office Services

POLICY 12.13 • Timeliness and Accuracy of Data Entry

POLICY 12.14 • Lag Time — Date of Service

POLICY 12.15 • Charge Correction

POLICY 12.16 • Managed Care Manual

POLICY 12.17 • False Claims

POLICY 12.18 • Insurance Update Request

POLICY 12.19 • Billing Insurance Claims

POLICY 12.20 • Liability Accounts

POLICY 12.21 • Payment Posting

POLICY 12.22 • Unapplied Payments

POLICY 12.23 • Interest Payments

POLICY 12.24 • Credits

POLICY 12.25 • Unclaimed Property Escheat

POLICY 12.26 • Account Adjustments

POLICY 12.27 • Claim Denials

POLICY 12.28 • Third Party Payer Follow-Up

POLICY 12.29 • Patient Communication on Balances

POLICY 12.30 • Open Claims

POLICY 12.31 • Write-Offs

POLICY 12.32 • Small Balances

POLICY 12.33 • Payment Plans

POLICY 12.34 • Patient Collections

POLICY 12.35 • Collection Vendors

POLICY 12.28 • Collection Disputes

POLICY 12.36 • Settlements

POLICY 12.38 • Financial Hardship

POLICY 12.39 • Bankruptcy

POLICY 12.40 • Estates

POLICY 12.41 • Bad Addresses

POLICY 12.42 • Nonsufficient Funds

POLICY 12.43 • Court Time and Deposition Billing

BUSINESS OFFICE • POLICY 12.01

Financial Policy

It is the policy of the Practice to provide all patients with a copy of the Practice's financial policy. The policy should include implementation guidelines so employees will understand the action they should take in different situations in order to treat patients in an equitable fashion. Furthermore, employees should be made fully aware of any exceptions that may be allowed and by whom they must be authorized.

PROCEDURES

1. The financial policy will include information regarding the Practice's policy as it relates to the following:

   a) Insurance companies — participation and billing process;

   b) Time-of-service collection and payments;

   c) Patient financial responsibility;

   d) Referrals;

   e) Workers' Compensation;

   f) Personal injury and automobile accidents;

   g) Collections and past due accounts;

   h) Contact information for the business office;

   i) Out-of-network services; and

   j) Fees for form completion, collection accounts, no-show appointments, and others.

2. The financial policy will be posted on the Practice's Website and patient portal. The financial policy will be presented to patients upon their registration at the Practice. Once patients read the financial policy, the patients will be asked if there are any questions. If yes, answers will be provided to clear up any misunderstandings. All patients will be asked to sign or electronically verify that they have received and understand the financial policy.

BUSINESS OFFICE • POLICY 12.02

Time-of-Service Payment

It is the policy of the Practice to require payment at the time of service. Payment includes all funds for which the patient is financially responsible according to his or her insurance coverage.

PROCEDURES

1. Patients will be reminded of the expectation to make time-of-service payments via the Practice's Website, patient portal, written financial policy, appointment scheduling, and appointment reminders.

2. The amount due to the Practice at the time of service will be determined prior to the patient's arrival based on an insurance verification and benefits eligibility check, collectively called the *financial clearance process*. The check may be performed manually or electronically.

3. The amount due may include one or more of the following:

   - Balance;
   - Unmet deductible;
   - Copayment;
   - Coinsurance;
   - Non-covered or elective service; and/or
   - Pre-payment for procedure or surgery.

4. If the patient is self-insured or insured by a plan with which the Practice does not participate, a minimum upfront payment of $200 or the estimated charge for the visit, whichever is less, will be collected.

5. If the patient is being seen for an employer-authorized work-related injury, the Practice will bill Workers' Compensation directly. If the employer's verification of injury cannot be obtained, the patient will be told that he or she may be ultimately responsible for payment, and private patient billing information will be obtained.

6. If the patient is employed by a company that has established an account with the Practice and the employer has authorized the visit, the Practice will follow the billing arrangement established with the employer. Authorization can be recorded on the standard practice authorization form. Telephone or Website authorization must be documented in writing by the Practice employees on the authorization form. The authorization form is scanned and indexed in the patient's chart.

7. Payments will be posted to the practice management system. A receipt will be automatically generated from the practice management system for any funds collected and it will be given to the patient.

8. The Practice may grant a patient a discount based on two circumstances:

   a. Uninsured patients or patients covered by an insurer that considered out of network may be granted a discount if payment is made at the time of service.

   b. Patients who meet financial hardship criteria may receive a discount based on the level of hardship.

   See related policies and procedures regarding self-pay discounts and financial hardship.

9. The business office will prepare a summary of the amount due, to include any necessary specifics, and transmit it to the practice site(s) on a daily basis. An example follows:

   Ms. Smith: $55 account balance from 1/1/16 visit (applied to her deductible); $20 co-insurance.

10. In addition to a summary of time-of-service payments, the front office employees will be trained and have access to scanned copies of explanations of benefits (EOBs) to use if patients have questions about balances.

11. The business office will be available to answer any questions that may arise from patients during time-of-service payment collection.

BUSINESS OFFICE • POLICY 12.03

Time-of-Service Payment Controls

It is the policy of the Practice to ensure timely and accurate tracking, reconciliation, and deposits of all payments received (checks, cash, and credit and debit cards) at the time of service.

PROCEDURES

1. Each employee logs on the practice management system using his or her personal identification and password.

2. The change drawer is stocked with $100 at the beginning of each shift, to include two $20 bills, two $10 bills, four $5 bills, and twenty $1 bills. (Note that the practice may designate a different amount should this not be sufficient.)

3. If the employee takes a break during the shift, he or she must log off. If applicable, the covering employee enters charges and payments under his or her own log-on identification and password.

4. All patient payments are entered to the system at the time they are received, unless otherwise designated to be the business office's responsibility.

5. Every check received is endorsed with the Practice's bank endorsement stamp immediately at the time of receipt.

6. Credit card payments are transmitted daily in accordance with the procedure as defined by the merchant processor.

7. At the end of the shift, the employee entering charges and/or time-of-service payments runs a daily system summary in the practice management system, showing all patient charges and payments (cash, check, and credit and debit card) by employee identification.

8. Each employee responsible for charge and/or payment entry must balance patient charges, as well as receipts for his or her allotted shift, and record the information on the designated Daily Balance Form, as follows:

    a. Total charges for all arrived patients during the shift.

    b. The grand total of time-of-service payments (run on a calculator tape) must match the daily summary of payments as displayed in the practice management system, respectively, for the shift.

    c. The employee running the tape shall resolve any discrepancies.

    d. When discrepancies are resolved, the employee attaches the tape to the Daily Balance Form and receipts, and staples them together.

    e. For each of these batches, the employee responsible for balancing completes a Daily Balance Form. (See below.)

9. The cash/change drawer must balance to $100 at the end of every shift.

10. The cash, check, and credit card receipts and the corresponding daily summary are then placed in a locked safe.

11. Each shift repeats the same process.

12. At the end of the day, a missing charges report is run to confirm that all patient charges are cross-referenced with the patient schedule for that day, verifying that an encounter has occurred and that a charge has been generated with every arrived patient (including any add-ons for the day).

13. No shows, cancellations, and reschedules are noted on the schedule as they occur. All patients seen are marked as arrived on the schedule. Designating these actions ensure that the missing charges report is accurate.

14. The Daily Balance Form is given to the business office manager or designee with the batch.

15. At the end of the business day (or the next business morning at the latest), the business office manager or designee prepares the deposit as follows:

    a. Dates the deposit slip with the date of service.

    b. Totals all cash and writes the amount in the cash area on the deposit slip.

    c. Lists each check by check number on the deposit slip.

d. Writes the total of cash and checks to be deposited in the appropriate space on the deposit slip.

e. Does not list credit card payments on the deposit slip.

f. Writes the name of the originating practice site on the lower-left corner of the deposit slip.

g. Removes the white and yellow copies of the deposit slip from the deposit book; retains the pink copy in the deposit book for practice records.

h. Paper clips the original copy (white) to the cash and checks and places the copy in a white envelope.

i. Attaches the yellow copy to the Daily Deposit Log. (See below.)

16. The deposit total plus the credit and debit card charges must balance to the daily summaries.

    a. If it does not, the Administrator or designee reviews all charge tickets, daily summaries, and cash and check totals.

    b. The review will be repeated until balance occurs.

    c. If balance does not occur, notify the Administrator or designee.

    d. Separate and detailed documentation must support the error requiring attention and adjustment.

    e. The business office manager or designee shall submit the error documentation on the Request for Edit/Correction Form on the day of the corresponding daily deposit information. (See below.)

17. The Administrator or designee shall enclose checks, cash, and the deposit slip for a single date of service in a white envelope stamped with the date of service, the total of the deposit, and the name of the originating office.

18. Employees are instructed to use a separate envelope for each date of service and seal it.

19. The business office manager or designee shall place all envelope(s) in the site-specific, numbered bank pouch, and lock the pouch.

20. The business office manager or designee shall keep the bank pouch in a locked safe for pick-up by the courier.

21. The bank pouch is given to the courier, who initials and dates a courier deposit log acknowledging receipt of the envelope.

22. Each deposit must be listed on the Daily Deposit Log by date and amount.

23. The Administrator or designee shall attach the yellow copy of the deposit by paper clip to the log sheet.

24. Each individual credit card total (by credit card type) is noted daily as a line item under the cash/check deposit for the day on the calculator tape to ensure balancing to the transmitted credit card charges.

25. A copy of this tape is marked “Total Credit Card Charges,” dated with the date of receipt, and attached to the Daily Deposit Log with the cash and check deposit slip for the day.

DAILY BALANCE FORM

Name: _____ Date of batch: _____

Total charges: _____

Total cash: _____

Total credit cards: _____

Total checks: _____

Total payments: _____

Note: *Total payments* must equal the deposit total, which is the sum of *total cash*, *total credit cards*, and *total checks*.

Attach payments and tapes to the back of this form, and return the form to your supervisor.

DAILY DEPOSIT LOG

Practice site: _____

Date	Deposit Total	Prepared By
12/1/XX	CASH $500.00	EWW
12/1/XX	MC $50.00	EWW
12/1/XX	VISA $50.00	EWW
12/1/XX	Discover $35.00	EWW
12/1/XX	TOTAL $635.00	EWW

REQUEST FOR EDIT/CORRECTION FORM

Account number: _____

Patient name: _____

Date of service to be edited: _____

Requester: _____

Date: _____

Approval granted by: _____

Date: _____

Notes of approval not granted: _____

_____

Attach any available, appropriate documentation.

BUSINESS OFFICE • POLICY 12.04

Waiver of Patient Financial Responsibility

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state and federal law.*

It is the policy of the Practice to treat all patients fairly when collecting account balances. In accordance with law, as well as many participation agreements with third-party insurers, the Practice does not routinely waive, fail to collect, or discount copayments, deductibles, coinsurance, or other patient financial responsibility. No part of patient financial responsibility, including deductibles, coinsurance, and copayments, are waived for a patient covered by Medicare, Medicaid, or other governmentally funded healthcare programs, except for financial hardship as documented in the Practice's financial hardship policy.

PROCEDURES

1. The Practice does not advertise waivers of patient financial responsibility, nor does it routinely offer waivers to patients.

2. A reasonable attempt is made to collect all applicable deductibles, co-insurance, and copayments defined by a patient's third-party insurer health plan. The only regular exceptions to this procedure are outlined in this policy.

3. Full or partial financial responsibility may be waived only in the following situations:

    a. Financial hardship *(see related policy 12.34 on Financial Hardship).*

    b. The entire fee is waived and no insurer is billed any amount for the services rendered, upon approval of the Administrator or designee.

    c. The patient is self-pay and maintains no health benefits (to the best of the Practice's knowledge) or the patient maintains health benefits with an insurer with which the practice is not contracted. The discount policy applies.

d. Reasonable efforts have been made to collect on the account. Once the patient has proceeded through the Practice's normal collection cycle and the amounts are deemed uncollectible, the amounts can be sent to a collection agency (or adjusted as a small balance adjustment, if applicable).

e. In situations in which the Practice will realize administrative cost savings as a result of full payment, without having to pursue payment through the Practice's normal billing and collection cycle. This includes time-of-service payments. The maximum discount is a level to be established by the Administrator; however, the discount will not be added to the discount to self-pay patients previously outlined.

4. In the event that the guarantor returns to the Practice, an attempt to collect these monies should be made. After reversing the write-off, the payment can be posted to the charge.

BUSINESS OFFICE • POLICY 12.05

Fee Schedules

It is the policy of the Practice to maintain a consistent and current schedule of fees for all services it renders.

PROCEDURES

1. The Practice will establish its fee schedule for all charges based on the resource-based relative value scale (RBRVS). The relative value units will be multiplied by a conversion factor. The conversion factor will be chosen so that the result (unit times a conversion factor) will be slightly higher than all expected reimbursement from insurers. The Practice may choose to use a separate conversion factor for designated services, such as procedures, surgeries, lab tests, imaging, evaluation and management, and so forth. The methodology will be clearly documented and filed in the Practice's permanent records.

2. The fee schedule is analyzed and updated, if necessary, annually, on or about November 1. Changes to charges will be effective January 1.

3. The business office manager will alert the Administrator and providers to the change in fee schedule, which will increase the accounts receivable. An alert should be provided, as this change in receivables should not be considered a reflection of poor billing and collection performance. To the extent possible, the business office manager shall identify the expected effect on the receivables indicators (e.g., days in receivables outstanding).

4. At the time of the fee schedule analysis, the Practice will analyze its reimbursement from all insurers to ensure that the insurer is making payments based on expected reimbursement and to determine if the Practice should renegotiate and/or discontinue a relationship with an insurer based on reimbursement and/or administrative hassle. This detailed analysis should also ensure that the fee schedule is higher than the Practice's expected reimbursement.

5. Practice employees engaged in payment posting will promptly alert the business office manager or designee for any claims adjudicated at 100 percent of the Practice's charge. At that time, the business office manager and the Administrator will confer to decide if raising the fee is appropriate. If so, the fee will be raised consistent with the methodology previously listed (using units times a conversion factor).

6. For all new services performed, the Practice will use the RBRVS units for that particular procedure code multiplied by the conversion factor. If the service has never been billed before, Practice employees will communicate the new service and designated fee to the Administrator or designee for review.

7. The Practice will use its fee schedule for all physicians and advanced practice providers without exception. Fees may be discounted according to agreements with participating insurers, prompt payment at the time of service, and financial hardship. (See related policies on patient financial responsibility waiver and financial hardship.)

8. The Practice may choose to use the RBRVS units from a designated year and stay with that year to protect against unpredictable changes in relative values and/or restriction within contracts that limit the percentage of increases that can be applied by the Practice.

BUSINESS OFFICE • POLICY 12.06

Billing Inquiries

It is the policy of the Practice that incoming inquiries via letter, statement, telephone, portal, fax, and e-mail regarding patients' financial accounts are directed to the business office. The business office provides assistance.

PROCEDURES

1. A direct telephone number to the business office is established for billing inquiries. The number is staffed from 8 a.m. to 5 p.m. Monday through Friday. Every effort is made to answer the call "live"; voicemail is used only in extenuating circumstances. In the event that patients call the main Practice number, the business office maintains a current list of account representatives and provides it to the telephone support staff to ensure the appropriate and expedient transfer of inquiring patients.

2. Electronic communication is offered for patients to contact the business office. Patients are instructed to communicate through the Practice's patient portal. A separate and distinct e-mail account is established for billing inquires. The instructions to reach the business office are published on patients' statements. If the patient uses email to make an inquiry, the employee should consider the content before returning the email. Because email is inherently unsecure, email messages sent in response to an email-based inquiry from a patient will not include protected health information (PHI). If PHI is required to answer the patient's communication, the Practice employee returns the patient's inquiry over the telephone or in person (see related policy 8.06 on E-mail Communication with Patients).

3. Every piece of correspondence from a patient, whether a letter, electronic communication, or a note on a statement, is time and date stamped and forwarded on the day it is received to a Practice employee who can review it and take action on the inquiry. Response time to communicate back to patients is 48 business hours, unless extenuating circumstances prevent communication.

4. If a patient verbally communicates updated insurance or demographic information to an employee who is appropriately trained, the person accepting the communication registers the information and documents the update in the practice management system with details regarding the person who communicated the information. If any changes are provided in writing, the document is scanned and indexed in the patient's account with corresponding documentation

    a. When an update is made, the employee making the change initiates a task to the business office after scanning and indexing the patient's correspondence about the account.

    b. In the task, the employee summarizes the changes made.

    c. This task is given high priority so that the business office can re-file any outstanding claims or re-send statements that may be affected by the change.

5. All patient financial inquiries and resolutions are recorded in the notes section of the patient's account in the practice management system. All notes are marked with the Practice employee's initials taking the message and/or the action, and dated. If applicable, all source documents are scanned and indexed in the patient's accounts.

6. Patient inquiries that cannot be achieved immediately (e.g., during the telephone call) are followed up within 24 business hours.

7. Requests that cannot be immediately resolved are printed or placed in an electronic task queue as a tracking log to ensure timely resolution.

8. Reports of outstanding inquiries are generated on a weekly basis, and each account representative follows up on the status to ensure prompt resolution.

9. Consistent communication is maintained with the patient to convey steps being taken to resolve the issue.

BUSINESS OFFICE • POLICY 12.07

Workers' Compensation

It is the policy of the Practice to pursue reimbursement for providing medical care to patients who seek treatment as a result of injuries or illnesses that occur at work by making a claim with the appropriate Workers' Compensation carrier.

PROCEDURES

1. At registration, all patients are questioned about the nature of their complaint as it relates to their employment. The Practice asks, "Is this injury or illness work related?"

2. If a patient states that his or her injury or illness is work related, an employee gathers detailed information about the patient's employer. Within two business days, the employee contacts the employer to confirm the status of the employee's injury or illness and acquires all pertinent information to bill the appropriate insurer.

3. The claim for the services rendered to the patient is submitted to the appropriate Workers' Compensation carrier within two business days following the date of service. Within five days of submitting the claim, the Practice communicates with a case manager and submits any applicable paperwork and/or documentation necessary for payment on the claim.

4. The Practice pursues payment from the Workers' Compensation carrier according to the protocols set forth for insurance follow-up activities (see related policy 12.24 on Third-Party Payer Follow-Up).

5. If the patient was injured while working, the Practice pursues payment from the employer and/or its workers' compensation carrier. The patient cannot be billed for the debt due.

6. If the claim is ruled non-work related, the Practice bills the patient and/or his or her private insurance company.

BUSINESS OFFICE • POLICY 12.08

Financial Agreement for Surgeries and Procedures

It is the policy of the Practice that patients who will be responsible for some portion of their bill will receive financial information regarding all non-emergent surgeries and procedures prior to the surgery or procedure being performed. This policy is established to keep patients informed to the best of our ability and expedite the payment of the patient's portion of his or her bill for services rendered.

PROCEDURES

1. When a surgery or procedure is scheduled, the Practice completes all information regarding the surgery or procedure (to include the date of service) on the financial agreement form. (See form on next page.) The Practice employees assigned to assist the patient will look up the patient's account and record the account number and insurer on the form. The practice employees will contact the insurer and/or query the insurer's Website to inquire about authorization(s), the amount that the insurance company is expected to pay, and the expected patient portion of payment. The completed form will be reviewed with the patient.

2. The Practice expects patients to pay a minimum of 50 percent of the expected patient responsibility or $200, whichever is greater, prior to service.

3. If the patient is uninsured, the financial agreement will be based upon the Practice's charge, and the patient will be granted a discount consistent with the patient discount policy if full payment is made prior to service.

4. Payment plans may be executed at the time of the agreement.

5. If the Practice's participation agreement with the patient's insurer prevents the practice from collecting prior to the service, the patient is exempt from this requirement.

6. If applicable, the agreement is scanned and indexed in the patient's account.

FINANCIAL AGREEMENT FOR SURGERIES AND PROCEDURES

Today's date: _____ Date of surgery/procedure: _____

Patient's name: _____ Patient's account #: _____

Description of surgery/procedure, including CPT code(s) and ICD-10 code(s): _____

_____

Is preauthorization required? Y / N If yes, preauthorization #: _____

Date, time, contact: _____

Estimated total cost of surgery/procedure: _____

Amount insurance is expected to pay: _____

Discounts (if applicable): _____

Total expected balance to patient: _____

Expected payment prior to surgery/procedure: _____

Remaining balance: _____

Payment plan? Y / N Terms: _____

Patient's/Guarantor's signature: _____ Date: _____

Employee's signature: _____ Date: _____

Notes: _____

_____

_____

_____

BUSINESS OFFICE • POLICY 12.09

Medicare Non-covered Services — Advance Beneficiary Notice of Non-coverage (ABN)

It is the policy of the Practice to comply with communicating all non-covered services to Medicare beneficiaries. If the Practice will perform a service that is non-covered, that fact will be communicated to the patient prior to treatment. Documentation of the patient's acceptance of financial responsibility will be obtained prior to providing the service.

PROCEDURES

1. At the time of appointment scheduling, if the service to be provided is recognized as one that is not covered by Medicare, the patient will be so informed.

2. When the Practice determines to perform a service and identifies it as non-covered by Medicare, an ABN will be provided to the patient with the appropriate fields completed. The ABN form will be explained to the patient and the patient will be asked to sign the ABN as his or her acceptance of the financial responsibility for the service. ABN forms are available from CMS.[16]

3. ABN forms will be maintained in the examination room and in the electronic health record (EHR) system to facilitate the expedient completion of the form.

4. Upon completion, the ABN form will be scanned and indexed in the patient's record.

[16] http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html. Accessed July 15, 2015.

BUSINESS OFFICE • POLICY 12.10

Charge Accuracy and Completeness

It is the policy of the Practice that charges will be accurate and complete at the time of service.

PROCEDURES

1. The physicians and advanced practice providers will document all services rendered to the patient.

2. The provider will complete electronic or paper charge documents at the time the service is rendered.

3. Diagnosis rule-outs are not permitted. A diagnosis must be made and coded based on the information available and the symptoms presented.

4. Providers will match procedure codes (i.e., CPT® codes) to the appropriate diagnosis codes (i.e., ICD-10-CM codes) using a numeric method and/or via the methodology provided by the practice management system for linking diagnosis codes if and when multiple procedure codes are used.

5. Illegible, unscannable, incorrect, or incomplete charges will be returned to the provider for correction within 24 business hours so that timely charge submission can be performed.

BUSINESS OFFICE • POLICY 12.11

Charge Reconciliation – Office and Outpatient Services

It is the policy of the Practice that charges for office and outpatient visits will be collected and entered throughout the day. Charges will be reconciled with the appointment schedule to ensure that all services are billed. A missing charge report will be generated on a daily basis to confirm that all charges have been entered for each patient who arrived and received medical services.

PROCEDURES

1. Charges will be generated for all patients who arrive and receive services. The Practice will deploy charge submission as per the protocols of the practice management system. For electronic charge submission, which is preferred, the charges are generated via the documentation process embedded in the electronic health record (EHR) system. The physician or advanced practice provider is responsible for reviewing the documentation, and (if applicable), the procedure codes recommended by the EHR system based on the documentation. The choice of the code – including whether to override the code and choose an alternate code – is that of the treating physician or advanced practice provider. If there is a separate billing provider, the Practice facilitates an audit and review process for ensuring that the decision regarding the code(s) to use is appropriate based on documentation. For an electronic process, patients who cancel or do not show for their appointment are marked in the practice management system accordingly, so that only arrived patients have charges associated with them. If paper charge tickets are required, the Practice instructs employees to generate a charge ticket for all scheduled appointments. If a patient cancels or does not present for his or her visit, employees will mark this fact on the charge ticket and record the information regarding the cancellation or no-show in the practice management system. If a patient walks in without a scheduled appointment, employees will generate the appointment in the practice management system. If applicable, a charge ticket is printed at that time if one is required.

2. At the end of the day, the business office generates a missing charge report that confirms all arrived patients and corresponding charges for the day are included. This report is generated regardless of the nature of charge submission.

3. Employees will generate an appointment reconciliation report to compare the scheduled patients who arrive for their appointments to those patients with charges on their accounts.

4. If applicable, all charge tickets will be sequentially numbered to provide an additional mechanism for monitoring missing tickets.

5. In the event that a charge is missing, the treating physician or advanced practice provider must be notified. The provider will be asked to generate the charge(s) for the services that were rendered by selecting the appropriate procedure and diagnosis code(s).

BUSINESS OFFICE • POLICY 12.12

Charge Reconciliation – Non-Office Services

It is the policy of the Practice that all charges are captured for billing purposes. The Practice will develop protocols to ensure that all services performed outside of the office are captured and submitted using a formal charge reconciliation process.

PROCEDURES

1. For manual charges that are submitted to the business office, logs will be developed to record all charges that are submitted to the business office. In this fashion, missing dates of service and missing data will be identified.

2. A source document is identified for each service rendered. A reconciliation against submitted charges will be performed automatically or manually on a monthly schedule, at minimum. Source documents include hospital census reports, labor and delivery logs, operating room logs, electrocardiogram (EKG) logs, and other similar documentation.

3. A service analysis report will be developed for each key service in the Practice. The service analysis will be compared to projected service volumes to assist in identifying variation from expected productivity levels, which could signify missing charges.

4. A log of missing charges will be created automatically or manually. All correspondence and activity to resolve the charge submission will be recorded in the log, to include employees and dates. This information will be reviewed, at minimum, on a quarterly basis by the Administrator, medical director, and business office manager.

5. In the event that missing charges are identified, the employee will first determine if the documentation for the service(s) exists. If it does, it will be routed, as appropriate, through the coding and submission process. The action taken will be recorded on the missing charges log. If there is evidence of a service being performed, but no documentation, an employee will send an internal electronic communication to the physician or advanced practice provider(s) listed as performing the service, with a copy to the business office manager. A resolution to the missing charges must be communicated within 72 hours of this notification. Before the charge is entered, documentation must be obtained and reviewed to ensure that the service was rendered, coded, and charged correctly. If the service was not rendered (i.e., it was mistakenly identified as having been rendered on the missing charges log), the provider should communicate that fact.

6. All efforts will be made to automate the charge reconciliation process for non-office services.

7. Should a consistent pattern of failure to document services and/or record charges for said services be revealed for a physician or advanced practice provider, the situation shall be addressed with the medical director and the Administrator. At that point, this policy defers to the policy and procedure that addresses disciplinary actions for providers.

BUSINESS OFFICE • POLICY 12.13

Timeliness and Accuracy of Data Entry

It is the policy of the Practice that all demographic, clinical, and financial data entry will occur in a timely and accurate manner.

PROCEDURES

1. Employees will enter data according to the following time frames:

   - Registration and patient demographic data will be entered at the time the patient schedules the appointment, with updates entered at the time of service;
   - Documentation will be recorded and finalized on the date of service or within 24 hours of the date of service;
   - All charges will be submitted and entered into the system within 48 hours of the completion of the coding of services performed; and
   - All payments will be entered into the system at the time of service or within 24 hours.

2. For charges that are manually entered, employees must achieve a 99 percent accuracy rate for data entry. Employees not achieving this goal will be assigned to complete a day of training in charge entry and related tasks. If an employee is not able to achieve accuracy during this additional training, the employee will be considered for transfer to another work area or dismissal from employment.

BUSINESS OFFICE • POLICY 12.14

Lag Time – Date of Service to Date of Bill Release

It is the policy of the Practice to facilitate a timely and efficient billing and collection process. To that end, the Practice will comply with pre-determined lag times for key billing processes.

PROCEDURES

1. Physicians and advanced practice providers will be responsible for documenting all services within 24 hours of the date of service. All providers will submit all procedure and diagnosis codes within 24 hours of rendering services in the office, and 72 hours for services out of the office. If coding is not performed by providers, the coding process performed by Practice employees may consume a maximum of 48 hours from the completion of documentation.

2. For charges that must be submitted manually, employees will be responsible for entering charges, whether by keying, scanning, or interfacing with the electronic health record system, within 48 hours of the date of coding.

3. Employees will be responsible for reviewing and editing the charges before they are submitted. This process may consume up to the 48-hour period allowed between the date of coding and the date of charge submission. Exceptions, such as causing a charge ticket to be returned to a provider for further review, will not exceed 72 hours.

4. Employees will submit claims within 72 hours of charge submission.

5. Employees will submit claims on a daily basis.

6. The lag times for the following key processes will be tracked and monitored by the business office manager every week. Outliers will be reported to the Administrator, and a performance improvement initiative will commence.

    - Date of service to date of documentation: 0–24 hours
    - Date of documentation to date of coding: 0–72 hours
    - Date of coding to date of charge submission: 0–48 hours
    - Date of charge submission to date of claim release: 24–72 hours

BUSINESS OFFICE • POLICY 12.15

Charge Correction

It is the policy of the Practice that a charge cannot be deleted. For management purposes, an audit trail is necessary to assess the origination and reason for all deleted charges.

PROCEDURES

1. Only designated employees will be permitted to correct a charge that has been entered into the practice management system.

2. If a correction to a charge is necessary, the charge must be written off to the appropriate adjustment code as per the practice management system, and then the correct charge entered.

3. A note of explanation regarding the charge correction will be documented in the notes section of the patient's account to include the employee's initials and date, as well as a description of the correction.

4. Charge corrections may occur because of the following errors:

   - Charge posted to the incorrect account;
   - Incorrect amount of charge;
   - Duplicate posting;
   - Incorrect charge code and fee; and/or
   - Other.

5. The business office manager will audit charge corrections at least monthly to ensure compliance with this policy and procedure.

BUSINESS OFFICE • POLICY 12.16

Managed Care Manual

It is the policy of the Practice to maintain detailed information about each health plan in which the Practice participates so all employees are knowledgeable about the plan.

PROCEDURES

1. The Practice's Managed Care Manual (see below) is updated as often as possible and, at a minimum, when any changes are communicated by the plans.
2. The manual is maintained electronically on the Practice's shared drive or intranet.
3. Every workstation has access to the manual.
4. The manual may not be able to capture all information in a timely manner given the pace of change.
5. When a Practice employee observes a change in any plan, he or she should submit the change in writing to the business office manager or designee for verification.
6. The manual is updated within three business days of verification of change of information.
7. The manual shown should be used as a guide.

MANAGED CARE MANUAL

PAYER:	ANY NAME PAYER
PLAN NAME:	ANY NAME HMO
WEBSITE:	www.anynamehmo.com
PASSWORD:	Issued to all Practice staff; see business office manager if questions
PARTICIPATION:	All XYZ Practice providers
HOSPITALS:	ABC Medical Center
OUTPATIENT SURGERY:	EFG Surgery Center, HIJ Ambulatory Surgery Center
DIAGNOSTICS, MRI, ETC.:	Call primary care provider for authorization; ABC MRI, QRS Imaging Center
LABORATORY:	Call primary care provider for authorization; MNO Laboratory Corp.
PHYSICAL THERAPY:	Call primary care provider for authorization; HIJ Therapy Center
PROSTHETICS:	Call primary care provider to inform; TUV Orthotics and Prosthetics
PRE-CERTIFICATION:	Required for all hospital admits and surgeries (888) 123-4567 Available on health plan's website
PRE-AUTHORIZATION:	Required for all services
REFER TO OTHER DRS:	Refer back to primary provider only
BENEFIT VERIFICATION:	See card
CLAIMS QUESTIONS:	(888) 123-4567
SUBMIT CLAIMS TO:	ANY NAME HMO, 789 Anywhere Street, Anytown, USA 12345
COPAYMENT:	Insurance cards state the following options: Value option: $40.00 Platinum option: $25.00 Preop and postop: $0.00
ALLOWABLE:	Fee schedule is 85% of the 2016 Medicare allowable
INSURANCE CARD:	Card color is gray with white stripe at the top and navy blue writing
SAMPLE COPY OF CARD:	(Scan in sample[s])
NOTES:	

BUSINESS OFFICE • POLICY 12.17

False Claims

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable federal and state law.*

It is the policy of the Practice to ensure that all employees, including management, and any contractors or agents are educated regarding the federal and state false claims statutes and the role of such laws in preventing and detecting fraud, waste, and abuse in federal healthcare programs. The purpose of this policy is to comply with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws.

FALSE CLAIMS LAWS

One of the primary purposes of false claims laws is to combat fraud and abuse in government healthcare. False claims laws do this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. These laws often permit qui tam suits as well, which are lawsuits brought by lay people, typically employees or former employees of healthcare facilities that submit false claims.

There is a federal False Claims Act, and there are also state laws that address fraud and abuse in the Medicaid programs. Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. The fines include a penalty of up to three times the Government's damages, civil penalties ranging from $5,500 to $11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. Generally, the federal False Claims Act applies to any federally funded program. The False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.

One of the unique aspects of the federal False Claims Act is the qui tam provision, commonly referred to as the "whistleblower" provision. This allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government. The purpose of bringing the qui tam suit is to recover the funds paid by the Government as a result of the false claims. Sometimes the United States Government decides to join the qui tam suit. If the suit is ultimately successful, the whistleblower who initially brought the suit may be awarded a percentage of the funds recovered. Because the Government assumes responsibility for all of the expenses associated with a suit when it joins a false claims action, the percentage is lower when the Government joins a qui tam claim.

However, regardless of whether the Government participates in the lawsuit, the court may reduce the whistleblower's share of the proceeds if the court finds that the whistleblower planned and initiated the false claims violation. Further, if the whistleblower is convicted of criminal conduct related to his or her role in the preparation or submission of the false claims, the whistleblower will be dismissed from the civil action without receiving any portion of the proceeds.

The federal False Claims Act also contains a provision that protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment as a result of the employee's lawful acts in furtherance of a false claims action. The whistleblower may bring an action in the appropriate federal district court and is entitled to reinstatement with the same seniority status, two times the amount of back pay, interest on the back pay, and compensation for any special damages as a result of the discrimination, such as litigation costs and reasonable attorney's fees.

A similar federal law is the Program Fraud Civil Remedies Act of 1986 (PFCRA). PFCRA provides administrative remedies for knowingly submitting false claims and statements. A false claim or statement includes submitting a claim or making a written statement that is for services that were not provided, or that asserts a material fact that is false, or that omits a material fact. A violation of the PFCRA results in a maximum civil penalty of $5,000 per claim plus an assessment of up to twice the amount of each false or fraudulent claim.

PROCEDURES

1. The Practice takes issues regarding false claims and fraud and abuse seriously. The Practice encourages all employees, management, and contractors or agents of the Practice's affiliated facilities to be aware of the laws regarding fraud and abuse and false claims and to identify and resolve any issues immediately.

    a. Issues are resolved fastest and most effectively when given prompt attention at the local level.

        1) The Practice encourages employees, managers, and contractors to report concerns to their immediate supervisor when appropriate.

        2) If the supervisor is not deemed to be the appropriate contact or if the supervisor fails to respond quickly and appropriately to the concern, the individual with the concern is encouraged to discuss the situation with the Administrator or another member of management.

2. The Practice ensures that all employees, including management, and any contractors or agents of the practice, are provided with this policy within 30 days of commencing employment or contractor status.

BUSINESS OFFICE • POLICY 12.18

Insurance Update Request

It is the policy of the Practice to maintain current records of all health plans in its practice management system to allow timely and effective processing of claims.

PROCEDURES

1. All new health plan and all changes to the information about existing health plans, including name, address, website URL, and phone number, are updated in the master file by the Administrator or designee.

2. To update information regarding a health plan in the practice management system, a Practice employee completes an Insurance Update Request Form (see below). The employee sends the completed form electronically or manually to the Administrator or designee for approval.

3. If approved, the requested change is made in no more than three business days.

4. If the insurance update affects claims that have previously been submitted to the insurer, the claims must be resubmitted. The resubmission should occur within 24 hours of the discovery of the updated information.

INSURANCE UPDATE REQUEST FORM

Check:

- Health plan in database_____
- New health plan

Insurance code (if in database): _____

Information to be updated/added: _____

Phone #: _____

Health plan name: _____

Insurer's name (if different): _____

Address: _____

Insurance type: _____

Major employer(s) in community with plan: _____

Comments: _____

Requested by: _____ Date of request: _____

Approved by: _____ Date of approval: _____

Changed by: _____ Date of change/addition: _____

BUSINESS OFFICE • POLICY 12.19

Billing Insurance Claims

It is the policy of the Practice to submit clean claims to all insurers in a timely manner and to receive expedient payment for services rendered to their beneficiaries.

PROCEDURES

1. Prior to submitting claims, charges will be reviewed automatically or manually for accuracy. Every effort will be made to eliminate errors in registration, procedure and diagnosis coding, and charge submission to ensure timely reimbursement. During the review process, any discrepancies will be resolved immediately. If necessary, the physician or advanced practice provider rendering the service for which the charge is being billed will be contacted regarding the charge, via a communication platform that is integrated in the practice management system or electronic health record (EHR) system. This allows the communication to be documented and referenced via the patient's account. Providers will have 72 hours to respond to questions about charges.

2. Following the edit process, clean claims will be electronically sent on a daily basis.

3. Exception reports generated from the submission that produce errors will be worked on a same-day basis.

4. Claims will not be suspended unless absolutely necessary. An electronic log of suspended claims will be maintained and monitored to ensure that they are resolved expediently. The age and volume (as reported by dollars and number) will be maintained on the Practice's financial dashboard.

5. The Practice will submit secondary and tertiary claims in the event that a patient maintains a secondary or tertiary insurance policy. The secondary insurer will be billed for the remainder of the balance after the primary adjudicates the claim and, if applicable, the tertiary insurer will be billed after the secondary pays. The Practice will make best efforts to work with insurers to crossover secondary and tertiary claims automatically. If not, the primary explanation of benefits (EOB) will be flagged manually or electronically and submitted to Practice employees to bill the secondary or tertiary. Secondary and tertiary claims will be submitted within 24 business hours of notification of the responsibility of another insurer.

6. The full balance of primary, secondary, and tertiary claims submitted to insurers with which the Practice does *not* participate will be transferred to patient responsibility at 30 days, or another time period for which the business office may designate.

7. For services covered under a capitated plan, charges will be posted for tracking purposes but automatically adjusted by the practice management system. If the insurer offering capitated or bundled services' reimbursement requires that a claim be submitted with a record of the service accompanied by a $0 charge, the Practice will comply with these obligations. If a patient receives a service for which the patient is covered but which is not included in the capitation agreement, a claim will be sent to the insurer. If a patient who is a beneficiary under a capitated or bundled services' plan receives a service that is non-covered or carved out of his or her policy, the charge will be the patient's responsibility and billed according to the Practice's policies and procedures for patient billing.

BUSINESS OFFICE • POLICY 12.20

Liability Accounts

It is the policy of the Practice to send claims for services resulting from an automobile or other accident to the appropriate auto insurance company, health plan or insurance company for reimbursement; however, the patient is held responsible for the payment unless otherwise permitted by law.

PROCEDURES

1. The account representative designated to handle liability accounts posts and submits the claims for these services.

2. All efforts are made by the Practice for the patient to assign his or her benefits to the Practice. This protocol is facilitated by requesting the patient to complete an assignment of benefits form upon registering as a new patient to the Practice.

3. The account representative ensures that all required attachments are sent to the insurer at the time of claim submission.

4. Claims are submitted electronically to the appropriate insurer when the insurer can accept such transmission and via paper claim when the insurer cannot. Supporting documentation, if required, is submitted with the claim.

5. The account representative designated to handle liability accounts follows up on all liability accounts. Regular reports are generated to monitor the aging of these accounts.

6. Monthly statements are sent to a patient requesting payment in the event that the insurer has not yet paid the claim, unless the law does not allow for patient financial responsibility.

7. After 60 days, if the balance is unpaid, the patient receives a letter explaining the status of his or her account with a request for immediate payment. If payment does not occur within 30 days, the patient receives notification that the account is submitted to a collection agency.

8. If a balance remains after 120 days, the account is forwarded to a collection agency.

BUSINESS OFFICE • POLICY 12.21

Payment Posting

It is the policy of the Practice that payments received by the Practice will be handled in a timely manner with sensitivity to internal controls.

PROCEDURES

1. The Practice will accept payments remitted and transferred electronically from all insurers offering electronic remittance advice (ERA) and electronic funds transfer (EFT). Remittances will be accepted when available from the insurer, but will not be posted until the Practice employees confirm the remittance total to the funds transferred.

2. The Practice will accept all non-electronic payments through a lockbox at a reputable, secure financial institution. This will include all non-electronic, paper checks from insurers and patients.

3. The financial institution will notify the business office of the deposits on a daily basis. The bank will transmit scanned copies of all checks on the same or day following receipt and deposit. Payments received will be placed into batches and assigned to the appropriate employee(s) for manual posting. Practice employees are responsible for balancing the batches assigned to them. A summary of all batches posted will be reconciled to the daily deposit and provided to the business office manager or designee.

4. All correspondence with no payments attached, to include denials, will be entered to the practice management system. A transaction code will be posted to the line-item level on the account to identify the type of denial, with the encounter transmitted to the automated work file of the assigned account follow-up employee.

5. Practice employees posting payments are responsible for accurate posting on a line-item basis.

6. Practice employees posting payments are responsible for transferring responsibility for the account balance to secondary or tertiary insurers (and manually or electronically marking the primary ERA or EOB, unless the claim was automatically crossed over by the primary insurer), or the guarantor.

7. Payment posting will be closely monitored to assure timeliness and accuracy, as well as to identify opportunities for improvement.

BUSINESS OFFICE • POLICY 12.22

Unapplied Payments

It is the policy of the Practice to account for all payments and apply them to specific charges on corresponding dates of service. These payments are resolved and posted in a timely basis.

PROCEDURES

1. Employee designated to post payments key all payments to the corresponding dates of service based upon the information provided from insurers on the explanation of benefits.

2. Payment postings are researched for any amounts that are not directly tied to a date of service and specific services. All open batches are posted before the end-of-day closing. Research may require calling the insurer to clarify assignment of the payment. All payments are identified in a timely, accurate manner.

3. A payment that is received prior to posting the charge is posted to the patient's account according to the protocol established by the practice management system. The payment is linked to the charge when it is posted. Office charges are posted within 24 business hours of date of service, and therefore, reconciliation and posting of these monies must occur in the same time frame.

4. If the patient is identified, but the date of service is not available, such as when a patient sends a check toward his or her account balance, the payment is posted to the patient's account proportionally, or to the oldest charges. If the account has insurance claims outstanding, the account representative researches the account to ensure proper posting of the payment.

5. The Practice employee posting payments documents how unapplied payments were allocated. The details of the allocation are documented on the account in the notes section of the patient account. This allows the account representative immediate access to critical information in the research process.

6. If a payment cannot be reconciled within the day to balance the closing, the amount is posted to the unapplied payment account until the employee serving as an account representative can research and reconcile the payment posting.

7. Documents that contain unidentified payments remain a part of the posted batch and are given to an account representative for research and resolution.

8. All open and unresolved, unapplied payments are resolved by an account representative within 15 days. Any case he or she is unable to resolve is communicated to the business office manager in writing, with supporting documents included.

9. Upon resolution, the account representative applies the payment to the correct patient and line item service and posts a reversal to the unapplied payment account. A notation in the unapplied account is noted to indicate where the payment was posted. This includes the patient and account number, as well as the employee making the charge, the date, and any applicable notes.

10. The business office manager reports on and monitors the unapplied payment account to ensure that all unapplied payments are resolved in a timely manner. The Administrator follows up on negative trends with the appropriate staff.

BUSINESS OFFICE • POLICY 12.23

Interest Payments

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice to pursue interest due based on contractual or legal obligations by insurers in the case of delayed payments to the Practice.

PROCEDURES

1. The Administrator or designee will monitor contracts and state law regarding prompt payment and interest due to the Practice for failing to abide by these obligations.

2. The business office will develop a report to monitor payment time periods by insurers. For insurers that are contractually or legally obligated to pay interest, requests for payments will be submitted by the Practice.

3. When interest is earned on claims that have exceeded the allowed amount of time for payment, the interest will be posted to a designated interest account to monitor this revenue.

4. The business office manager or designee will conduct a reconciliation of the interest account at the end of each month.

BUSINESS OFFICE • POLICY 12.24

Credits

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state, city and county may differ, and this suggested general policy should not be implemented without considering applicable state and local law.*

It is the policy of the Practice to return all funds that are not due to the Practice. These may include overpayments from patients or insurers. The Practice is committed to comply with state and federal laws, as well as to minimize the effect that credits have on receivables (i.e., credits understate the accounts receivable). In compliance with federal law, actions to process the appropriate refund commence at the time that the credit is identified.

PROCEDURES

1. Credits will be flagged (electronically or manually) at payment posting when they are created. The credits will be worked by a designated refund unit in the business office.

2. Credit invoices should be identified and refunded to the patient, guarantor, or insurer within 60 days. Any credits identified that can be transferred to another outstanding invoice should be performed within 60 days of creation date. The oldest credits are worked first, with the exception of government payers which are given priority to ensure processing within 60 days of creation.

3. If a credit occurs for a guarantor with multiple patients on the account and a debit balance remains on the total account, the credit will be posted as an open balance payment on the account.

4. Credits of less than $5 will not be refunded. They will be maintained on the patient's account and applied to future services, in a time frame that complies with the state's escheats law.

5. Refunds will be posted to the patient's account upon the issuance of the refund check or credit or debit card refund.

6. Requests for refund checks will be submitted to the Administrator or designee in writing or via internal e-mail on a standard manual or electronic refund request form and will require the designated supervisor's approval prior to debiting to the account.

7. All insurer refund procedures will be followed in accordance with the applicable terms as outlined in the contract.

8. In accordance with the time frame and protocols established by state law, the Practice reports and tenders to the appropriate representative of the state all unclaimed funds subject to escheat (see related policy 12.25 on Unclaimed Property Escheat).

REFUND REQUEST FORM

Practice Name:		Address:		
Request for Refund: Practice Tax Identification Number (TIN):				
Practice Location	Site 1	Site 2	(Circle One)	
Today's date: _____				
Amount to refund: $_____				
Patient Information				
Patient name:			Date of birth: _____	
Subscriber ID #:				
Service date to refund:				
Acct #:				
Reason for Refund				
01 Corrected DOS	04 Not our Patient	12 Insufficient Documentation	15 Medical Necessity	
02 Duplicate Charge 02a Duplicate Payment 02b Overpayment by Insurance	05 Modifier Add/Remove	13 Patient Enrolled in HMO	16 Other (Explain)	
03 Corrected CPT	06 Billed in Error	14 Services Not Rendered	16a: Insurance Required	16b: Patient Not Eligible for DOS
Remit To				
Insurer name:				
Street address:				
City, State, ZIP				
Attention:				
Attachments required?	Yes	No		

Requested by:	
Approved by:	
Check issued:	
Check #:	
Amount:	$

BUSINESS OFFICE • POLICY 12.25

Unclaimed Property Escheat

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law.*

It is the policy of the Practice to comply with state law regarding the accurate and appropriate disposition of all payments received including unidentified payments and returned refund checks. The Practice utilizes all available resources to locate the insurance company of any unidentified payment and, if unable to identify the applicable account or insurer, transfers such unidentified accounts to the appropriate state agency as indicated by state law. State law may require such unclaimed payments to be retained for a specific period of time prior to transfer and may vary by each state's unclaimed fund statutes. Accordingly, these payments are held in a suspense account for the specified period after which the unclaimed payments are transferred to the state for reciprocity with other states' unclaimed property agencies.

PROCEDURES

1. The Practice identifies and resolves unclaimed refunds that have created a credit balance on accounts.

2. The Practice complies with the "reach back" period as determined by the state. A designated employee uses this time period to research unclaimed refunds so that the appropriate report can be submitted to the appropriate state department.

3. Processing of returned and uncashed refund checks is the responsibility of the accounting department in conjunction with the business office manager. The following workflow is used to resolve these unclaimed payments:

a. If a refund check is returned or it is not cashed within 120 days, the party is contacted using the Practice's information for the patient. Uncashed and returned checks are researched for a current address or phone number.

    1) If new information is obtained, the check is re-sent to the most current address.

    2) The account is updated with the new demographic information, and the re-issuance is noted in the account.

b. If a new address is not available for returned checks using the tools of the practice to skip trace the patient's (or insurer's) demographic information, and there is not a good phone number where the party can be reached, the refund check is marked "VOID."

    1) Voided checks are logged with the business office manager, copied (for an "escheat" file), batched, and sent to the accounting department.

    2) The check is voided in the accounting system.

    3) The transaction is assigned a category of "escheat" so that it can be reported on in the future.

    4) The voided amount is posted to the transaction(s) in the patient's account in the practice management system, and the daily batch posting within the practice management system is noted with a transaction code of escheat for reporting from within the practice management system.

c. Accounts with a credit escheat balance are aged for a period of one year at which time the account information is researched again to determine if there is a new current address. If one is found, the refund is re-issued. If no new information is available, the credit is transferred to the appropriate unclaimed fund account for reimbursement to the state.

d. The Administrator or designee prepares the authoritative accounting report required by the state and submits the report along with the monies equaling the total dollars due.

4. The Practice reports unclaimed property to the state of last known address of the owner. (All 50 states have unclaimed property laws.) If the practice records do not show a state of last known address for some accounts, those properties are reported to the Practice's state of incorporation. Many states have reciprocal agreements to exchange property not reported to the owner's state of last known address. The Practice confirms with its state before reporting property to a state other than the state of last known address.

5. Forms required by the state are used to identify each owner of the unpaid property.

6. In the event that a patient requests a refund after the credit balance has been paid to the state, the patient is directed to contact the state to which the refund was issued for reimbursement.

BUSINESS OFFICE • POLICY 12.26

Account Adjustments

It is the policy of the Practice to track and monitor all funds that are adjusted from the original charge submitted to an insurer. Two distinct categories of adjustments will be handled and monitored separately: contractual (amounts considered to be uncollectible as a result of the allowance contracted with the insurer) and non-contractual (amounts considered to be uncollectible as a result of failure to obtain the amount allowed by the insurer).

PROCEDURES

1. To track and monitor all adjustments, the Practice maintains a dictionary of detailed codes for contractual and non-contractual adjustments, as consistent with the group, reason, and remark codes considered industry standard for the processing of claims.

2. The Practice will maintain current fee schedules, by procedure code, for each health plan. As a payment is posted, the Practice employee is responsible for verifying that the payment allowance matches the expected reimbursement. To assist employees, the Practice management system will display the contractual reimbursement for each procedure code posted, based on the agreement with each insurer, and any variance.

3. If the payment allowance matches the expected reimbursement, the residual money (Practice charge less payment allowance) will be written off with the appropriate contractual adjustment code. If the payment does not match the expected reimbursement, the variance is highlighted and the line item is flagged manually or electronically for follow-up.

4. From time to time, Practice employees may work on an account that has a balance outstanding with an insurer that cannot be collected. The reasons for the Practice's inability to collect on the account may include, but not be limited to, a missed timely filing or missed appeal deadline or failure to obtain an appropriate authorization or referral. If such an adjustment is identified, Practice employees must receive approval to write off the account from a supervisor. The employees working the account in question shall identify their efforts to work the account and the recommendation for the write-off. The request will be sent in a standard format via secure electronic internal communication. (The business office manager may decide that Practice employees may adjust accounts up to a maximum dollar amount without a supervisor's approval; if this decision is made, the amounts shall be placed in writing, and this policy and procedure updated.)

BUSINESS OFFICE • POLICY 12.27

Claim Denials

It is the policy of the Practice to identify, monitor, and take action on all claims submitted by the Practice that are denied by insurers.

PROCEDURES

1. Practice employees will be assigned responsibility for reviewing and taking action on all denials. Denials will be tracked and monitored at the line-item level, based on submitted charges. All denials will be reviewed and acted upon within 72 hours of receipt.

2. Practice employees will use all available resources to research and correct the claim, including but not limited to, the documentation of the service; medical literature; authorizations and referrals; procedure and diagnosis coding manuals and reference materials; specialty society policy statements; insurers' payment policies; and state and federal government coverage policies. Depending on the nature of the denial, a claim will be corrected and resubmitted or an appeal will be communicated in accordance with the insurer's guidelines for the appeal.

3. Denied claims will not be resubmitted without ensuring that the service has been documented in the medical record. Any claims that have missing documentation must be brought to the attention of the Practice's compliance officer immediately.

4. Denied claims will not be resubmitted until corrections are made to the claim. Resubmitting claims without correction is grounds for disciplinary action for Practice employees who are assigned the responsibility to work denied claims.

5. The business office will monitor and research claims denied by insurers to determine the causes of the denials. The claims denial report will be analyzed to determine the specific charges on claims that have been denied and the causes for denial. The analysis will be used to train physicians, advanced practice providers and employees regarding steps that can be taken to reduce claim denials received by the Practice.

BUSINESS OFFICE • POLICY 12.28

Third Party Payer Follow-Up

It is the policy of the Practice that the business office is responsible for timely follow-up on payments owed to the Practice from third party payers.

PROCEDURES

1. Electronic work files will be generated from the practice management system, with employees assigned to work the accounts to ensure timely payment.

2. For denied or pended claims, the following actions will be taken based on the denial code indicated on the explanation of benefits or electronic remittance advice:

   a. If the patient is not eligible for benefits, or if the service is not a covered benefit, and the group code is marked as "PR" (patient responsibility), the balance will be transferred immediately to patient responsibility;

   b. If additional information is required, the claim will be resent with the appropriate information or attachments; or

   c. If demographic information or policy numbers are incomplete or inaccurate, the patient will be contacted to obtain valid data. This updated information will be verified and then immediately entered into the system and rebilled.

3. The following schedule, which should be dictated by insurer based on predicted payment cycle, will be followed to ensure consistent follow-up. If there is no documentation of the payment cycle, the maximum time frame is 45 days after initial claim submission:

   a. Confirm receipt of payment.

   b. If no payment, run an automated search to determine the claim status or contact the insurer directly.

c. If the claim was filed as a courtesy to an insurer with which the billing physician or advanced practice provider has no contract, financial responsibility is transferred to the patient.

d. Determine the reason(s) for the denial or claim hold and the actions required for payment to be released.

e. Assemble any documentation requested to adjudicate the claim.

f. Resubmit the corrected claim for payment or initiate the appeal process; copy the patient on the appeal letter if appropriate.

4. If payment still has not been received at 90 days after initial claim submission:

a. Confirm receipt of payment.

b. If no payment, run an automated search to determine claim status or contact the insurer directly (particularly in the case of an appeal).

c. Determine the reason(s) for claim hold and the actions required for payment to be released.

d. Assemble any documentation requested to adjudicate the claim.

e. Resubmit the corrected claim for payment or initiate the second level of the appeal process.

f. Contact the patient and request his or her assistance immediately.

5. If possible, conduct a three-way conference call with the patient, insurer, and the Practice's business office employee assigned to this account.

6. Summarize efforts to follow up on this claim in a letter, and bill the patient for the balance due, if the contract with the insurer in question allows it.

7. If payment still has not been received at 120 days after initial claim submission:

a. Confirm receipt of payment.

b. If no payment, document your efforts to date. Give the documentation to the business office manager and/or the treating physician or advanced practice provider with your recommendation(s) regarding follow-up activity.

BUSINESS OFFICE • POLICY 12.29

Patient Communication on Balances

It is the policy of the Practice to communicate and work with patients to assist, when necessary, to resolve payment on their outstanding balances.

PROCEDURES

1. If a Practice employee receives a claim that is denied based on the patient's insurance company waiting for information from its beneficiary (the patient), a Patient Information Request Form (see next page) is generated manually or automatically.

   a. The form highlights the information that the patient is requested to submit.

   b. The Practice waits 30 days for a response.

   c. At that time, another communication regarding the request is made to the patient, preferably by telephone contact.

   d. Both requests are documented in the patient's account notes with details as to the date and time of the notification.

2. If the patient fails to respond to the insurer's notification, as well as to the two notifications from the Practice, the balance pending with insurer is shifted to the patient's responsibility and the Practice pursues its normal collection process unless it is prevented by its contract with the insurer.

3. The Practice presents this policy to all insurers with which it participates for inclusion in its participation contract.

PATIENT INFORMATION REQUEST FORM

Date of notice: _____

Patient's name: _____

Patient's account #: _____

Date of service: _____

Provider: _____

Amount due: _____

1. Please contact your insurance company immediately.

___ Your insurance company is requesting accident details.

___ Your insurance company is requesting student status.

___ Your insurance company is requesting preexisting information for this diagnosis.

___ Your insurance company needs a completed claim form signed by the guarantor of your policy.

___ Your insurance company is requesting additional information.

___ Your insurance company needs _____ .

2. Please contact the office immediately.

___ Your insurance company is processing your claim out of network. It does not have a Primary Care Provider (PCP) on file for you.

___ Your insurance company was unable to identify the insured/policy holder, with the information in our records.

___ Please provide us with a copy of your insurance card. (Please mail, scan/electronically submit via the portal or fax it to my attention at xxx-xxx-xxxx.)

Please respond within 30 days or you will be responsible for your bill. Please contact me if you have any questions.

Sincerely,

[Practice Employee]

[Phone Number]

[Email address or Portal contact]

BUSINESS OFFICE • POLICY 12.30

Open Claims

It is the policy of the Practice to proactively identify and resolve any problems with open or outstanding claims from third party payers.

PROCEDURES

1. A Practice employee assigned responsibility for third party payer follow-up runs an open claims report once a week.

2. A report is run that identifies all outstanding claims, by payer, based on the average payment time frame. For example, if the Practice expects all clean Medicare claims to adjudicate properly within 14 days, an open claims report is run for all outstanding claims more than 15 days. The report is organized in hierarchical order, with the highest dollar amount outstanding listed first.

3. The employee responsible for this function uses all of his or her skills, experience, resources, and knowledge to identify the status of an outstanding claim and take action. Action may include, but is not limited to:

    a. Identifying that the claim was never received and resubmitting the claim;

    b. Submitting medical documentation to third-party insurers if the claim is under review;

    c. Appealing an adverse decision for payment; or

    d. Communicating with the patient if the third-party payer is waiting for information from the patient.

4. If the employee identifies a series of open claims from a specific date-of-claim transmission, the business office manager or designee is alerted to determine if the source of the open claims was a failed batch (i.e., it failed to transmit to third-party insurers). In that case, the affected claims are resubmitted immediately.

5. The employee is expected to follow up on all outstanding claims until payment is received or a determination is made that the claim should be transferred to another party's responsibility or written off.

BUSINESS OFFICE • POLICY 12.31

Write-Offs

It is the policy of the Practice to track and monitor all monies that are written off from the original charge submitted to a third-party payer. Two distinct categories of write-offs are handled and monitored separately: (1) contractual amounts, which are considered uncollectible as a result of a contractual agreement with a third-party insurer, and (2) noncontractual amounts, which are considered uncollectible for reasons other than the contract.

PROCEDURES

1. To track and monitor all write-offs, the Practice maintains a dictionary of detailed adjustment transaction codes for contractual and non-contractual write-offs. The non-contractual write-offs may also be attached with transaction message codes, if applicable.

2. The Practice maintains current fee schedules, by procedure code, for each third-party insurer health plan. As a third-party payment is posted, the assigned Practice employee is responsible for verifying that the payment allowance matches the expected reimbursement according to the procedure code and any applicable modifiers. To assist staff, the practice management system displays the contractual reimbursement for each procedure code posted, based on the agreement with each third-party insurer.

3. If the payment allowance matches the expected reimbursement, the residual money (Practice charge less payment allowance) is written off with the appropriate contractual adjustment code. If the payment does not match the expected reimbursement, the line item is flagged manually or electronically for follow-up (see related policy 12.27 on Claim Denials).

4. From time to time, Practice staff may work on an account that has an outstanding balance with a third-party payer that cannot be collected. The reasons for the Practice's inability to collect on the account may include, but are not limited to: (1) a missed timely filing or appeal deadline, or (2) failure to obtain an appropriate authorization or referral. If this type of write-off is identified, Practice staff must receive approval to write off the account from a supervisor by completing and submitting a Non-Contractual Write-off Request form (see below). The Practice employee processing the account in question also identifies his or her work on the account. The request is sent in a standard format via internal electronic communication or a manual form.

5. The business office manager may decide that Practice staff may write off a specified maximum dollar amount without a supervisor's approval. The amount shall not exceed $100 unless approved by the Administrator or designee.

NON-CONTRACTUAL WRITE-OFF REQUEST

Name: _____

Date: _____

Account #: _____

Date of service: _____

Procedure code and modifiers:_____Diagnosis code(s): _____

Description of reason requesting write-off: _____

_____

Summary of actions taken on the account to date: _____

_____

Supervisor's recommendations:

- Continue to work with these recommended efforts: _____

  _____

- Write-off: _____
- Refer to: _____ [Provider, Administrator, Biller, Coder, Other]

Supervisor's signature: _____ Date: _____

Final action: _____ Date: _____

Name: _____

Notes: _____

_____

_____

BUSINESS OFFICE • POLICY 12.32

Small Balances

It is the policy of the Practice that patient account balances equal to or less than $9.99 will be written off if the account meets certain criteria.

PROCEDURES

1. If the account balance meets all of the following criteria, the account will be written off:
    a. Less than or equal to $9.99;
    b. More than 120 days old from the date it became patient responsibility;
    c. There is no balance from the insurance company; and
    d. There is no violation of a contractual obligation to continue collection. *
2. On a monthly basis, a report will be generated to identify accounts that meet these criteria. The account representative will review the list for appropriate criteria and authorize the monthly write-off. The small balance adjustment will be conducted automatically by the practice management system, as initiated by the business office manager or designee.
3. Though the small balance adjustment is made to the account, when the patient presents for future services, this amount will be collected from the patient at the time of service, with the adjustment reversed and the payment posted to the patient's account.

**It is of note that the Centers for Medicare & Medicaid Services (CMS) defines a "reasonable" collection effort as follows: "Presumption of Noncollectibility: If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."*[17]

[17] "Section 310.2, Chapter 3: Bad Debts, Charity and Courtesy Allowance," in The Provider Reimbursement Manual, Centers for Medicare & Medicaid Services, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html. Accessed July 15, 2015.

BUSINESS OFFICE • POLICY 12.33

Payment Plans

It is the policy of the Practice to offer payment plans to assist patients experiencing financial hardship in paying off outstanding accounts. This may include patients who have an insurance plan with which the practice does not participate, have no health insurance, are unable to pay their account balance in a single payment, or do not qualify for financial hardship according to the Practice's financial hardship policy.

PROCEDURES

1. Practice employees will encourage all patients to pay in full. However, if they are unable to make full payment, a payment plan may be created to pay the outstanding balance over time. Payment plans may be used for outstanding balances or pre-service deposits for procedures, surgeries, or non-covered services.

2. The business office manager or designee will train and assign responsibility to Practice employees to execute payment plans.

3. Payment plans may be established with patients in person or via telephone. If in person, Practice employees will ask patients to agree to a payment plan by acknowledging the agreement with a signature.

4. If the balance is less than $500, it must be paid within three months. If it is greater than $500, it must be paid within six months. The business office manager (or designee) must approve any exceptions to these parameters.

5. Patients who are granted payment plans will be required to participate in a recurring, automated credit or debit card method of payment, such as a credit card on file program. Exceptions to this requirement will be made on a case-by-case basis by a supervisor.

6. Once the business office and the patient have agreed to a payment plan, the particulars will be keyed into the practice management system.

7. Upon establishing a payment plan, a confirmation letter stating the patient's commitment to pay and the particulars of the plan will be generated automatically or manually for the patient. The account will be assigned as a payment plan for tracking and monitoring purposes.

8. Practice employees will follow up on all payment plans every month. A listing of delinquent (more than 30 days since last payment) payment plan accounts will be printed each week.

9. Delinquent accounts are given one month to make up the missed payment. If they fail to meet this schedule, the account is no longer eligible for a payment plan, and is expected to be paid in full. If the account is more than 120 days old, it is eligible for placement with the collection vendor. A standard letter will be sent informing the patient of the change in the account status.

BUSINESS OFFICE • POLICY 12.34

Patient Collections

It is the policy of the Practice that accounts assigned to the responsibility of the patient will receive a series of statements and a final collection notice. Failure to respond will cause the account to be considered for external collection efforts.

PROCEDURES

1. Patients will receive two statements; one is generated on the day that the responsibility is created, followed by a second notice 30 days from that date.

   Thirty days later (60 days following the initial statement), the patient will receive a collection notification from the Practice requesting that the patient make payment or contact the Practice to discuss alternatives within 10 days. The statements will have dunning notices embedded based on statement number, and the collection notification will have an actual due date.

   At the time the collection letter is sent to the patient, a business office employee will alert the billing physician or advanced practice provider to the status of the outstanding balance by communicating the patient's name, outstanding balance, and any applicable notes about the account. The communication is performed through an internal, secure electronic notice.

2. Providers will be requested to provide any guidance about these accounts within 10 days on a standard form that can be electronically transmitted back to the business office. If the provider does not wish the account to be referred to the collection vendor, the account information will be forwarded to the business office manager, who will confer with the provider to determine the appropriate action to be taken. During that 10-day period, if resources allow, telephone calls will be placed to patients urging them to pay or make contact with the Practice.

3. Patient balances will be considered for transfer to an external vendor specializing in collections if the following are applicable:

    a. Patient balance is not paid in full;

    b. Patient balance is outstanding 75 days from date of patient notification of responsibility;

    c. Patient has received two statements and one collection letter;

    d. Patient balance exceeds $9.99; and

    e. Patient has failed to make payments according to the plan to which he or she agreed or to otherwise meet commitments made to Practice employees engaged in collection activities.

4. If a patient balance remains after patient balance follow-up, a minimum of 75 days has passed from the date of posting, and it is determined that the patient balance will not be written off, the account will be turned over to a collection vendor.

5. The account will be sent to the collection vendor or written off using the appropriate adjustment code.

6. Upon physician or advanced practice provider approval, the patient will be notified in writing via certified mail that he or she has been discharged from the Practice, or that process which is recommended by the Practice's malpractice insurance carrier. Appropriate time to find a new provider will be accommodated by the Practice.

7. The patient account will be flagged as bad debt. This flag will be apparent when a patient attempts to schedule an appointment. The patient will be reminded that he or she has been discharged from the Practice and an appointment will not be scheduled until full payment is received. Services will be denied except in the case of an emergency or that which would be considered an abandonment of care.

8. Patient accounts will be turned over to the collection vendor according to the format required by the vendor. If possible, such actions will be automated through an interface between the Practice and the vendor.

COLLECTION LETTER

Dear [Patient Name]:

Your account with this Practice has been unpaid for several months, and we have exhausted all routine attempts to aid you in settling your debt to no avail.

Because of rising business costs and in fairness to our patients who have paid their bills, our accountant will not allow us to carry your unpaid balance any longer.

Therefore, please be advised that if this balance is not paid by [list date], it will be given to [collection vendor] for collection processing. We will allow you 30 days of emergency care while you are seeking another healthcare provider; however, after [list date], you will be terminated as a patient in this Practice.

We sincerely hope that you will contact us at [telephone number] to clear your unpaid bill so that you can maintain good standing with our Practice and your credit rating.

Sincerely,

[Provider name]

PHYSICIAN APPROVAL FORM
ACCOUNT BALANCES TO COLLECTION AGENCY

Date: _____

Patient name: _____

City, State, ZIP: _____

Home phone #: _____ Work phone #: _____

Patient account #:_____

Insurance coverage: _____

Account balance: _____

Efforts made to collect: _____

_____

This patient's account balance has been taken through the standard collection procedure process of the Practice. The patient has not responded to three notices of payment due. A final collection letter was sent to the patient and therefore it is recommended that this account be turned over to a collection vendor for further collection.

Please indicate your approval for disposition of this patient account balance through the collection vendor process. If the business office manager does not receive a response to this correspondence within 10 business days, it is assumed that it is appropriate to send the account to collection and the process is initiated soon thereafter.

Physician: _____ Date: _____

BUSINESS OFFICE • POLICY 12.35

Collection Vendors

It is the policy of the Practice to use external collection efforts for the recovery of bad debt through a collection vendor. The Practice will track and monitor the cost of, activities of, and funds recovered by the collection vendor with which it contracts to work accounts assigned to bad debt status.

PROCEDURES

1. The balance of the account assigned to a collection vendor shall be written off to a collection vendor account code at the time the account is placed with the vendor.

2. Patient accounts in bad debt status will be turned over according to the format required by the collection vendor. If possible, such actions will be totally automated through an interface between the Practice and the vendor.

3. Collection vendors will provide monthly account activity reports that identify all new accounts received, payments on existing accounts, closed accounts, estate status, skip-trace information, and/or litigation status. The information from these reports will be documented, when appropriate, for each patient's account.

4. Collection vendors will forward all payments received on a regular and consistent basis. The payments will be posted immediately and included in the daily deposit.

5. Payments received by the Practice on accounts that have been assigned to a collection vendor will be posted to the patient's account using the payment code for bad debt recovery with a secondary code assigned to the particular vendor who was assigned responsibility for that account.

6. The cost of the collection vendor will be recorded on the Practice's general ledger (GL) as an expense, assigned to the expense account associated with that collection vendor.

7. A monthly collection vendor report will be generated to collectively report all payments received by the Practice for collection accounts. These reports will be forwarded to the appropriate collection vendor(s).

8. The collection vendor may deem an account uncollectible upon completion of judicial collection processes. When this occurs, the vendor will no longer follow up on the account and will report this determination to the Practice.

9. The business office manager will closely monitor fees and recovery rates by agency. Contracts and vendor(s) used will be reevaluated at least annually.

BUSINESS OFFICE • POLICY 12.36

Collection Disputes

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice to handle special circumstances regarding collection disputes with a high degree of professionalism, sensitivity, and timeliness. These special circumstances include minors of divorced parents, adult children, and patients whose accounts have already been turned over to a collection vendor.

PROCEDURES

1. Generally, the employee assigned the responsibility of handling collection disputes should be able to recognize the simplest and most common types of billing disputes and handle them without sending them on to management.

2. After determining the details of a dispute, the employee who receives such a notification refers any dispute in which medical malpractice or a legal threat is charged to the Administrator. The Administrator immediately notifies the medical director of the Practice, who will advise how to proceed.

3. In the event of a dispute related to a minor, charges incurred by minors are the responsibility of the parent or individual who presents the patient for care. If the patient is covered by insurance as part of court order arising from marriage dissolution, the Practice bills the insurer of the court ordered designation. Any remaining patient balance is the responsibility of the party who presented the minor for care.

4. When a minor reaches the age of emancipation according to state law, he or she is emancipated and is considered an adult. Cost of treatment up to that date is the parent's responsibility or that of the person who presented the minor for care. After emancipation, the adult child is responsible.

5. After an account is turned over to a collection vendor, the employees of the Practice no longer make arrangements for payment plans or negotiate any settlement of the account. The patient is directed to contact the assigned collection vendor.

6. If a patient whose account has been sent to a collection vendor calls to pay via telephone or submits payment via the Practice's online bill payment system, the payment is received, the affiliated vendor is notified, and the account is credited for the payment (see related policy 12.34 on Collection Vendors).

BUSINESS OFFICE • POLICY 12.37

Settlements

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice to offer an incentive for patients to settle their accounts. Patients with account balances ready to be assigned to a collection vendor are eligible to receive a discount if their balance is paid in full. The terms of the settlement are based upon specific criteria.

PROCEDURES

1. The Administrator or designee must approve options for discounted settlements. Patients are not offered a settlement option until the account has met the criteria for collection vendor assignment.
2. Accounts must be at least 90 days in arrears to qualify for the settlement option.
3. Accounts with a balance of $9.99 or less are not eligible for the settlement option.
4. The following schedule determines the discount offered:
    a. 10 percent on balances between $10 and $299;
    b. 20 percent on balances between $300 and $499; or
    c. 30 percent on balances over $500.
5. When a settlement is agreed upon, the patient is instructed to submit the payment immediately, but no later than three days. The Practice receives the payment and posts it to the patient's account using the settlement adjustment transaction code to write off the residual balance (e.g., the amount of the discount).
6. The payment is then included in the day's deposit according to the procedures for daily deposits.

BUSINESS OFFICE • POLICY 12.38

Financial Hardship

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice that patients are expected to pay for services rendered. The Practice will assist patients who are residents in the service area to document their inability to meet their financial obligations as a benefit to the community. Patients may be determined as eligible for partial to full discounts using the current poverty guidelines issued by appropriate government agencies.

PROCEDURES

1. Exclusions from this policy are:

    a. Cosmetic or aesthetic services; and

    b. Services rendered to persons who are eligible, but have not applied for, medical insurance or assistance programs sponsored by federal, state, or local government.

2. Financial hardship may be extended to those who qualify for all of these reasons:

    a. The patient is a resident of the Practice's service area;

    b. The patient is not eligible for Medicaid or pending Medicaid approval;

    c. The patient is determined to be unable to pay for services provided;

    d. The patient is unable to accept an installment payment arrangement; and

    e. The patient agrees to make payment at the time the discount is granted.

For patients who identify themselves or are identified by Practice employees to be considered for financial hardship or charity care, employees will obtain information from the patient. Presumptive eligibility can be based on their current status with federal and state agencies. If not applicable, patients will be requested to submit a copy of their last two paycheck stubs; current-year tax return; and, if applicable, unemployment benefits check stubs. The Practice will assist patients as much as possible in completing their information.

3. The business office will determine eligibility for financial hardship or charity care. Discounts on charges will be calculated as follows:

Percentage of state poverty level	Percentage of discount
300	30
200	50
100	75
<100	100

An adjustment code will be assigned to each level of discount.

4. The granting of the discount will be noted in the patient's account. The patient's account status, however, will never be permanently designated as financial hardship. The patient's status will be reviewed on a regular schedule, not to exceed 12 months.

PATIENT FINANCIAL ASSESSMENT FORM PAGE 1

Date: _____ Account #: _____

Patient last name: _____ First name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Alternate phone #: _____

Name of responsible party (if not patient, print name of Guarantor): _____

Patient's employer: _____ Employer phone #: _____

Employer address: _____ City: _____ State: ____ ZIP: _____

Length of employment: _____ If unemployed, last date of employment: _____

Spouse last name: _____ First name: _____

Spouse employer: _____ Employer phone #: _____

Employer address: _____ City: _____ State: ____ ZIP: _____

Length of employment: _____ If unemployed, last date of employment: _____

Total in household (include yourself): Adults (18+) _____ Minors (under 18) _____

Guarantor (responsible party) employer: _____ Phone #: _____

Employer address: _____ City: _____ State: ____ ZIP: _____

Length of employment: _____ If unemployed, last date of employment: _____

Income (monthly)	**Patient**	**Spouse**	**Responsible Party**	**Children Working**
Gross Monthly Salary	$	$	$	$
Public Assistance Benefits	$	$	$	$
Unemployment Benefits	$	$	$	$
Social Security Benefits	$	$	$	$
Workers' Compensation	$	$	$	$
Child Support	$	$	$	$
Other (Alimony, Pension, Life Insurance, Veterans Administration [VA] Benefits, Disability)	$	$	$	$

PATIENT FINANCIAL ASSESSMENT FORM PAGE 2

Totals: $_____ $_____ $_____ $_____

*Total family monthly income: $*_____

Other assistance: _____

Have you applied for Medicaid: Yes No (circle)

If "yes," provide current status or attach denial letter: _____

Have you tried to obtain financial assistance from other organizations? Yes No (circle)

List the organizations and current status:

_____

_____

List all outstanding medical bills:

1. _____
2. _____
3. _____
4. _____
5. _____

Please provide any additional information/comments:

(Attach additional sheet if more space is required, or use the back of this form.)

_____

_____

Financial Documentation: (attach copies)

Previous year 1040 IRS: $_____ Year _____

W-2s: $_____ Year _____

If patient claims income is less than the previous calendar year tax form; attach most recent four pay stubs.

$ _____ Date _____

$ _____ Date _____

$ _____ Date _____

$ _____ Date _____

Other (unemployment, Social Security, disability and workers' compensation): (attach copies)

$ _____

$ _____

PATIENT FINANCIAL ASSESSMENT FORM PAGE 3

	Monthly Payment
Mortgage/rent	$
Gas & electric	$
Telephone	$
Car insurance	$
Food	$
Total monthly expenses this column	$
Total monthly expenses other column	$
Monthly expense grand total	$
Yearly Household Income	
Gross:	$
Net:	$

	Credit Limit	**Balance**	**Monthly Payment**
VISA	$_____	$_____	$_____
MC	$_____	$_____	$_____
AMEX	$_____	$_____	$_____
Discover	$_____	$_____	$_____

Other Expenses (Provide Explanation)

_____ $_____

_____ $_____

_____ $_____

_____ $_____

_____ $_____

Total $_____

PATIENT FINANCIAL ASSESSMENT FORM PAGE 4

** I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to [Practice name] is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges.*

** By signing and submitting this request, I give [Practice name] permission to determine my need for financial assistance, including review of my credit file. I also give permission to [Practice name] to release or disclose this information to [Practice name] for the purpose of evaluating my financial status in response for assistance with my medical charges.*

** I understand that it is my responsibility to advise [Practice name] of any changes in status in regards to my income or assets while this application is in process.*

Signature of patient: _____ Date:_____

Signature of spouse or guarantor: _____ Date:_____

Return this form and supporting documentation within 30 days to the Practice where you received services or mail to [address]. If you have questions, you may call [telephone number].

For Office Use Only

Total wages for calendar year: $ _____

Total household: $ _____

Eligible discount: $ _____

Date completed: _____ By: _____

Notes: _____

_____

Check when completed:

__ Discount screen

__ Patient alert(s)

__ Added to practice management system

Name/Phone #: _____

BUSINESS OFFICE • POLICY 12.39

Bankruptcy

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state, city and county may differ, and this suggested general policy should not be implemented without considering applicable state and local law.*

It is the policy of the Practice to process all accounts impacted by bankruptcy in a timely and consistent manner. Bankruptcy impacts the Practice's collection activities regarding insurance accounts or patient accounts. A company or person filing bankruptcy has little or no assets, and an unsecured creditor often receives no money.

PROCEDURES

1. The Practice abides by state and federal laws governing companies and individuals who have declared bankruptcy.

2. If bankruptcy is declared by the court on behalf of a patient, the Practice files a claim as a creditor within one week after receiving written notification of the bankruptcy of a guarantor. The claim is filed in accordance with the protocols established by the court. All collection efforts are halted upon receipt of the written notification.

3. In the case of an insurance company bankruptcy, the Practice notifies its local and state medical societies to determine if any options to pursue collections in the future remain. The Practice acts upon their advice.

4. Collection efforts ensue until such time as the Practice receives an official, written notice about the bankruptcy from the court of authorized authority. If the patient or company verbally indicates that the patient or company has filed bankruptcy, but notification has not been received, the Practice continues to pursue collection efforts. If the court fails to grant the company or individual declaring the bankruptcy (i.e., the debtor) a discharge, and provides an official notification of such, the Practice continues to pursue its collection efforts.

5. Upon receipt of bankruptcy notification from the representative court, the account balance is written off to a bankruptcy adjustment transaction code.

6. If the account was previously submitted to an external collection vendor, the vendor is notified of the bankruptcy and copies of the official documents are submitted.

7. In the case of an insurer declaring bankruptcy, the business office manager or designee generates a report to identify all pending claims. Outstanding monies on the claims are written off to a bankruptcy adjustment transaction code and marked with a sub-code to identify the specific circumstance for tracking purposes.

8. The patient's account is identified as a bankruptcy account so future financial arrangements can be determined based on the patient's financial history.

9. No further contact is to be made with the patient or guarantor for the dates of service included in the bankruptcy filing. Communication regarding subsequent balances may be addressed by employees.

BUSINESS OFFICE • POLICY 12.40

Estates

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without considering applicable state law.*

It is the policy of the Practice to handle the accounts of deceased patients in a consistent manner.

PROCEDURES

1. The Practice attempts to proactively identify any patients who pass away. If the Practice cannot proactively identify deceased patients, Practice employees make all attempts to identify deceased patients (e.g., through a collection call) during normal business operations.
2. Evidence of a deceased patient includes, but is not limited to:
    a. Newspaper reports;
    b. Death certificates;
    c. Health information exchange;
    d. Affiliated hospital or other facilities; or
    e. Reports from other medical authorities.
3. Accounts are marked to identify a deceased patient.
4. A report is generated for employees responsible for collections.

5. Practice employees responsible for collections review the patient's account to determine if an opportunity to pursue collections from an estate or surviving family member exists. If so, the Practice follows state regulations regarding a deceased person's probate of estate. Unless otherwise prohibited by state regulations, the Practice contacts any relative and/or the executor or the attorney. The Practice obtains necessary information and files a probate form with the appropriate court. Notably, the Practice pursues this action in a timely manner and in accordance with all applicable laws, as the executor of the estate is prohibited by law from paying a late or improperly filed claim, no matter how valid the debt. The appropriate court rules on the validity of the debt. Payment is made at the time the estate is settled.

6. After unsuccessful attempts to collect the account through normal collection processes of the Practice, the account balance of deceased patients is written off to an estate adjustment transaction code to identify that the cause of the write-off was a deceased patient without adequate estate funds.

BUSINESS OFFICE • POLICY 12.41

Bad Addresses

It is the policy of the Practice to promptly address all mail returned because of a "bad address." The Practice makes all reasonable attempts to obtain the correct mailing information.

PROCEDURES

1. The Practice confirms a patient's address during registration at every visit in an effort to maintain current and correct demographic information.

2. The Practice utilizes the services available from the U.S. Postal Service, to include the "Address Service Requested" notification system. A notification of a forwarding address supplied by the USPS is logged into the patient's account within 24 hours of receipt, and a statement to the new address is immediately generated.

3. Practice employees request to scan a patient's driver's license upon registration or change of demographic information. The image is indexed in the appropriate section of the patient's electronic health record (EHR).

4. Upon notification of a bad address, the account is marked to suspend statements until the account is corrected.

5. An employee verifies the patient's demographic information contained in the practice management system and/or EHR system. Verification includes a review of the scanned image of the license. If accessible, a Practice employee queries the registration database(s) of the hospital and other facilities, insurers, and any other source of demographic information available.

6. If no other information is available, an employee calls all of the patient's phone numbers, starting with any cell phone number(s) listed.

7. If the patient cannot be reached or the telephone numbers are non-working, the emergency contact listed is contacted in an attempt to secure a current address. The employee does not reveal any attempt to collect payment, but rather he or she indicates that the Practice needs a current address for its records.

8. If these efforts fail, the Practice uses Internet-based address search services.

9. If all efforts to secure a current address fail, the account is referred to a collection vendor for pursuit of the balance. Upon transferring the balance to the vendor and may be written off using a collection agency adjustment transaction code. The account is marked with a sub-code that designates the bad address, and the notes include a description of the situation (see related policy 12.34 on Collection Agencies).

10. Accounts with inaccurate contact information are flagged with an appropriate message to ensure that no further correspondence is sent and the issue is immediately apparent if the patient attempts to schedule an appointment.

11. Subsequent appointments are not scheduled for a patient with a bad address on record until the incorrect information is updated and any balance on the patient's account is paid.

BUSINESS OFFICE • POLICY 12.42

Nonsufficient Funds

It is the policy of the Practice that any patient who has written a check(s) that is returned because of nonsufficient funds (NSF) is immediately contacted and aggressive efforts are made to collect the funds.

PROCEDURES

1. The Practice attempts to eliminate or reduce NSF checks through the use of an automatic check verification and remote deposit process.

2. The Practice notifies patients in writing of a $35 returned check fee that is applied for every NSF check. The fee is evaluated on an annual basis, and may be changed by the board of directors.

3. The NSF check fee of $35 is posted to the patient's account with an appropriate charge code to indicate NSF fee.

4. If the NSF check was posted as a payment on the patient's account, the payment is reversed to create a balance equal to the amount due. The employee making the reversal uses appropriate adjustment codes and documents a summary of the problem in the patient's account notes.

5 When the Practice receives an NSF notification, a Practice employee immediately contacts the responsible party. The employee informs the person who wrote the NSF check, and requests that he or she provide a credit card on the telephone or via online bill payment. Alternatively, the patient is requested to bring cash for the original amount of the check and the $35 returned check fee to the Practice as soon as possible.

6. After 30 days, if payment is still not received, a certified letter with return receipt requested is sent to the patient informing the patient that the balance will be transferred to a collection vendor within 15 days. A due date is provided to the patient in the letter.

7. The balance is transferred to the collection vendor in accordance with the Practice's policy and procedure for Collection Accounts.

8. If a responsible party who has provided an NSF check returns to the Practice, his or her personal checks are no longer accepted by the Practice.

BUSINESS OFFICE • POLICY 12.43

Court Time and Deposition Billing

Consistent with policy 5.12 *Subpeona Duces Tecum*, it is the policy of the Practice that attorneys are billed for a physician's time as needed in court-related issues. The accounting for this service is maintained in the general ledger accounting system and monitored and controlled by the Administrator or designee.

The Practice takes the following steps when an attorney requests a physician's time.

PROCEDURES

1. When the Practice receives a call from an attorney:

    a. A clinical assistant schedules the review of medical records or the physician/attorney deposition.

    b. The clinical assistant notifies the attorney of the fees, to include the minimum fee and hourly rate, and the Practice's prepayment policy and cancellation policy. In the event that the attorney needs to cancel the physician's time, 48 business hours are required in order to receive a refund. There are no exceptions unless authorized by the physician.

    c. The clinical assistant tells the business office who to bill (including name, address, how much should be billed, type of service, and date of meeting with the attorney).

2. The Practice maintains a minimum fee of $500 for legal work. An hourly rate for legal work is established by the board of directors and reviewed for currency each year.

3. The business office invoices the attorney $500 and collects the minimum fee due prior to the physician's meeting with the attorney.

4. The business office notifies the clinical assistant when the fee is received or if the attorney missed the deadline, which is two weeks prior to the requested date of service.

    a. If the attorney has missed the deadline, the clinical assistant may ask the attorney to overnight a check to the business office or may cancel the appointment.

    b. Either way, the clinical assistant notifies the business office of the decision.

5. If the attorney cancels within the policy time frame, the clinical assistant completes a check request to refund the money to the attorney. Information related to the cancellation and refund is documented.

6. The business office forwards all monies to the accounting department. Accounting posts the monies collected to "other" income on the income statement and tracks the receipts by physician.

7. Questions regarding the interaction between this policy and policy 5.12 regarding responses to subpoenas shall be directed to the Administrator for consultation with legal counsel, as needed.

CHAPTER 13

Disaster Planning

POLICY 13.01 • Disaster Preparation

POLICY 13.02 • Disaster Warning

POLICY 13.03 • Bombs and Arson Threats

POLICY 13.04 • Post-Disaster Protocols

DISASTER PLANNING • POLICY 13.01

Disaster Preparation

It is the policy of the Practice to assume that all threats made to the safety of its employees, patients, facility and other resources are to be taken seriously. All hostile actions of a violent or hurtful nature or any action that represents an intention to harm or damage the Practice or a specific person employed, contracted or physically located at the Practice, are to be considered genuine threats until proven otherwise.

PROCEDURES

1. General preparation

    a. The Practice adheres to all local warnings and advisories during a natural disaster. If evacuation orders are issued, physicians, advanced practice providers and employees will immediate evacuate everyone in the office.

    b. The Practice will designate an emergency exit route and establish an evacuation and protection plan for patients who may be in the office when the disaster (e.g., tornado) strikes.

        1) Perform a disaster drill at least once per annum.

        2) Train all providers and employees about the disaster plan during new employee orientation with periodic updates during staff meetings and when responsibilities or policies change.

        3) Actively participate with any community disaster preparedness exercise.

    c. The Practice will maintain insurance coverage adequate to maintain or replace the Practice's facilities, assets, and ongoing business operations.

        1) Maintain business interruption insurance.

2) Conduct an annual review of all insurance policies and send a report to the board of directors.

d. The Practice will establish protocols for the Administrator or designee to query a report of patients scheduled for visits from an off-site location from its practice management system.

1) The Administrator or designee prepares a list of patients with scheduled appointments, surgeries, procedures, obstetrical deliveries, and any other services that are planned for patients of the Practice.

2) If time allows, the Administrator or designee assigns responsibility to an employee to contact affected patients to reschedule their appointments and/or give them instructions on shelters and hospital procedures. The Practice transmits a secure electronic message to all affected patients who are registered on the Practice's patient portal. (This does not, however, replace the phone call.)

3) The Administrator or designee provides a copy of the list of patients to all providers and, as appropriate, employees. The list is transmitted through the Practice's internal electronic communications that are encrypted and secure.

4) If time does not allow an advanced notification, the Administrator, after conferring with the providers, decides on the instructions to be provided to all patients.

e. Maintain flashlights and batteries, first-aid supplies, fire extinguishers and any other supplies or equipment recommended for businesses in the local area based on potential natural disasters, and store them in designated areas.

1) Notify all providers and employees and provide periodic training on the location of these items.

f. Establish and maintain a current contact list for bank, insurance, maintenance, telephone repair, computer, water, electric, and emergency services. Save the list to the Practice's intranet that is available remotely.

g. Establish and maintain a current contact list of physicians, advanced practice providers and employees that includes cell phone numbers, e-mail addresses, street addresses, and emergency contact information. Save the list to the Practice's intranet.

h. Organize a notification system for physicians, advanced practice providers and employees in the event that telephone and e-mail communication are disrupted. Base the system on physical location (e.g., home address and/or ZIP code) as well as an alternative communication system.

i. Designate an alternative location at which employees are instructed to meet following the disaster in the event that the Practice's facility is lost during the disaster. Inform all employees and providers of the location.

j. The Practice may purchase and maintain a satellite telephone in the event of all communications being disrupted.

k. The Administrator or designee is responsible for updating employees and providers on the status of the office, where to report, and when the practice will resume operations.

2. Imminent disaster

a. When a natural disaster watch is posted for the area, or if a disaster is reported that may impact the Practice, its facilities, or personnel, preparations begin immediately for securing the Practice.

b. With adequate notice in the event of a hurricane, tornado, or other weather with high winds expected, the Administrator or designee contacts maintenance staff to install shutters on the exterior of the building (in the event of a hurricane or tornado) and/or make other preparations for the building and furnishings.

c. If high winds are expected, computers and equipment are moved away from the windows and up off the floor. People are moved away from any windows and external doors.

d. In the event of an imminent disaster, the Administrator or designee provides instructions to prepare the inside of the building for flooding and storm damage.

1) Move all medications and injectables to a secure location and maintain proper temperature.

2) Clean out refrigerators and remove all foods that could spoil.

3) Stock up ice and ice packs.

4) Make sure supplies of water, nonperishables, and waterless hand cleansers are adequate.

5) Distribute clean scrubs for on-call providers.

e. If time permits, the Administrator or designee prepares month-end and payroll reports, backs up all systems, and secures all important paperwork or other perishable business data in watertight, fireproof containers.

f. The Administrator or designee secures the server room and the phone room.

g. If patients are in the office during a disaster, physicians, advanced practice providers and employees will provide comfort and ensure patients are not in distress. Vital signs such as blood pressure and heart rate will be monitored by clinical personnel, with instructions and management provided by the medical director or designee.

h. As soon as a disaster is imminent or has occurred without warning, the Administrator or designee performs the following:

1) Contacts the bank and has enough cash on hand to conduct business for 7 to 10 days;

2) Notifies key vendors (e.g., medical supply vendor), highlighting the need for potential imminent replenishment of products or services;

3) Communicates with the Practice's insurance agent;

4) Calls the answering service and gives alternate numbers and/or make arrangements with the hospital operator for on-call or emergency patient needs; and

5) Contacts the media to keep the public informed as to the status of the Practice, including the operating hours and, if necessary, the alternate location.

3. Disaster Preparation Checklist

a. Complete the Disaster Preparation Checklist to ensure all preparations have been made (see below).

DISASTER PREPARATION CHECKLIST

In the event of an impending disaster, the Practice uses this checklist to assure that all preparations are made.

_____ Contact list is updated and distributed.

_____ Alternate communication plan is established and details distributed.

_____ Arrangements for after-hours coverage are set.

_____ The media is contacted regarding the status of the Practice, if applicable.

_____ Patients with scheduled services are contacted. Affected patients are rescheduled. All patients who are registered with the Practice's patient portal are sent a custom message, reminding them of their cancelled appointment and to reschedule. Information is provided about shelters and patient instructions.

_____ A notification is posted on the Practice's patient portal. Depending on the circumstances, a secure, electronic notification is transmitted to all patients via the portal.

_____ Batteries, flashlights and all other necessary supplies are ready.

_____ Cell phones are charged and spare, charged battery packs are available for essential equipment.

_____ Computers and other equipment are moved away from the windows. Personnel are instructed to move to the interior of the facility.

_____ Exterior of the building is prepped and ready.

_____ Storm shutters are installed, if applicable.

_____ Ice and cold packs are located on site.

_____ Perishables and medications are contained.

_____ Water, canned goods, and waterless hand cleaner supplies are obtained.

_____ Fire extinguishers and first-aid supplies are ready.

_____ Scrubs are located on site for on-call providers.

_____ Arrangements are made with the bank for cash and deposits.

_____ Contact is made with the Practice's insurance agent.

_____ Vital information on paper is collected and put in watertight, fireproof containers.

_____ Server room and phone room are secured and protected.

_____ Other:

_____

_____

_____

DISASTER PLANNING • POLICY 13.03

Disaster Warning

It is the policy of the Practice to be prepared for a disaster. When the National Weather Service posts a warning about an impending natural disaster, or the Practice confirms the approach of a disaster, the Practice will be secured and closed.

PROCEDURES

1. Complete storm preparations within a minimum of 12 hours after a disaster warning is posted for the Practice's local area. Closely monitor the news and weather for updates, if applicable.

2. Collect the list of emergency contacts for bank, insurance, maintenance, telephone repair, computer, water, electric, security, and emergency services. Provide copies of this list to the Administrator, supervisors, and providers. Save the list to the Practice's intranet.

3. Unplug and cover computers and other medical equipment.

4. Raise computers and other medical equipment off the floor and move them away from the windows.

5. Set refrigerators and freezers to their coldest settings.

6. Put medications and injectables in cold storage or watertight containers.

7. Put vital information in secure locations. Copy or scan important documents if time permits.

8. Cancel patient appointments for the working days anticipated to be impacted by the disaster by calling patients as well as transmitting secure electronic messages. Post a message on the patient portal regarding the impact.

9. Lock cash in the safe and raise the safe off the floor.

10. Have the Administrator or designee and providers keep call schedules and patient schedules (including contact information) with them until such time the Practice is fully operational.

11. Inventory medications and injectables in coolers for security purposes. (The Administrator and nursing supervisor maintain the inventory.)

12. Prepare the latest payroll hours report.

13. Make the final bank deposit as soon as possible.

14. Provide the names and contact information of on-call providers to the hospital.

15. Have on-call providers report to the hospital (depending on hospital policy).

16. Complete the Disaster Warning Checklist to ensure all preparations have been made (see next page).

17. Put vital documents that are paper-based in a waterproof container. Refer to the Checklist for Vital Information Storage (see next page).

DISASTER WARNING CHECKLIST

_____ Computers and other medical equipment are unplugged, raised, covered, and moved away from windows.

_____ Refrigerators and freezers are set to the coldest setting.

_____ Medications and injectables are inventoried and secured.

_____ Vital information are secured. Checklist is put into a container.

_____ Final deposit is made to the bank.

_____ Visual walk-through and lockup are completed.

_____ Medical staff services are notified of providers on call through the disaster.

_____ On-call providers report to the hospital according to the hospital policy.

_____ Telephones are turned over to the answering service before leaving the building.

_____ Internal communication plans are finalized, depending on the disaster's arrival and end.

_____ A list of emergency contacts is completed and saved on the Practice's intranet for bank, insurance, maintenance, telephone repair, computer, water, electric, and emergency services.

_____ A notification to patient is posted on the Practice's patient portal.

_____ Other: _____

CHECKLIST FOR VITAL INFORMATION STORAGE

_____ Monthly, quarterly, and annual reports

_____ Titles, deeds, and licenses for all properties

_____ Insurance agreements

_____ Telephone lists and emergency contacts

_____ Accounts receivable report

_____ Checkbook and deposit tickets

_____ Appointment lists

_____ Payroll reports

_____ Checks and accounts receivable not yet posted

_____ Employee documents

_____ Petty cash

_____ Equipment log with model numbers, serial numbers, purchase date and purchase price

_____ Video of office walk through

_____ Other: _____

DISASTER PLANNING • POLICY 13.03

Bomb and Arson Threats

It is the policy of the Practice to assume that all threats made to the safety of its employees, patients, facility and other resources are to be taken seriously. All hostile actions of a violent or hurtful nature or any action that represents an intention to harm or damage the Practice or a specific person employed, contracted or physically located at the Practice, are to be considered genuine threats until proven otherwise.

PROCEDURES

1. All threats, including bombs, arson or other hostile action, that would adversely affect the employees, patients, or facilities of the Practice are to be taken seriously and reported to local law enforcement authorities immediately.

2. If the threat is made by telephone, the individual receiving the call should remain calm, speak courteously, request the caller's identity and, if applicable, the location of the threat (for example, bomb), and note any details provided. (See Scenario Tool for Threat below).

3. The individual receiving the threat should not hang up or put the caller making the treat on hold; instead, they should get the attention of another employee(s) who can alert local law enforcement authorities and the Practice's manager or designee.

4. If applicable, the caller's threat is recorded in writing or via recording device.

5. When the Practice receives a bomb threat, the practice manager and/or safety officer on duty is notified immediately, and the Practice's evacuation plan is initiated for employees and patients to depart the building safely. If applicable, a building manager is notified so that a response and evacuation plan for the facility (including other tenants) may be initiated.

6. If the Practice receives a written threat, employees will retain all materials related to the threat. These materials are to be handled by as few employees as possible to preserve them for local authorities.

7. Orientation and annual safety training provided to the employees will include education on how to handle callers who threaten the Practice or specific persons with a hostile action.

8. If an object is found that could be a bomb or other type of device intended to cause harm on the property of the Practice, local law enforcement authorities are to be notified immediately. Employees shall make no attempt to move the suspicious object or tamper with it in any way.

SCENARIO TOOL FOR THREAT

The employee receiving a threat—whether by telephone, text, email or other electronic media, or in person—should remain calm, speak courteously and try to obtain the following information from the person making the threat. If the threat is made by telephone, the employee should make notes that will help describe the caller's voice and possible background noises to local law enforcement authorities.

1. What to ask when receiving a threat related to a bomb or other explosive device:**
   - When is the bomb going to explode?
   - Where is the bomb (floor, area, etc.)?
   - What does the bomb look like?
   - What kind of bomb is it?
   - What will cause the bomb to explode?
   - Where are you calling from?
   - What is your name?

**If possible, ask another person to monitor the call; ask the caller to repeat the original message (it may invoke the caller to provide more details).

2. When receiving a threat by telephone, listen carefully to note your impressions of the caller. These include:
   a. The caller's voice:
      - Gender: Male or female or unknown?
      - Tone: Calm, nervous, agitated?
      - Age: Young, adult, elderly?
      - Speech: Unusual words, phrases or pronunciations?
   b. Background sounds:
      - Traffic, music, other voices, machinery, other sounds?
   c. Other information to note:
      - Did the caller seem to be familiar with the facility and/or the staff (names, locations, etc.)?
      - What line did the call come in on?
      - Did the voice sound familiar?

DISASTER PLANNING • POLICY 13.04

Post-Disaster Protocols

It is the policy of the Practice to access the facility and determine the safety and security of the building before allowing staff to return to work. When the safety and security are determined, the Practice takes measures to resume normal office hours for patient care.

PROCEDURES

1. After the disaster passes and emergency management has deemed it safe to travel on local roads, the Administrator evaluates the office to determine the extent of damage and if the building is safe to enter. Video tape a walkthrough to record any damage.

2. If power has been restored and the building is deemed safe, the Post-Disaster Checklist (see next page) is used to determine if the Practice can return to normal office hours.

3. The communication policy is executed to inform providers and employees when and where to report for work.

4. If the building has no power or water, the Administrator evaluates whether emergency patients can be treated on site.

5. If the office has sustained damage and cannot open, the Administrator follows the proper procedures to document damage based on insurance company policy and protocols.

    a. The Administrator determines if alternate office space can be obtained and whether patients can be treated there.

    b. On-call providers remain at the local hospital to evaluate and treat patients.

6. Depending on the nature and impact of the disaster, the Practice offers counseling options to physicians, advanced practice providers, employees and/or patients.

7. An update on the status of the Practice is posted on the Practice's patient portal. As applicable, individual patients are also contacted personally.

POST-DISASTER CHECKLIST

_____ Inspect the building exterior for downed power lines and tree limbs, roof damage, and broken windows.

_____ Enter the building from the rear and check for power. If the power is off, use flashlights for safety until panels can be removed.

_____ Inspect the office for interior damage, such as water, broken ceiling tiles, and broken glass.

_____ If the building has power, turn the lights on and check that the telephones are working properly.

_____ Contact the information technology vendor to bring the server back up.

_____ When the server is restored, slowly start computers and run diagnostic tests.

_____ Contact the answering service and/or hospital operator to update information for patients who are calling.

_____ Notify scheduled patients by telephone of operating conditions, including whether the office is open or closed and where they should go for care.

_____ Post a notification on the Practice's patient portal.

_____ Contact the water company to determine whether a "boil water" order is in effect.

_____ Contact supervisors and other management team members to update them on the building status. Inform employees when to report to work and how to dress.

_____ If damage has been sustained, document the damage with photos. Contact the insurance company and obtain the claim number and instructions for becoming operational.

_____ Begin an inventory log of damaged equipment and furnishings. Contact suppliers to check availability of items to be replaced.

_____ Check medications and injectables to ensure that proper temperatures were maintained. (If not, dispose of the medications and injectables as appropriate.)

_____ Take the bank deposit to the bank as soon as possible.

_____ Reactivate the alarm system as soon as possible.

_____ Call the hospital to determine if patient care areas are open and back to normal. If not, determine where to care for patients.

CHAPTER 14

Exposure Control

Alert: *The policies in this chapter are suggested policies for educational and illustrative purposes only. The particular laws of each state may differ, and these suggested general policies should not be implemented without considering applicable state law.*

Note: *The Bloodborne Pathogens Exposure Control Plan includes policies 14.01 through 14.07.*

POLICY 14.01 • Bloodborne Pathogens Exposure Control Plan

POLICY 14.02 • Universal and Standard Precautions

POLICY 14.03 • Work Practice Controls

POLICY 14.04 • Personal Protective Equipment

POLICY 14.05 • Hand Hygiene

POLICY 14.06 • Cleaning, Decontamination, and Disposal of Waste

POLICY 14.07 • Sharps and Needlesticks

POLICY 14.08 • Hazard Communication Program

POLICY 14.09 • Tuberculosis (TB) Exposure Control Plan

POLICY 14.10 • Tuberculosis (TB) Communication and Training

POLICY 14.11 • Tuberculosis (TB) Reporting

EXPOSURE CONTROL • POLICY 14.01

Bloodborne Pathogens Exposure Control Plan

It is the policy of the Practice to adopt an exposure control plan to assist in complying with the Occupational Safety and Health Administration (OSHA) regulations on bloodborne pathogens. It is used in conjunction with the complete standard, Title 29 Code of Federal Regulations, 1910.1030,[18][19] or its state OSHA plan equivalent.

The intent of this policy is to provide guidance to the Practice in meeting two goals:

- To protect employees from occupational exposure to bloodborne pathogens and other potentially infectious materials; and
- To protect patients from accidental exposure to blood and other potentially infectious materials.

[18] United States Department of Labor. Occupational Safety and Health Administration. Title 29 Code of Federal Regulations, 1910.1030 Bloodborne pathogens. Available at: www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051. Accessed January 30, 2016.

[19] United States Department of Labor. Occupational Safety and Health Administration. *Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard Communications Standards*. Available at: www.osha.gov/Publications/osha3186.html. Accessed January 30, 2016.

PROCEDURES

The Practice protects its employees by performing the following procedures.

Administrator

The Practice identifies an Administrator of the Bloodborne Pathogens Exposure Control Plan (ECP).

The ECP Administrator is:

Name: _____

Contact: _____

The Practice identifies which office procedures involve risk of exposure to biohazardous materials. The primary material is human blood, but the full list of fluids listed by OSHA also includes semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between fluids.

JOB CLASSIFICATION AND EXPOSURE DETERMINATION

The Practice identifies which job classifications and employees are responsible for performing the at-risk procedures. See the Employee Exposure Determination form below.

EMPLOYEE EXPOSURE DETERMINATION

The following is a list of all job classifications at our establishment in which all employees have occupational exposure:

Job Title	**Department/Location**
(Example: Phlebotomists)	(Clinical Lab)
(Use as many lines as necessary.)	

_____

_____

The following is a list of job classifications in which some employees at our establishment have occupational exposure. Included is a list of tasks and procedures, or groups of closely related tasks and procedures, in which occupational exposure may occur for these individuals:

Example:

Job Title	**Department/Location**	**Task/Procedure**
Housekeeper	Environmental Services	Handling Regulated Waste
(Use as many lines as necessary.)		

_____

_____

Note: Full-time, part-time, per diem, temporary and contract employees are covered by the bloodborne pathogens standard. This ECP describes how the standard will be met for these employees.

Communication of Hazards

The Practice provides appropriate labels and signs identifying biohazardous materials, storage areas, and shipping containers.

ECP Annual Review and Documentation

All employees involved in at-risk activities, including physicians, advanced practice providers and full-time, part-time, per-diem, temporary or contract employees, are trained initially and (if permanent) offered annual training in the protection from bloodborne pathogens.

Solicitation of Input from Non-Managerial Employees

The Practice solicits documented input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps.

The Practice creates a safe and healthful working environment. The Practice observes universal/standard precautions and other methods of compliance to prevent contact with blood or other potentially infectious materials and always treats such materials as if they were all infectious for human immunodeficiency virus (HIV) and hepatitis B virus (HBV).

Annual Review and Update

The Practice provides engineering controls and work practices to reduce exposure risk, such as hand hygiene facilities, sharps disposal containers, self-sheathing needles, and safer medical devices, such as sharps with engineered injury protections and needleless systems. The Practice documents these efforts at least annually in the Engineering Controls form (see below).

Safer Medical Devices

The Practice annually evaluates and implements commercially available appropriate and effective safer medical devices designed to eliminate or minimize occupational exposure. The Practice documents these efforts (see policy 14.07).

Personal Protective Equipment

The Practice identifies and supplies employees with appropriate personal protective equipment (PPE), such as gloves, masks, gowns, and face protection. See policy 14.04.

Housekeeping

The Practice develops written cleaning procedures and schedules for regular cleaning and decontaminating work areas (see policy 14.06). The Practice properly collects, handles, and disposes of all biohazardous waste in accordance with existing OSHA, U.S. Department of Transportation (DOT), and state and local laws. The Practice uses biohazard warning labels and signs. A written schedule for cleaning is available, outlining the method of cleaning or decontamination to be used in each situation. A copy of this schedule is also incorporated into this Bloodborne Pathogens Exposure Control Plan.

HBV Immunization

The Practice offers free vaccination for hepatitis B to all current and new employees who perform at-risk tasks. Those who decline vaccination are required to sign a declination form (see below).

Post-Exposure Prophylaxis

The Practice provides post-exposure evaluation and follow-up to all employees exposed to potentially biohazardous materials.

Recordkeeping

- The Practice establishes a medical record for each employee having an occupational exposure incident. The Practice maintains this record for 30 years past the last date of employment, or that which is required by state law. The Practice keeps the record confidential and separate from other personnel records. The Practice maintains the record. The record contains:
  a. Employee full name;
  b. Social Security number;
  c. Hepatitis B vaccination status, including dates of vaccination and the written opinion of the healthcare professional regarding the vaccination;
  d. Documentation of any occupational exposure incident, including results of any testing following the incident, as required by the state;
  e. The written post-exposure evaluation opinion of the healthcare professional concerning an occupational exposure incident; and
  f. Documentation of any information provided to the healthcare professional regarding an occupational exposure incident.
- The Practice keeps complete written records of all compliance activities requiring documentation.
- The Practice develops a written plan for specific evaluation and follow-up procedures to be used when an exposure incident involving bloodborne pathogens has occurred with an employee.
- The Practice establishes a training record to document each training session conducted at the Practice and retains that record for a period of three years (see below). The record includes:
  a. Trainer's name and qualifications;
  b. Date(s) of training;
  c. Contents or a summary of the training; and

d. Names and job titles of all persons attending the training sessions. The Practice provides employees with potential exposure training on bloodborne pathogens 1) upon hire; 2) whenever a change of procedure or assignments results in a new potential for exposure to infectious body fluids; and 3) annually thereafter.

Evaluation of Exposure Incidents

The Practice establishes a process to gather information and report accidents and/or incidents to the ECP Administrator that occur in and/or around the Practice facility.

a. Anyone witnessing an accident or incident should immediately report it to the ECP Administrator.

b. The witness completes an accident/incident investigation report.

c. The ECP Administrator reviews the completed accident/incident investigation report and prepares the Occupational Exposure Evaluation Form (see below).

d. The ECP Administrator determines, as appropriate and guided by this and related policies, to report the incident to an external agency.

e. If the ECP Administrator determines it appropriate, the report is presented no later than at the next board meeting to determine the necessary follow-up with the party or parties involved.

f. The ECP Administrator determines and implements improved processes to prevent the accident/incident from reoccurring.

ENGINEERING CONTROLS PAGE 1

The following engineering controls are present at the sites noted at this Practice and are in use as of the recorded date. These controls are inspected and maintained on a:

___ weekly ___ bi-weekly ___ monthly ___ other_____ basis.

The inspector for the Practice is: _____

_____ (full name).

Hand hygiene facilities are available at the following locations:

_____

_____

_____

_____

Where hand hygiene facilities are not available, antiseptic hand cleanser and clean towels or towelettes are available at the following locations:

_____

_____

_____

_____

Date: _____

Mechanical pipettes are available and in use at this Practice, where necessary. Mouth pipetting or suctioning is prohibited.

Date: _____

Safer medical devices are evaluated at the Practice on an ongoing basis as new products become available, with records of such evaluations maintained in the Practice at the following location: _____. Consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure are performed and documented, at minimum, annually. This documentation is available from our ECP Administrator.

Date: _____

ENGINEERING CONTROLS PAGE 2

Regulated (biohazardous) waste of the following types is generated by the activities at this Practice:

- Any item containing blood or potentially infectious materials
- Any item soiled with blood or potentially infectious materials
- Bandages, gauze
- Paper towelettes
- Patient specimens
- Swabs
- Thermometers/covers
- Tongue depressors
- Used gloves
- Used sharps
- Other: _____

In accordance with state law, this waste is kept in red color-coded and/or biohazard-labeled closed containers that can contain all contents during handling, storage, and transport without leaking. Disposal is as follows:

_____

_____

_____

_____

_____

_____

Types of container(s) in use:

_____

_____

_____

Date: _____

ENGINEERING CONTROLS PAGE 3

Sharps containers that are leak-resistant, puncture-resistant, red color-coded, and marked with appropriate labels are available at the following locations:

_____

_____

_____

Types of container(s) in use:

_____

_____

_____

All containers for reusable sharps in use at this location are designed to be emptied without risk to the person emptying them.

Date: _____

Specimens of blood or other potentially infectious materials are kept in leak-resistant containers during collection, handling, and storage. Types of container(s) in use:

_____

_____

_____

When packages that contain specimens of blood or other potentially infectious materials are shipped, a biohazard label is attached to the outside of the package.

If a secondary outer container is necessary to protect against leakage, such a container is also appropriately biohazard-labeled.

Date: _____

Other engineering controls listed below are in use at this Practice (e.g., hoods for specimen preparation, needle guards, etc.):

_____

_____

_____

HEPATITIS B VACCINATION DECLINATION FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee name: _____

Employee signature: _____

Witness signature: _____

Date: _____

OCCUPATIONAL EXPOSURE EVALUATION FORM
CONFIDENTIAL PAGE 1

Name: _____ Date of birth: _____

Employee #: _____ Department: _____

Job title: _____ Work phone: _____ Home phone: _____

INCIDENT

Date and time of exposure: _____ Location: _____

Date and time reported: _____

Description of incident, including where and how the exposure occurred, exposure site(s) on employee's body. If related to sharp device, list the type and brand of device: _____

_____

Details of the Exposure

Check which of the following type of fluid or material were involved in the incident:

_____Blood _____Pericardial fluid _____ Cerebrospinal fluid _____ Amniotic fluid _____ Semen

_____Pleural fluid _____ Synovial fluid _____ Vaginal secretions _____Peritoneal fluid _____ Other

(If other, please explain in detail) _____

_____

_____

If any of the above substances are checked, provide information on the amount of fluid or material and the severity of the exposure below.

_____

_____

_____

Was exposure site washed or flushed? Yes: _____ No: _____

Document the post-exposure management, counseling, and follow-up. (Please elaborate, including dates, times, and persons involved.)

_____

_____

_____

_____

_____

_____

_____

_____

Information about the Source of the Exposure

Did the source material contain human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV)? (If yes, please provide detail.)

If the source patient is HIV infected, what is the stage of the disease, CD4 cell count, HIV viral load, history of antiretroviral therapy, and antiretroviral resistance information? (Please elaborate.)

_____

_____

_____

_____

_____

_____

Signature of individual preparing this form: _____ Date: _____

The form is to report and document the occupational exposure. The employee should also be treated according to the injury he or she sustained and the advice of his or her physician. The employee with the occupational exposure and, if applicable, the exposure source patient, should be evaluated by a physician. Under a physician's care, the employee should be tested and treated in accordance with his or her injury. All testing and treatment of the exposed employee and the source patient must be documented.

EXPOSURE CONTROL • POLICY 14.02

Universal and Standard Precautions

It is the policy of the Practice that all blood and body fluids from every person are considered potentially infectious. The Practice takes all precautions to ensure that infections do not occur.

PROCEDURES

1. Blood and body fluid precautions are used with every patient and specimen. In addition, disease-specific precautions are used as indicated.

2. Gloves are worn when touching blood, body fluids, mucous membranes, and non-intact skin of all patients. Gloves are also worn for handling items on surfaces soiled with blood or body fluids and performing venipuncture or other vascular access procedures.

3. Hand hygiene is performed before and after each patient contact. If gloves are used, they are changed between each patient contact.

4. Masks, protective goggles, and gowns are worn during procedures likely to generate droplets of blood or airborne particles.

5. Hands or other skin surfaces are washed with soap and warm water immediately if contaminated with blood or body fluids. All blood or body fluid spills are cleaned up immediately. Appropriate disinfectants as well as utility gloves are used. Clean-up material is handled as biohazardous waste and disposed of accordingly.

6. Sharps are handled with great care to avoid contamination of personnel. Sharps are disposed of in labeled, puncture-resistant, biohazardous sharps containers (see related policy 14.07 on Sharps and Needlesticks).

7. Mouthpieces, resuscitation bags, or other ventilation devices are available for use for emergency mouth-to-mouth resuscitation. Affected employees are trained in the use of these devices.

8. Employees do not eat, drink, or handle contact lenses or make-up in laboratories and other work areas where blood or other potentially infectious materials are present. Food and drinks are not stored in refrigerators, freezers, cabinets, or other areas where blood or other potentially infectious material may be located.

9. Employees with oxidative lesions or weeping dermatitis refrain from all direct patient care and equipment handling until the condition resolves.

EXPOSURE CONTROL • POLICY 14.03

Work Practice Controls

It is the policy of the Practice to establish and maintain work practice controls.

PROCEDURES

1. Work practice controls are the responsibility of the ECP Administrator or designee. They are responsible for reviewing and approving the Practice's adherence to the work practice controls.

2. Biohazard labels and/or signs, or red color-coded containers, are used to identify potentially hazardous items, including, but not limited to, the following:

   a. Refrigerators, freezers, cabinets, or other storage areas containing blood or other potentially infectious materials (on the exterior and where possible on the interior of each);

   b. Regulated medical waste;

   c. Sharps containers;

   d. Regulated medical waste transport containers, shipping containers for blood and other body fluids; and

   e. Other bio-hazardous items that may be identified.

3. Eating, drinking, applying cosmetics, smoking, and caring for contact lenses are prohibited in areas where there is risk of occupational exposure.

4. Refrigerators, freezers, cabinets, and other areas where potentially infectious materials are off-limits for the storage of food and drink.

5. Hand hygiene is required. This includes after removing gloves and after contact with body fluids. Employees are instructed in the correct procedure, and necessary facilities are provided.

6. Regulated waste such as used gloves, bandages, tongue depressors, and swabs that have been in contact with potentially infectious materials are disposed of in red color-coded and/or biohazard-labeled containers according to local and state laws. Contaminated broken glass is cleaned up with a brush or tongs and disposed of in a sharps container.

7. Sharps containers are puncture-resistant and leak-resistant. Employees are trained to keep them upright and to close them whenever they are moved.

8. Used sharps are placed in appropriate containers for disposal. This container is replaced when two-thirds full or when the preplaced manufacturer's guideline is reached on the container. This container is placed in a second "over-package" if needed to ensure safety in case of leakage and is appropriately biohazard-labeled. These containers meet Occupational Safety and Health Administration (OSHA) standards, and employees are trained in their proper use.

9. Bending, breaking, and recapping of sharps are prohibited. In the rare event (such as drawing a blood gas sample) that needles must be recapped, employees are trained in the following procedures:

    a. Use of a device for one-handed technique;

    b. Recapping method using an engineering control such as a hemostat or forceps; and

    c. Other procedures as appropriate for the situation.

10. Specimen and sample storage is limited to leak-resistant, appropriately labeled containers.

11. Universal and standard precautions are observed at all times to prevent contact with blood or other potentially infectious materials.

EXPOSURE CONTROL • POLICY 14.04

Personal Protective Equipment

It is the policy of the Practice to provide personal protective equipment (PPE) for use by all employees with occupational exposure to potentially infectious materials. In accordance with the Occupational Safety and Health Administration (OSHA) Personal Protective Equipment Standard 1910.132,[20] protective equipment, including personal protective equipment for eyes, face, head, and extremities; protective clothing; respiratory devices; and protective shields and barriers shall be provided, used, and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of processes or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation, or physical contact. The protective equipment, including PPE, used to comply with this policy shall be provided by the Practice at no cost to employees.

PROCEDURES

The Practice complies with current OSHA standards, as follows:

1. Employee-owned equipment

    a. Where employees provide their own protective equipment on a voluntary basis, the Practice shall be responsible to assure its adequacy, including proper maintenance and sanitation of such equipment.

    b. In all cases when PPE is required, the PPE will be provided by the Practice.

    c. For employees wearing scrubs, laboratory coats, uniforms and/or other articles of clothing, these personally laundered clothing shall be maintained in a clean and orderly manner. Personally laundered clothing should be laundered on a daily basis.

[20] United States Department of Labor. Occupational Safety and Health Administration. Title 29 Code of Federal Regulations, 1910.132(a) General requirements. Available at: www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9777. Accessed January 30, 2016.

2. Design

    a. All PPE shall be of safe design and construction for the work to be performed.

3. Hazard assessment and equipment selection

    a. The Practice performs a hazard assessment of the workplace. Documentation of the assessment is maintained by the Practice for 30 years, or that which is required by state law and is available from the ECP Administrator.

    b. The Practice assesses the workplace to determine if hazards are present, or are likely to be present, that necessitate the use of PPE. If such hazards are present, or likely to be present, the Practice shall:

        1) Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;

        2) Communicate selection decisions to each affected employee; and

        3) Select PPE that properly fits each affected employee.

    c. The Practice shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and that which identifies the document as a certification of hazard assessment is available from the ECP Administrator.

4. Defective and damaged equipment

    a. Defective or damaged PPE shall not be used and should be properly disposed of and removed from the premises.

5. Training

    a. The Practice shall provide training to each employee who is required by this section to use PPE. Each such employee shall be trained to know at least the following:

        1) When PPE is necessary;

        2) What PPE is necessary;

        3) How to properly don, doff, adjust, and wear PPE;

        4) The limitations of the PPE; and

        5) The proper care, maintenance, useful life, and disposal of the PPE.

b. Each affected employee shall demonstrate an understanding of the training as specified, and the ability to use PPE properly, before being allowed to perform work requiring the use of PPE.

c. When the Practice has reason to believe that any affected employee who has already been trained does not have the understanding and skill required, the Practice shall retrain each such employee. Circumstances where retraining is required include, but are not limited to, situations in which:

   1) Changes in the workplace render previous training obsolete; or

   2) Changes in the types of PPE to be used render previous training obsolete; or

   3) Inadequacies in an affected employee's knowledge or use of assigned PPE indicate that the employee has not retained the requisite understanding or skill.

d. The Practice shall verify that each affected employee has received and understood the required training through a written certification that contains the name of each employee trained and the date(s) of training, and that identifies the subject of the certification. Documentation of the training is maintained for 30 years, or that which is required by the state and is available from the Exposure Control Plan Administrator.

6. Employees are required to use PPE when performing tasks that involve risk of exposure.

7. Employees must remove all PPE as soon as possible after leaving their work area and place them in designated areas for storage, washing, decontamination, or disposal as appropriate. On rare occasions, employees may briefly decline to use PPE because, in their professional judgment, its use in that specific instance would prevent the delivery of healthcare or public safety services, or would pose an increased hazard to the safety of the employee or co-worker. When the employee makes this judgment, the circumstances must be documented and are investigated to determine whether changes can be instituted to prevent such occurrences in the future. See Documentation of Election Not to Use Personal Protective Equipment form (see below).

DOCUMENTATION OF ELECTION NOT TO USE PERSONAL PROTECTIVE EQUIPMENT

This form is used to document instances during which an employee declines to use personal protective equipment (PPE) while performing a task that involves risk of exposure to potentially infectious materials. On rare occasions, an employee may briefly decline to use PPE because, in his or her professional judgment, its use in that specific instance would prevent the delivery of healthcare or public safety services, or would pose an increased hazard to the safety of the employee or a co-worker.

Name: _____

Title: _____

Task being performed: _____

Patient name (if applicable): _____

Reason PPE was not used: _____

_____

_____

Action taken: _____

_____

_____

_____

Recommendations for future policy: _____

_____

_____

Signature: _____

Date: _____

EXPOSURE CONTROL • POLICY 14.05

Hand Hygiene

Alert: *The Practice should evaluate the following policy and procedure, and include all appplicable procedures as that which would reflect the specialty and services performed by the providers and clinical staff.*

It is the policy of the Practice to use proper hand hygiene as the single most important means of controlling the spread of infection and minimizing any effects of chemical contact with skin. The Practice complies with the recommendations regarding hand hygiene promulgated by the Centers for Disease Control and Prevention.[21]

PROCEDURES

1. Indications for hand washing and hand antisepsis

    a. All Practice employees wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water when hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids.

        1) Antimicrobial-impregnated wipes (i.e., towelettes) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with an antimicrobial soap and water for reducing bacterial counts on the hands of employees, they are not a substitute for using an alcohol-based hand rub or antimicrobial soap.

    b. If hands are not visibly soiled, Practice employees use an alcohol-based hand rub or wash with an antimicrobial soap and water for routinely decontaminating hands in the following clinical situations:

[21] Centers for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings. *MMWR* 51(PR-16): October 25, 2002. Available at: www.cdc.gov/mmwr/PDF/rr/rr5116.pdf and http://www.cdc.gov/handhygiene/Guidelines.html. Accessed January 30, 2016.

1) Before having direct contact with patients;

2) Before donning sterile gloves when inserting a central intravascular catheter;

3) Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure;

4) After coming into contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient);

5) After coming into contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled;

6) If moving from a contaminated body site to a clean body site during patient care;

7) After coming into contact with inanimate objects (including medical and computer equipment) in the immediate vicinity of the patient; and

8) After removing gloves.

c. All Practice employees wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water before eating, after using the restroom and after touching a personal handheld device.

d. All Practice employees wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if exposure to *Bacillus anthracis* (the etiologic agent of anthrax) is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores.

e. All Practice employees wash hands with non-antimicrobial soap and water or with antimicrobial soap and water followed by use the use of an alcohol-based hand rub if exposure to methicillin-resistant *Staphylococcus aureus* (MRSA) is suspected or proven. The physical action of washing and rinsing hands and the alcohol-based hand rub has been found to reduce the transmission of MRSA.

2. Hand-hygiene technique

a. When decontaminating hands with an alcohol-based hand rub, physicians, advanced practice providers and employees are trained and instructed to apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Follow the manufacturer's recommendations regarding the volume of product to use.

b. When washing hands with soap and water, providers and employees are trained and instructed to wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use a towel to turn off the faucet. Avoid using hot water, because repeated exposure to hot water may increase the risk of dermatitis.

c. Liquid, bar, leaflet, or powdered forms of plain soap are acceptable when washing hands with a non-antimicrobial soap and water. When bar soap is used, soap racks that facilitate drainage and small bars of soap should be used.

d. Multiple-use cloth towels of the hanging or roll type are not used at any office or facility of the Practice.

EXPOSURE CONTROL • POLICY 14.06

Cleaning, Decontamination, and Disposal of Waste

To ensure appropriate levels of cleanliness and infection control, it is the policy of the Practice to prevent contamination. In the event that a contamination occurs, the Practice maintains a consistent protocol to avoid or control the negative impact of a contamination.

PROCEDURES

1. Contaminated work surfaces in all exam rooms are washed with disinfectant each day. A provider or a clinical assistant washes surfaces after any procedures where contamination is possible. Blood spills are cleaned promptly with a disinfectant solution. Household bleach is an effective disinfectant and can be used in a 10 percent solution to clean up spills. Other germicides registered by the Environmental Protection Agency (EPA)[22] or cleared by the Food and Drug Administration (FDA) within the Practice can also be used. Appropriate disinfectants include the following:
   a. The diluted bleach solution;
   b. EPA-registered tuberculocides
   c. Sterilants registered by the EPA;
   d. Products registered against human immunodeficiency virus (HIV)/hepatitis B virus (HBV); or
   e. Sterilants/high-level disinfectants cleared by the FDA.
2. Work areas at the Practice are maintained in a clean and sanitary condition. A written schedule for cleaning, outlining the method of cleaning or decontamination to be used for each situation, is incorporated into the Bloodborne Pathogens Exposure Control Plan (see below).

[22] Environmental Protection Agency, selected EPA-registered Disinfectants, multiple lists, http://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants, Accessed January 26, 2016.

3. Contaminated equipment is cleaned and decontaminated as necessary.
    a. If such equipment must be shipped for service and cannot be completely decontaminated, appropriate parts are biohazard-labeled, and the equipment is sealed in a red color-coded or biohazard-labeled wrap before shipping.
    b. Outer packaging is biohazard-labeled as well.
4. Contaminated instruments are cleaned and decontaminated or sterilized as necessary for use.
5. The personal clothing of a contaminated employee's is red bagged as soon as it is removed.
    a. The clothing is disinfected and washed in accordance with the Practice's policy on contaminated laundry.
    b. Extra clothes are available to be provided to the employee by the Practice at no cost to the employee.
6. Contaminated laundry is bagged as soon as it is removed.
    a. Appropriate gloves or other protective equipment are worn when handling visibly contaminated laundry. The following checklist can be used, as applicable:
        - Laundry is stored in a red laundry bag, which is kept in a designated area or container.
        - Laundry is stored in a conventional laundry bag, but all employees recognize red laundry bags as contaminated, and have been trained in how to handle them.
        - Contaminated laundry is sent to a commercial laundry and is red-bagged separately from non-contaminated laundry. The commercial laundry is advised of this policy in writing, and is notified in writing when a red laundry bag is sent for cleaning.
7. Contaminated surfaces are decontaminated with an appropriate disinfectant as identified in item 1 above upon completion of procedures and at the end of every work shift.
8. Equipment that might become contaminated is inspected at the following interval(s) and is cleaned and decontaminated as necessary. Surfaces and equipment protected with plastic wrap, foil, or other non-absorbent materials are inspected frequently for contamination, and protective coverings are changed when they are found to be contaminated. The cleaning inspection schedule is (the Practice shall indicate which is applicable for each work area):
    - Every day at start of day
    - Every day at end of day
    - Every ____ days
    - Every week
    - When contamination is suspected
    - Other: _____

9. Infectious or biohazardous waste consists of liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items caked with dried blood or potentially infectious materials capable of releasing them if handled; contaminated sharps; and pathological and microbial waste containing blood or other potentially infectious materials. This regulated medical waste is removed from this Practice according to federal, local, and state law.
    a. Contaminated sharps are disposed of in closable, puncture-resistant, leak-resistant, red and/or biohazard-labeled containers, in accordance with state law. These containers are disposed of when the manufacturer-placed indicator on the container is reached.
    b. Other regulated waste, including disposable laundry and other personal protective equipment, is disposed of in closable, leak-resistant, red and/or biohazard-labeled bags or containers, in accordance with state law. If outside contamination of this container occurs, it is placed in a second container that is closable, leak resistant, and appropriately labeled.
10. Laundry equipment used to wash contaminated laundry is cleaned by running a load cycle with appropriate disinfectant on the following schedule, if performed in-house (the Practice shall indicate which is applicable for each work area):
    - Every day at start of day
    - Every day at end of day
    - Every ____ days
    - Every week
    - When contamination is suspected
    - Other: _____
11. Waste cans and pails are inspected and decontaminated on a regular basis.
12. Tablets, kiosks and other devices that are used by patients and/or employees are properly cleaned with alcohol wipes between usage. Alcohol wipes are made available for patients to use at kiosk stations, as applicable.
13. The Practice shall maintain a consistent housekeeping schedule that ensures a safe, clean facility with proper cleaning of all work areas.
14. Hand sanitizers are available in each hallway, or that which is recommended by the ECP Administrator or designee. Sanitizer stations are made available to patients at the entrance and exit of the Practice, unless otherwise available outside of the door(s) in the facility.

EXPOSURE CONTROL • POLICY 14.07

Sharps and Needlesticks

It is the policy of the Practice to provide safe disposal by employees and nonemployees of used needles, syringes, and other "sharps" (e.g., scalpel blades, blood vials, used slides, and pipettes) in a container clearly identified for the purpose of storing biohazardous waste until such time that it can safely be disposed. Safe disposal of sharps protects employees and others from injury and transmission of disease by contaminated materials.

Under the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard, an occupational exposure incident is defined as "a specific eye, mouth, or other mucous membrane, nonintact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties." When such an incident occurs, certain follow-up activities are performed. These post-exposure protocols and follow-up activities are provided by the Practice at no cost to the employee and are conducted in a confidential manner.

PROCEDURES

1. A sharps container that is puncture resistant, leak-proof, and labeled and/or color coded as biohazardous waste is located within easy access to any work area where medical services are performed (e.g., exam rooms, lab area, cast room, and treatment rooms).

2. All contaminated uncapped needles, syringes, and other sharps are discarded into a designated sharps biohazardous container immediately after use without recapping, bending, or cutting. Contaminated needles are not recapped unless medically necessary. In the rare event that recapping a contaminated needle is medically necessary, a one-handed technique or a mechanical device is used. In addition, no one is permitted to bend, shear, or break a contaminated needle or scalpel. Scalpel blades are removed using hemostats or needle holders. Bare or gloved hands do not touch the scalpel blade.

3. Biohazardous sharps containers are kept upright at all times. The lid is tightly sealed prior to removal of the container, and the sharps container is removed when the contents reach the manufacturer's fill line. The containers are closed and appropriately sealed per manufacturer's guidelines prior to removal to prevent spillage or protrusion of contents during the disposal process. If there is any chance of leakage, the sharps container is placed in a second secure, closable, and leakproof container that is labeled with a biohazardous sticker.

4. The sealed containers are placed in the designated biohazardous waste pick-up area. Biohazardous waste containers are removed from each site by a permitted biohazard disposal service and disposed of in a manner that complies with local and state regulations.

5. The sharps container is replaced with a new sharps disposal container at the time the old (full) one is removed.

6. Reusable containers are not opened, emptied, or cleaned manually in any manner that could expose employees, providers, or patients to sharps injury.

7. To the extent possible, needleless systems are provided and used as an alternative to needles for specified procedures, thereby reducing the risk of percutaneous injury involving contaminated sharps.

8. Input is solicited from non-managerial employees responsible for direct patient care in the identification, evaluation, and selection of engineering and work practice controls.

9. A Sharps Injury Log (see below) is maintained by the ECP Administrator of all employee injuries from sharps. All sharps injuries are documented in the log, which is maintained for five years from the end of the calendar year in which the exposure occurred, or that which is required by state law. The identity of injured workers is <u>not</u> recorded in the Sharps Injury Log. All exposed employees are offered post-exposure and follow-up treatment according to the procedure prescribed by the U.S. Public Health Service.

10. The ECP Administrator designates a safety control officer to oversee the protocols regarding sharps.

11. An employee exposed to bloodborne pathogens via a sharps incident immediately informs the designated safety control officer. If that person is unavailable, the employee informs the highest-ranking employee present. Following a report of an exposure incident, the Practice immediately makes available, at no cost to the employee, a confidential medical evaluation and follow-up.

12. After an incident, the ECP Administrator reviews the Sharps Injury Log, the Post-Exposure Checklist for Needlestick Incident form, the Procedure for the Evaluation of Circumstances Surrounding Exposure Incidents form, and the Safety Device Evaluation form (see below). He or she also offers a follow-up medical evaluation, which an

employee may refuse by completing the Informed Refusal of Post-Exposure Medical Evaluation form (see below). By policy, the employee is required to have an initial conference with his or her treating physician before refusing follow-up medical evaluation.

13. The ECP Administrator conducts regular inspections using the Safety Device Evaluation form (see below) to ensure the consistent use of effective safer medical devices and reduce the potential of exposure incidence involving a contaminated sharp.

14. The use of safer sharps is an integral part of this exposure control plan. The Practice uses automatically retracting capillary puncture devices, plastic or coated capillary tubes, and selected safer needle devices as appropriate.

SHARPS INJURY LOG

*The Sharps Injury Log must preserve the confidentiality of affected employees. Employee names or personal identifiers, therefore, are **not** permitted.*

Date	Case/Report # (not traceable to employee)	Type of device	Brand name of device	Work area where injury occurred	Brief description of the injury	Brief description of how the incident occurred

POST-EXPOSURE CHECKLIST FOR NEEDLESTICK INCIDENT

_____ Document all details of the incident (see Exposure Incident Report and Sharps Injury Log), including routes of exposure and circumstances under which the incident occurred.

_____ Require that the employee sign a declination form if no follow-up is desired. (Please note that the Practice, by policy, does require the employee to have an initial conference with a licensed healthcare provider. Please provide the details of compliance with this policy.) _____

_____ Identify the source individual, unless the identification is not feasible or prohibited by law.

_____ Obtain consent for a human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV) blood test from the source individual, unless consent is not required by law and blood is already available.

_____ Collect a blood specimen if not already available from the source patient.

_____ Obtain permission from the employee for baseline blood collection and storage or immediate testing.

_____ Collect a blood specimen from the employee for immediate or future testing. (Blood may be stored up to 90 days if the employee does not want immediate testing. The employee may request testing within that 90 days.)

_____ Choose—or let the employee choose—a licensed healthcare provider to perform the follow-up.

_____ Send specimens to a licensed laboratory for testing for HIV, HBV, and HCV with instructions to send reports only to that healthcare provider chosen to do the follow-up. If the source is known to be infected with HIV, HBV, or HCV, that test does not need to be repeated.

_____ Forward a copy of the detailed information concerning the incident to the selected healthcare provider. This information includes:

- _____ A description of the employee's duties as they relate to the incident;
- _____ Documentation of the routes of exposure and the circumstances under which the exposure occurred;
- _____ Results of the source individual's blood testing, if available; and
- _____ All medical records relevant to the appropriate treatment of the employee, including documentation of his or her vaccination status.

_____ Offer a hepatitis B vaccination to the employee if this has not already been done.

Note: *The healthcare provider is then responsible for informing the employee of the results, providing necessary prophylaxis and counseling, and for informing the Practice that this has been done.*

_____ Obtain the healthcare provider's written opinion and provide a copy to the employee within 15 days of the evaluation.

_____ Document summarized information.

_____ Maintain all relative documentation for 30 years after the end of the employee's employment, or that which is required by state law.

EXPOSURE INCIDENT REPORT FORM
CONFIDENTIAL

Exposed employee: _____ Date of exposure: _____

Job position: _____ Time of exposure: _____

Department: _____ Date of report: _____

Source patient: _____

Procedure being performed: _____

Instrument being used: _____ Brand: _____ Size: ____

Incident as described by exposed employee: _____

_____

Was a safety device used? ____Yes ____No

If "yes," was the safety feature activated? ____Yes ____No

If a safety device was not used, could a safety device have prevented the injury? ____Yes ____No

Did the injury occur before or after ____ Before ____ After activation of protective mechanism?

If so, how? _____

Could any of the following controls have prevented the injury? If so, describe how.

____ Engineering control: _____

____ Administrative control: _____

____ Work practice control: _____

Signed: _____ Date: _____
Exposed employee

Safety coordinator: _____ Date: _____

PROCEDURE FOR THE EVALUATION OF CIRCUMSTANCES SURROUNDING EXPOSURE INCIDENTS CONFIDENTIAL

Employee: _____

Injury: _____

What workplace condition, practice, or personal protective equipment contributed to the incident?

_____

_____

_____

Describe corrective action required to prevent repeat of incident: _____

_____

_____

Have corrective measures been taken? _____Yes _____No

If no, why not? _____

_____

If no, when will corrective measures be taken? _____

Was a company safety policy violated? _____Yes _____No

If yes, which policy? _____

Was the employee aware of this policy? _____Yes _____No

INFORMED REFUSAL OF POST-EXPOSURE MEDICAL EVALUATION
CONFIDENTIAL

I, _____, am employed by the Practice. My employer has provided to me training regarding infection control and the risk of disease transmission in the medical office.

On _____, I was involved in an exposure incident when I

(describe incident): _____

_____

_____

_____

_____

_____

I have met with _____, a licensed healthcare provider.

My employer has offered to provide follow-up medical evaluation for me in order to ensure that I have full knowledge of whether I have been exposed to or contracted an infectious disease from this incident.

However, I, of my own free will and volition, and despite my employer's offer, have elected not to have a medical evaluation. I have personal reasons for making this decision.

Signature of Exposed Employee:

Name (printed): _____

Address: _____

City/State/ZIP: _____

Date: _____

Witnessed by: _____

Date: _____

Note: *Maintain this record for duration of employment plus 30 years, or that which is required by state law.*

SAFETY DEVICE EVALUATION

<table>
<tr><td>Device</td><td>Brand</td></tr>
<tr><td rowspan="3">Does this device meet these criteria?
1. Allows/requires employees' hands to stay behind the needle after use?
( ) Yes ( ) No
2. Is the safety feature an integral part of the device, present before the device was contaminated?
( ) Yes ( ) No
3. Does the safety feature stay in place throughout the waste stream?
( ) Yes ( ) No
4. Is it easy to use with little instruction?
( ) Yes ( ) No
5. Does it interfere with patient care?
( ) Yes ( ) No
6. Is the safety feature activated with a one-handed technique?
( ) Yes ( ) No</td><td>Description of safety feature:</td></tr>
<tr><td>Type of safety feature:
_____
_____</td></tr>
<tr><td>Ease of use:
_____
_____
_____
_____</td></tr>
<tr><td></td><td>This device can be used for the following procedures:
1._____
2. _____
3. _____
4._____
5. _____
Is this device acceptable to employees as signed below?
( ) Yes ( ) No</td></tr>
</table>

This device has been evaluated by the following employees and clinicians:

Signature	**Accept**	**Reject**	**Date**
1.			
2.			
3.			
4.			

EXPOSURE CONTROL • POLICY 14.08

Hazard Communication Program

It is the policy of the Practice to adopt a hazard communication program to inform employees of the hazards present in the workplace. The Practice complies with the Occupational Safety and Health Administration (OSHA) regulations on hazardous chemicals. It is used in conjunction with the complete standard, Title 29 Code of Federal Regulations, 1910.1200,[23,24] or its state OSHA plan equivalent.

Employees have the right to know the chemical hazards they encounter in the workplace and measures they can take to protect themselves from chemical hazards. The Practice complies with all applicable state "Right to Know" regulations.

OSHA requires employers to develop a written Hazard Communication Program that includes:

- Designation of a qualified program administrator;
- Employee training;
- Product labels and other forms of warning;
- Material safety data sheet (MSDS) for all hazardous chemicals, and a
- Master list of hazardous chemicals.

Employers must have a written Hazard Communication Program that describes how each of these is to be addressed. The written Hazard Communication Program is kept in the OSHA manual and is available for employee review. This material is covered during initial employee orientation.

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[23] United States Department of Labor. Occupational Safety and Health Administration. Title 29 Code of Federal Regulations, 1910.1200 Hazard Communication. Available at: www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=10099. Accessed January 30, 2016.

[24] United States Department of Labor. Occupational Safety and Health Administration. *Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard Communications Standards.* Available at: www.osha.gov/Publications/osha3186.html. Accessed January 30, 2016.

The Hazard Communication Program Administrator is:

Administrator: _____

Contact Information: _____

PROCEDURES

1. Each Practice site develops and maintains an inventory of hazardous chemicals used. The site list of hazardous chemicals is organized by each work area, including clinical areas, business office, laboratory, radiology, and housekeeping, etc.

2. The Practice uses information from the material safety data sheet (MSDS) from manufacturers to determine which materials are hazardous and updates the inventory list of hazardous chemicals as necessary.

    a. Manufacturers of hazardous chemicals must develop and distribute an MSDS for every hazardous product they sell. A MSDS is designed to give employers and employees all the information necessary to use the chemical safely. Although an MSDS may vary in structure from one manufacturer to another, it must contain the following information:

        1) Identification, including product name; manufacturer's name, address, phone number, and emergency phone number; the date of the MSDS; and the preparer's name.

        2) Ingredients, including name, permissible exposure limits, and percentage of ingredient for all hazardous ingredients in the product.

        3) Physical characteristics, including physical and chemical characteristics of the chemical, such as boiling point, vapor pressure, vapor density, melting point, evaporation rate, water solubility, appearance, and odor.

        4) Fire and explosion hazards, including flashpoint, flammable limits, extinguishing information, and special fire-fighting procedures.

        5) Reactivity hazards, including stability, conditions to avoid, incompatibilities, and hazardous decomposition that can occur.

        6) Health hazard data, including routes of entry, health hazards (acute and chronic), signs and symptoms of overexposure, carcinogenicity (cancer causing), medical conditions aggravated by exposure, and emergency first-aid procedures.

        7) Precautions for safe handling and use, including spill procedures, waste disposal methods, and precautions for handling and storage.

8) Control measures, including personal protective equipment, engineering controls, and hygienic work practices.

b. Each MSDS must be readily accessible during each work shift to employees when they are in their work areas. Employees are trained on the MSDS binder location at hire and annually thereafter.

3. All Practice sites that use hazardous chemicals ensure proper labeling of containers of hazardous chemicals. The chemical manufacturer, importer, or distributor label contains:

   a. Product name;

   b. Name and address of the manufacturer or supplier; and

   c. Appropriate hazard warning.

4. A written, pictorial, or symbolic hazard warning may be used to convey the hazards of the product in the container. Employee training includes information on how to interpret hazard warnings posted in the Practice.

5. The manufacturer's label is used whenever possible to satisfy hazard communication labeling. The manufacturer's label must have at least the information outlined above to serve as a proper label.

6. Generic adhesive labels serve as hazard communication secondary labels if:

   a. The manufacturer's label becomes illegible;

   b. The manufacturer's label falls off;

   c. The manufacturer's label is not adequate; or

   d. The product is transferred to a container without a label.

7. The Practice uses adhesive labels that adhere to the National Fire Protection Agency (NFPA) rating system, or another compliant labeling system, to warn employees of product hazards. The MSDS provides information necessary to complete a secondary label. A secondary label must contain at least the following two points of information:

   a. Identification of the hazardous chemical; and

   b. Appropriate hazard warnings.

8. All Practice sites that maintain hazardous chemicals in an area ensure proper labeling of the area. Hazard warnings appear on doors of restricted areas as required. Restricted areas contain one of the following hazards:

a. Radiation;

b. Laser;

c. Chemical;

d. Infectious agents; or

e. Asbestos abatement areas.

9. Chemical storeroom doors and tanks display the NFPA hazard warning diamond as appropriate.

10. Some areas of the Practice are restricted due to the presence of a hazardous material or agent. Warning signs such as "Laser Hazard," "Biohazard," "Radiation Hazard," and "Asbestos Work Area" are posted on doors, as required. Only authorized personnel are permitted to enter these areas.

11. Written hazard warnings must contain a signal word to alert the employee of the seriousness of the hazard and contain a brief description of the physical and health hazards present. Signal words ranking from most to least severe include:

a. DANGER

b. WARNING

c. CAUTION

12. Employee training includes information on how to identify restricted areas.

13. Fire extinguishers are placed in locations in the Practice, as recommended by the fire department. The Hazard Communication Program Administrator or designee is responsible for ensuring that the equipment is in working order, and that employees are trained on using an extinguisher.

14. The Practice is responsible for disclosing all of the Practice-based chemical hazards that contractors may be exposed to during their normal work activities. Private contractors are responsible for protecting themselves, their employees, and their subcontractors from disclosed hazards.

15. The Practice provides hazard communication training to employees at the following times:

a. Upon hire;

b. When an employee receives a new assignment;

c. When a new hazard is brought into the work area;

d. Before an employee performs a non-routine task with hazardous materials, and

e. Whenever state or local regulations require such training to be repeated.

16. The components of the Hazard Communication Program include the following categories:

a. Designation of categories of hazardous materials.

1) According to the OSHA regulation, a chemical or material is hazardous if it exhibits at least one of the following four characteristics (many hazardous materials exhibit more than one hazardous characteristic):

a) Flammable materials. These materials burn when ignited. The flammability of a liquid is determined by its flash point. The flash point is the temperature at which flammable liquids produce enough vapor to burn. The lower the flash point, the more flammable the liquid. Combustible materials are also included in this category. Combustibles must be heated before they will burn. Alcohol, nail polish remover, tincture of benzoin, collodion, and aerozoin are examples of flammable materials.

b) Corrosive materials. These materials cause burns or tissue damage upon contact. They also cause damage to metal. Corrosives come in a variety of strengths and concentrations. Diluted or weak corrosives are called irritants, and are less dangerous than pure corrosive materials. Sodium hydroxide, hydrogen peroxide, acetic acid, formaldehyde, and glutaraldehyde are examples of corrosive materials.

c) Toxic materials. These materials cause clinical symptoms or disease when over-exposure occurs. Toxicity may be: (1) acute, meaning that the symptoms or disease occur immediately upon over-exposure; or (2) chronic, meaning that the symptoms or disease occur after long-term over-exposure. A symptom or chemical disease can only occur if there is:

i.) An exposure route such as ingestion, inhalation, skin absorption, or skin contact;

ii.) A target organ such as the liver, nervous system, respiratory system, or skin; or

iii.) An over-exposure that is above the permissible exposure limit. Permissible exposure limits are determined by OSHA based on the amount of a hazardous material to which a person can be safely exposed. Permissible exposure limits are given in units of parts per million (ppm). An exposure

limit may be a time weighted average (TWA) of 8 hours, a short-term limit (STEL) of 15 minutes, or a ceiling limit (highest allowable exposure).

The following guidelines can be used to interpret an exposure limit of chemicals:

i.) Mildly toxic chemicals have exposure limits of 500 to 1,000 ppm;

ii.) Moderately toxic chemicals have exposure limits of 50 to 500 ppm;

iii.) Toxic chemicals have an exposure limit of 1 to 50 ppm; and

iv.) Highly toxic chemicals have an exposure limit of less than 1 ppm. Phenol, methyl alcohol, formaldehyde, mercury, and chemotherapeutic agents are examples of toxic materials.

d) Reactive materials. These materials may explode or release toxic gases if heated or mixed with incompatible materials. One large group of reactive materials is oxidizers. Oxidizers act as if oxygen were being added to a fire and make a fire more intense and difficult to extinguish. Silver nitrate, nitrous oxide, iodine, and chlorine are examples of reactive materials.

b. Procedures for safe handling.

1) The procedures for the safe handling of hazardous materials are as follows:

a) Flammable materials. When using flammable materials, limit the release of vapor and ignition sources. Safe work practices for flammable materials include:

i.) Eliminating ignition sources;

ii.) Cleaning up spills quickly;

iii.) Covering containers when not in use;

iv.) Using flammables in well-ventilated areas;

v.) Storing materials in tightly sealed containers;

vi.) Storing flammables separate from oxidizers and corrosives; and

vii.) Wearing gloves to protect hands. Prolonged skin contact with flammable liquids can cause drying and irritation. Wear goggles if splashing is likely. Some flammables are also toxic. Respiratory protection may be necessary if using a large volume of flammable liquid.

b) Corrosive materials. Many corrosives react violently when mixed with incompatible materials and also are destructive to metal. Safe handling procedures include:

i.) Not mixing strong acids and bases, which react violently;

ii.) Adding acid to water when diluting the acid, rather than adding water to acid;

iii.) Storing corrosives in tight-fitting plastic containers;

iv.) Storing containers of corrosives on the highest shelves possible;

v.) Flushing with water during drain disposal;

vi.) Cleaning up spills on metal surfaces quickly;

vii.) Avoiding skin and eye contact, which may result in tissue damage or irritation; and

viii.) Wearing protective gloves and goggles or a face shield if splashing is likely. When using large volumes, boots and aprons may also be necessary to prevent skin exposure.

c) Toxic materials. Toxic materials are the largest group of hazardous materials. Overexposure is prevented by knowing the route of exposure of a toxic material and using appropriate engineering controls and personal protective wear. Safe handling procedures include:

i.) Washing hands after handling toxic materials and before eating or smoking;

ii.) Not eating in areas where toxic materials are used;

iii.) Not storing food items in areas where toxic materials are used;

iv.) Using adequate ventilation or a fume hood to avoid inhalation;

v.) Wearing a respirator to avoid inhalation of toxic materials;

vi.) Wearing gloves, goggles, a face shield, boots, and an apron to avoid skin contact and skin absorption; and

vii.) Checking the MSDS for routes of exposure, target organs, exposure limits, and appropriate protective devices for a specific toxic material.

d) Reactive materials. Exposure to incompatible substances, heat, or shock may produce a violent reaction. Safe handling procedures include:

i.) Checking for incompatibilities on the MSDS before mixing products;

ii.) Storing incompatible materials separately;

iii.) Storing materials in a cool, dry place in sealed containers;

iv.) Preventing contact between oxidizers and combustible materials;

v.) Separating flammables/oxidizers during storage; and

vi.) Securing pressurized gas cylinders to prevent tipping.

Many reactive materials may also be toxic or corrosive. Read the MSDS and take the appropriate precautions.

c. First-aid procedures.

1) First-aid procedures are administered immediately upon exposure to hazardous materials. Specific first-aid procedures are available in the MSDS for each product. General first aid procedures are as follows:

a) Skin and eye contact. Following exposure to the eye, hold eyelids open while flushing the eyes with water. Flush the affected area with large amounts of water for at least 15 minutes. Seek medical treatment if irritation or pain develops.

b) Inhalation. Move to fresh air if experiencing symptoms. Move the exposed employee to fresh air and give artificial respiration if he or she is not breathing. Seek medical attention.

c) Ingestion. Check the MSDS before inducing vomiting. Dilute the ingestion by taking one or two glasses of water. Seek medical treatment.

d) Spill. Upon discovering a spill of a hazardous material, perform the following:

i.) Remove patients, visitors, physicians, advanced practice providers, and employees from the immediate spill site;

ii.) Report spills of mercury, chemotherapeutic agents, or small volumes (less than one gallon) of moderately hazardous materials (such as alcohol, acetone, and hydrogen peroxide) to the senior manager; and

iii.) Report all spills of highly hazardous materials and large spills (more than one gallon) of moderately hazardous materials to the senior Administrator,

Hazard Communication Program Administrator, the physician responsible for safety, quality and/or personnel and/or the persons as designated by the Practice for reporting of these matters.

17. Employee Training and Information. _____ (*Name of responsible person and/or position*) is responsible for the Hazard Communication Program and will ensure that all program elements are carried out.

    a. Everyone who works with or is potentially exposed to hazardous chemicals will receive initial training on the hazard communication standard and this plan before starting work. Each new employee will attend a health and safety orientation that includes the following information and training:

        1) An overview of the OSHA hazard communication standard;

        2) The hazardous chemicals present at his/her work area;

        3) The physical and health risks of the hazardous chemicals;

        4) Symptoms of overexposure;

        5) How to determine the presence or release of hazardous chemicals in the work area;

        6) How to reduce or prevent exposure to hazardous chemicals through use of control procedures, work practices and personal protective equipment;

        7) Steps the Practice has taken to reduce or prevent exposure to hazardous chemicals;

        8) Procedures to follow if employees are overexposed to hazardous chemicals;

        9) How to read labels and MSDSs to obtain hazard information; and

        10) Location of the MSDS binder and written Hazard Communication program.

    b. Prior to introducing a new chemical hazard, each employee is given information and training as outlined above for the new chemical hazard. The training format will be as follows: *(The Practice shall describe training format, such as audiovisuals, interactive computer programs, classroom instruction, etc.)*

18. Hazardous Non-routine Tasks.

    Periodically, employees are required to perform non-routine tasks that are hazardous.

    a. Prior to starting work on such projects, each affected employee will be given information by _____ (*name of responsible person and/or position*) about the hazardous chemicals he or she may encounter during such activity. This

information includes specific chemical hazards, protective and safety measures the employee should use, and steps the Practice is taking to reduce the hazards, including ventilation, respirators, the presence of another employee (i.e., buddy system), and emergency procedures.

b. Examples of non-routine tasks performed by employees of the Practice are:

Task	*Hazardous Chemical*
_____	_____
_____	_____

19. Informing Other Employers/Contractors.

a. It is the responsibility of _____ (*name of responsible person and/or position*) to provide other employers and contractors with information about hazardous chemicals that their employees may be exposed to at the Practice and suggested precautions for employees.

b. It is the responsibility of _____ (*name of responsible person and/or position*) to obtain information about hazardous chemicals used by other employers to which employees of this Practice may be exposed. Other employers and contractors will be provided with MSDSs for hazardous chemicals generated by this Practice's operations in the following manner:

(The Practice shall describe its protocols here.)

_____

_____

c. In addition to providing a copy of an MSDS to other employers, other employers will be informed of necessary precautionary measures to protect employees exposed to operations performed by this Practice.

d. Other employers will be informed of the hazard labels used by the Practice. If symbolic or numerical labeling systems are used, the other employees will be provided with information to understand the iconic labels used for hazardous chemicals for which their employees may have exposure.

20. List of Hazardous Chemicals.

A list of all known hazardous chemicals used by the Practice is attached to this plan. (*The Practice shall attach a list of all known hazardous chemicals used at any of its facilities*.)

a. This list includes the name of the chemical, the manufacturer, the work area in which the chemical is used, dates of use, and quantity used. Further information on each chemical may be obtained from the MSDSs, located in

_____ *(the Practice shall identify the location).*

b. When new chemicals are received, this list is updated (including date the chemicals were introduced) within 30 days. To ensure any new chemical is added in a timely manner, the following procedures shall be followed: *(the Practice shall identify procedures to be followed).*

c. The hazardous chemical inventory is compiled and maintained by _____ *(name of responsible person and/or position and telephone number).*

21. Program Availability. A copy of this program will be made available, upon request, to employees and their representatives.

Training Record

The following individuals attended a training session based on hazardous communications plan; OSHA regulations; a review and update of the Practice's Exposure Control Plan; and the hazardous chemicals present at his/her work area, how to reduce and react to exposure, how to read MSDS and where they are located.

Name: _____

Job title: _____

Name: _____

Job title: _____

Name: _____

Job title: _____

Name: _____

Job title: _____

Name: _____

Job title: _____

Name: _____

Job title: _____

Name: _____

Job title: _____

Contents or summary of the training: _____

Trainer's name: _____

Qualifications: _____

Date: _____

EXPOSURE CONTROL • POLICY 14.09

Tuberculosis (TB) Exposure Control Plan

It is the policy of the Practice to implement and maintain a tuberculosis (TB) exposure control plan (ECP) that incorporates the guidelines for preventing the transmission of *Mycobacterium (M.) tuberculosis* as published by the Centers for Disease Control and Prevention (CDC) on December 30, 2005[25]; is in accordance with the state Department of Public Health; and is in accordance with the local

TB authority.

The Practice is committed to protecting physicians, advanced practice providers, employees, patients, family members, caregivers and all other persons who visit the Practice from the disease caused by the transmission of TB. Individuals determined to have infectious TB are referred to facilities designed for the care of such patients.

The Administrator for the TB exposure control plan is:

Administrator: _____

Contact Information: _____

According to the CDC, the three TB screening risk classifications are: (1) low risk, (2) medium risk, and (3) potential ongoing transmission.

- Low Risk. The classification of Low Risk should be applied to settings in which persons with TB disease are not expected to be encountered, and, therefore, exposure to *M. tuberculosis* is unlikely. This classification should also be applied to employees who will never be exposed to persons with TB disease or to clinical specimens that might contain *M. tuberculosis.*

[25] Centers for Disease Control and Prevention. Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005. *MMWR* 54(RR-17): December 30, 2005. Available at: www.cdc.gov/mmwr/pdf/rr/rr5417.pdf. Accessed January 30, 2016.

- Medium Risk. The classification of Medium Risk should be applied to settings in which the risk assessment has determined that employees will or will possibly be exposed to persons with TB disease or to clinical specimens that might contain *M. tuberculosis*.

- Potential Ongoing Transmission. The classification of Potential Ongoing Transmission should be *temporarily* applied to any setting (or group of employees) if evidence suggestive of person-to-person (e.g., patient-to patient, patient-to-employee, employee-to-patient, or employee-to-employee) transmission of *M. tuberculosis* has occurred in the setting during the preceding year. Evidence of person-to person transmission of *M. tuberculosis* includes: (1) clusters of Tuberculin skin tests (TST) or Blood Assay for *Mycobacterium* ***Tuberculosis*** (BAMT) conversions, (2) employee with confirmed TB disease, (3) increased rates of TST or BAMT conversions, (4) unrecognized TB disease in patients or employees, or (5) recognition of an identical strain of *M. tuberculosis* in patients or employees with TB disease identified by deoxyribonucleic acid (DNA) fingerprinting.

If uncertainty exists regarding whether to classify a setting as low risk or medium risk, the setting typically should be classified as medium risk.

PROCEDURES

1. The Practice applies a TB exposure control plan (ECP). The TB ECP includes the following elements:

   a. Designation of a TB Administrator;

   b. Annual risk assessment;

   c. Exposure determination;

   d. Work practice procedures;

   e. Medical surveillance, which includes the following:

      1) Baseline skin tests;

      2) Medical histories;

      3) Post-exposure medical management and follow-up; and

      4) Periodic medical surveillance as required by the CDC guidelines or appropriate state requirements;

f. Medical removal and protection (MRP), where necessary;

g. Communication of hazards and training; and

h. Recordkeeping.

2. The Practice complies with the procedures recommended by the CDC or appropriate state requirements, in accordance with the risk category of the employee as discussed below.

a. TB screening procedures for employees who are healthcare workers classified as Low Risk:

1) All physicians, advanced practice providers, and employees shall receive a baseline TB screening upon hire, using two-step TST or a single BAMT to test for infection with *M. tuberculosis*.

2) After baseline testing for infection with *M. tuberculosis*, additional TB screening is not necessary unless an exposure to *M. tuberculosis* occurs.

3) Providers or employees with a baseline positive or newly positive test result for *M. tuberculosis* infection (i.e., TST or BAMT) or documentation of treatment for latent **TB** infection (LTBI) or TB disease should receive one chest radiograph (x-ray) to exclude TB disease (or an interpretable copy within a reasonable time frame, such as six months). Repeat x-rays are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician.

b. TB screening procedures for employees who are healthcare workers classified as Medium Risk:

1) All physicians, advanced practice providers and employees should receive baseline TB screening upon hire, using two-step TST or a single BAMT to test for infection with *M. tuberculosis*.

2) After baseline testing for infection with *M. tuberculosis*, physicians, advanced practice providers and employees should receive TB screening annually (i.e., symptom screen for all healthcare workers and testing for infection with *M. tuberculosis* for healthcare workers with baseline negative test results).

3) Physicians, advanced practice providers, and employees with a baseline positive or newly positive test result for *M. tuberculosis* infection or documentation of previous treatment for LTBI or TB disease should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, healthcare workers should receive a symptom screen annually. This screen should be accomplished by educating the healthcare worker about symptoms of TB disease and instructing the healthcare worker to report any such symptoms immediately to the occupational

health unit. Treatment for LTBI should be considered in accordance with CDC guidelines.

c. TB screening procedures for employees who are healthcare workers classified as Potential Ongoing Transmission:

1) Testing for infection with *M. tuberculosis* might need to be performed every 8 to 10 weeks until lapses in infection control have been corrected and no additional evidence of ongoing transmission is apparent.

2) The classification of potential ongoing transmission should be used as a temporary classification only. It warrants immediate investigation and corrective steps. After a determination that ongoing transmission has ceased, the setting should be reclassified as Medium Risk. Maintaining the classification of Medium Risk for at least one year is recommended.

3. The Practice provides initial TB training relevant to their work setting and additional occupation-specific education. The level and detail of baseline training varies according to the responsibilities of the healthcare worker and the risk classification of the setting. The Practice conducts an annual evaluation of the need for follow-up training and education (see related policy 14.10 on Tuberculosis [TB] Communication and Training).

4. The Practice implements environmental controls including technologies for the removal or inactivation of airborne *M. tuberculosis* in order to help to prevent the spread and reduce the concentration of infectious droplet nuclei in the air. These technologies include local exhaust ventilation, general ventilation, high-efficiency particulate air (HEPA) filtration, and ultraviolet germicidal irradiation (UVGI), as appropriate and as required.

5. The Practice requires the use of respiratory protective equipment in situations that pose a high risk for exposure. OSHA requires healthcare settings in which healthcare workers use respiratory protection to develop, implement, and maintain a respiratory protection program. The Practice shall ensure that healthcare workers who use respiratory protection are included in the program.

6. The Practice maintains, reviews, and updates the TB ECP at least annually, and whenever necessary to reflect new or modified tasks, procedures, and engineering controls that affect occupational exposure. The TB ECP is also reviewed and updated annually to reflect new or revised employee positions with occupational exposure. A copy of the current TB ECP is maintained in the human resources department, at the work station of the manager who serves as the TB administrator of the Practice, and on the Practice's intranet. The TB ECP may be viewed as necessary.

EXPOSURE CONTROL • POLICY 14.10

Tuberculosis (TB) Communication and Training

For the safety of employees and patients, it is the policy of the Practice to communicate and train new and existing physicians, advanced practice providers, and employees about tuberculosis (TB).

PROCEDURES

1. The Practice secures appropriate training for all physicians, advanced practice providers, and employees who have a potential risk for occupational exposure upon hire, initial assignment, and annually thereafter.

2. The training program includes:

   a. The epidemiology of TB, including signs and symptoms, and the difference between infection and disease;

   b. How employees can review the Practice's TB Exposure Control Plan (see related policy 14.09 on Tuberculosis [TB] Exposure Control Plan);

   c. Tasks that may involve occupational exposure;

   d. Use and limitations of engineering controls and work practices;

   e. Procedures to take after an exposure incident; and

   f. Procedures to follow if an employee develops signs or symptoms of TB.

3. All training records are maintained for five years, or that which is required by state law.

EXPOSURE CONTROL • POLICY 14.11

Tuberculosis (TB) Reporting

The Practice reports all suspected and confirmed cases of tuberculosis (TB) in accordance with the recommendations promulgated by the Centers for Disease Control and Prevention (CDC) and applicable state requirements. All reports are submitted to the local TB control authority.

All suspected or confirmed cases of TB that are immediately referred to the local TB control authority for further evaluation, diagnosis, and treatment are exempt from this reporting requirement.

PROCEDURES

1. Report forms and transmission of reports.

    a. Reports of suspected and confirmed cases of TB are made on forms available from the local TB control authority. The Practice follows the protocols of the local TB control authority with regards to submitting the form.

    The local TB control authority is:_____

    _____

    They may be contacted at: _____

    _____

2. Reports of suspected and confirmed cases of TB.

    a. Within seven calendar days (or that which is required by the state) after the diagnosis of a suspected or confirmed case of TB, the Practice notifies the local TB control authority of the following:

1) Diagnosis.

Information is provided about the diagnosis of a suspected or confirmed case of TB, including the dates and results in millimeters of Mendel-Mantoux test and the results of bacteriologic examinations and chest x-rays.

2) Clinical management information.

Information is provided about the clinical management of a suspected or confirmed case of TB, including the determination of the infectious or not infectious status, isolation precautions taken, treatment regimen, whether the client is at high risk for non-adherence to a prescribed treatment regimen, and past or present behavior that indicates a substantial likelihood of not cooperating with prevention and control measures.

3) Surveillance information.

Reportable demographic information regarding the suspected or confirmed case of TB includes name; address; date of birth; gender; race; ethnic origin; country of origin; month and year the person arrived in the United States (if applicable); non-prescribed drug use and excessive alcohol use within the year before the date of submission; occupation; address changes; name and addresses of close contacts; and other information required to complete the tuberculosis reporting form of the state Department of Public Health and the CDC.

4) Other information.

Any other relevant information requested by the local TB control authority is provided. Such information may include hospital post-discharge plans and locating information for persons with TB infection.

3. Employee medical records that are coordinated through the TB control officer are maintained for a period of 30 years after termination of employment, or that which is required by the state.

CHAPTER 15

Closing a Practice

POLICY 15.01 • Closing or Departing from a Practice

CLOSING A PRACTICE • POLICY 15.01

Closing or Departing from a Practice

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state, city and county may differ, and this suggested general policy should not be implemented without considering applicable state and local law.*

It is the policy of the Practice that due care is taken when a provider departs from the Practice. In the event that a provider departs from or closes the Practice, the Practice has a duty to ensure that patient's transition smoothly from the current provider to the new treating provider. This policy also guides the Practice in the event of closure to ensure that all business systems are closed in compliance with all federal, state, and local regulations.

PROCEDURES

1. Closing or departing from the Practice should occur with a minimum of disruption in continuity and quality of medical care being provided to patients.

2. Physicians and advanced practice providers have an obligation to respect the rights of patients to decide from whom they wish to receive care. Therefore, it is the responsibility of all providers and other parties that may be involved to ensure that:

    a. Patients are notified of changes in the Practice. The Practice shall communicate in writing (electronic notification via the Practice's patient portal accompanied by a letter mailed to the patient's address on file) to patients who are currently, or have recently been, under the provider's care. Additionally a notice is placed in the local newspaper. The communication explains the changes in the Practice, to include the departure of a provider, and/or the final date the Practice will remain open for business and, if appropriate, an authorization to transfer medical records to a new provider. When mailed letters are returned as undeliverable, the Practice shall attempt to reach these patients via telephone to inform them of changes. Place a copy of the dated closure notice in each patient's medical record.

b. Patients are provided with instructions for how to release their records, including the directions to view, download or transmit to a third party their medical records online, as well as the appropriate form to fax or mail to the Practice.

c. Patients are advised how to reach the provider(s) remaining in the Practice.

3. Except in cases of death or other incapacity of a provider, providers may not abandon a patient or abruptly withdraw from caring for a patient. Therefore, patients are given reasonable advance notice to allow them to secure other care. The Practice communicates 60 days prior to a planned departure of a physician or advanced practice provider, unless there are extenuating circumstances. In the event a provider departs from the Practice without giving appropriate notice, the Practice shall commit to continue care for the provider's patients, via other providers at the Practice, at the option of the affected patients.

4. The Practice ensures that the patient's protected health information (PHI) is private and secure and provides patients appropriate access to their PHI.

5. Where appropriate, the Practice makes referrals to new providers. In the event of a departing physician or provider, the Practice makes suggestions about other providers who are accepting patients. In the event that the Practice closes, the communication includes information about accessing the provider network available in the community. The Practice strives to effectively address the continuity of care for all patients. The Practice does not accept compensation of any kind from other providers for these referrals.

6. In addition to notifying patients, the Practice communicates with other key stakeholders, as dictated by the particular circumstances of the situation.

    a) The state Medical Board office to update the provider's address of record or notify it of the closure of the Practice;

    b) The Practice's malpractice insurance carrier to advise it of the change in status of the departing provider or Practice closure;

    c) Insurance companies, including state Medicaid programs and the Centers for Medicare & Medicaid Services, with which the provider or Practice participates;

    d) Provider membership organizations (e.g., state medical association, specialty societies, etc.), as they may also want to know of the departure of the provider or discontinuance of the Practice;

    e) Hospital(s) and other facilities where the departing provider or Practice that is closing are on medical staff or maintain courtesy privileges.

    f) Other stakeholders as appropriate.

7. Every effort will be made to make the transition smooth for employees. All employees will be notified in a prompt manner of the closure to minimize disruption. The need for temporary employees to fill any need if employees leave prior to closure will be evaluated.

8. In the event that a Practice discontinues all operations, the Practice will use the Practice Closure Plan (see next page) to guide closure. The plan provides guidance to the Practice to ensure due diligence, care, and processes are implemented to minimize disruption to patients, employees, and the financial position of the Practice.

9. The Practice will consult with an attorney, as applicable.

PRACTICE CLOSURE PLAN

Corporate Structure

- Determine the process to dissolve the legal entity
- Prepare the separation agreement between partners
- Prepare filing and dissolution documents for entity
- Determine the use of logos and trade names
- Collect all trade names, doing business as (D/B/A) names, and registrations to present to the attorney(s) for document preparation
- Collect all board of directors' minutes for the past two years to present to the attorney(s) for document preparation
- Agree upon a final closing date
- Make accommodations for addressing compensation issues for providers and employees
- Review the status of any related corporations and prepare transition plans
- Determine how expenses carried past close date (e.g. record storage, answering service) will be funded
- Determine how any recoupments from health plans identified after the close date will be funded

Determine Maintenance of Records

- Scan business records to electronic format; determine storage of the following documents:
  - Personnel records
  - Accounting records
  - Billing records
- Determine who will be managing custodian of the Practice's electronic health records and in compliance with state and federal privacy and security laws and where records will be stored
- Establish a system of retrieval for future inquiries into all records including appropriate phone numbers and mailing addresses after closing
- Notify malpractice insurance carrier where medical records are and will be located
- Notify state medical board where medical records are and will be located
- Determine the appropriate record retention timelines for retained documents pursuant to state and federal requirements

Asset Valuation

- Secure market valuation of all assets, to include building equipment, furniture, and inventory
- Determine how the Practice will dispose of furniture and equipment, including private sale, used equipment company or fire sale
- If applicable, contract with a real estate agent and/or place property for sale
- Solicit buyers
- Determine dismantle and distribution date
- Refer to Corporate Structure for resolution of any disputes over asset values

Letters of Termination/Notification

- All hospitals where providers have privileges
- All other facilities (e.g., ambulatory surgery center [ASC], nursing homes, etc.) at which providers practice
- Third-party payers with notice of where to send payments after closure of practice (if bank is closed) – consider for up to 1 year following date of service; also notice address for recoupment requests
- Centers for Medicare & Medicaid Services• Referring physicians
- Drug Enforcement Agency (DEA) and any state controlled substance oversight entity
- Appropriate state licensing entities, including the Board of Pharmacy for notice on prescription authority
- Patient notice: including how to view, download or transmit to a third party online access to their records, giving a minimum of 60 days' advance notice
- Referring physicians and ancillary services such as labs and imaging facilities: courtesy notice regarding closure and advance notice
- Retirement plans and 401K plans
- Malpractice and arrange for any tail coverage for malpractice, if necessary
- Business owners' insurance
- Health, vision, dental, life and disability insurance
- Workers' compensation
- State sales tax
- Tax identification number (TIN) (do not terminate until after all tax reports have been filed)
- Creditors
- Directors' and officers' insurance
- Crime policy
- Commercial liability
- Fiduciary liability
- Secretary of State (dissolve legal entity, if applicable, after all taxes have been filed)
- Payroll service
- Place notification in newspaper
- Website and patient portal hosting (maintain for 12 months after closure to redirect patients)
- Answering service (maintain for three months to redirect patients)
- Pagers
- Telephone company (inform company of date of termination of line service)
- Cell phone coverage
- Utilities (electricity/gas, water, trash, internet service provider)
- Hazardous materials pickup
- Shredding service

- Laundry/linen service; uniforms
- Housekeeping/janitorial/snow removal/lawn maintenance

Professional Organizations

- Specialty board
- Specialty college(s)
- State and county medical societies

Lease Terminations

- Space
- Practice management system/Electronic medical record licenses
- T-1 line
- Office equipment (e.g., copier, scanner, computer, server)
- Other

Financial Estimates for Closure

- Pay out on leased clinic space
- Pay out employee bonuses, vacation, sick, and/or paid time off (PTO) time, and severance pay for administration, if applicable
- Pay out on leased equipment that will not be sold or transferred
- Pay out for equipment maintenance agreements
- Pay out on software license agreements and support agreements
- Cost to maintain access to electronic health record (EHR) system
- Pay out of credit balances in accounts receivable, including state escheats
- Cost to remove assets that cannot be sold or disposed of
- Cost to pay off any outstanding loans or lines of credit

Address Change Notification

- Place notification in newspaper, Practice's Website and Practice's patient portal
- Notify utilities
- Notify hospital administration
- Notify hospital departments or floors specific to specialty
- Notify insurance companies
- Notify emergency department
- Notify or give contact to Board of Medical Examiners
- Arrange for message forwarding with the United States Postal Service

Terminate Service Contracts

- Imaging equipment
- Faxes and copiers
- Medical equipment

- Information systems
- Cloud storage/Electronic health records

Employees

- Analyze contracts, Workers' Compensation claims, and other issues affecting employment termination
- Assist with employee outplacement
- Stage departures to accommodate transition
- Consider bonuses to retain key employees until date of closure
- Determine date of termination and give notification as soon as possible to prevent negative impact of rumors
- Address severance pay
- File all unemployment returns through payroll service

Accounts Receivable (A/R)

- Determine outsource solution after closing
- Determine how long to retain business office employees or contract with billing service
- Determine what to do with receivables outstanding at the discontinuation of billing activities
- Handle any credit balances at the end, to include remitting unclaimed property as per state escheats guidelines
- Determine when to remove A/R from practice management software
- Provide incentives to collect as much as possible of the A/R prior to closure

Medical License Notification

- State(s)

Subscription Cancellations

- Professional journals
- Magazines
- Newspapers

Premium Refunds

- Health, vision and dental insurance
- Business liability insurance
- Business owners' insurance

Payables

- Arrange for payments after termination date
- Close credit cards

Banking

- Close bank accounts

- Pay off loans
- Keep checking account open for six months for straggling accounts payable and refunds
- Arrange for line of credit to pay off liabilities

Creditors

- Determine current payables and process all payments
- Notify of closing
- Request final billing

Address Change

- Place forwarding address at post office
- Place "Return to Sender" on all junk mail

Books, Texts, and Journals

- Donate books and journals
- Recycle remaining books and journals
- Office brochures/patient education material

Document Destruction

- Business cards
- Letterhead
- Prescription pads
- Others

Telephone Lines

- Call forward to new practice, if applicable
- Use answering service to transfer calls, if applicable

Insurance Policies

- Extend until date of close
- Pay tail coverage on officers and directors (O&D) insurance and fiduciary policy

Computers

- Obtain hard drives on which to place data; determine with whom the data will be stored
- Arrange for all data to be securely removed and wiped from computers and server prior to dissolution and release of hardware

Medications

- Appropriately dispose of prescription and over-the-counter drugs in inventory according to federal guidelines
- Contact drug sales representatives for the handling of unused samples
- Destroy all prescription pads by shredding, burning, pulping or pulverizing that every sheet is rendered essentially unreadable, indecipherable and otherwise cannot be reconstructed and notify the appropriate state entity, if required

CHAPTER 16

Privacy and Security

POLICY 16.01 • Right to Privacy

POLICY 16.02 • Internet Security

POLICY 16.03 • Security Violations

POLICY 16.04 • Identity Theft Protection—Red Flag

POLICY 16.05 • Consent to Photograph

POLICY 16.06 • Social Networks

POLICY 16.07 • Security of Electronic Health Records

PRIVACY AND SECURITY • POLICY 16.01

Right to Privacy

It is the policy of the Practice to comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA); the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (HITECH Act); regulations promulgated there under by the U.S. Department of Health and Human Services (HIPAA Regulations); and other applicable laws. This policy describes procedures implemented by the Practice to ensure the privacy of patients' protected health information (PHI). The Practice obtains acknowledgment of receipt of such notice from all patients.

PROCEDURES

1. A designated Privacy and Security Officer is appointed from within the Practice to oversee the policies and procedures to ensure that patients' rights to privacy are fulfilled.

2. All patients arriving for care receive a Notice of Patients' Privacy Rights (see below) and the Receipt of Notice of Privacy Practices Written Acknowledgment Form (see below). All patients are asked to sign the acknowledgment of receipt form prior to receiving care. If there is a change in the HIPAA law and/or policies, patients are asked to sign an updated acknowledgement. All patients sign an acknowledgement every three years.

3. The Practice website contains the most recent versions of the privacy notice, privacy practices, and the acknowledgment response.

4. The Practice obtains written acknowledgment from the patient or legal guardian prior to engaging in treatment, payment, or healthcare operations.

5. An individual has a right to receive an accounting of disclosures of PHI made by a covered entity in the three years prior to the date on which the accounting is requested, except for disclosures defined in HIPAA. (See the Request for an Accounting of Certain Health Information on p. 549.) The Practice obtains written authorization for use or disclosure of PHI in connection with research and marketing.

    a. When appropriate, the Practice uses a combined informed consent authorization form, especially as it relates to patients participating in research studies.

6. The Practice discloses only the minimum PHI to requesting entities and insurance companies in order to accomplish the intended purpose of the disclosure.

7. As a covered entity, the Practice fully complies with the HIPAA Privacy Rule, effective April 14, 2003.

8. The Practice provides the patient, in the Notice of Privacy Practices, a clear, written explanation of how a covered entity – including the Practice and its Business Associates – may use PHI.

9. Patients are given the opportunity to request a correction or amendment to their PHI by completing the Request for Correction/Amendment of Protected Health Information (see below). Any allowed corrections or modifications must be in a written amendment; no changes are made directly to the patient's medical record. The Practice must inform patients that a written request for a correction or amendment is required, and that the patient is required to provide a reason to support the requested change. The amendment is accepted or denied in a provider's written response, on a Disposition of Amendment Request (see below).

10. Patients are provided the ability to view, download or transmit to a third party online access to their medical records.

11. Anyone who feels the confidentiality of a patient's PHI has been violated may submit a Patient Complaint Form (see below) to the Privacy and Security Officer. Complaints are kept confidential, and no repercussion may occur due to the report. Complaints are logged in the Privacy and Security Officer's Incident Event Log (see below).

12. Sanctions are imposed upon employees who violate the privacy of a patient's PHI; sanctions may vary from a warning to termination. See the Personnel and Information Systems Chapters for specific policies related to employee permitted disclosure and sanctions.

13. All employees of the Practice receive initial and ongoing training on how to prevent misuse of PHI and how to obtain authorization for its use. Employees may use the Privacy Policy Training Checklist and HIPAA Training Log (see below).

14. The Practice secures a Health Information Technology for Economic and Clinical Health Act (HITECH)-compliant Business Associate Agreement (see below) between the Practice and other third parties that share PHI for treatment, payment and other health care operations. The Business Associate Agreement is signed prior to any third party receiving PHI from the Practice. The Privacy Officer documents all Business Associates, the date of the signed Agreement and information regarding security measures taken by the Business Associate to keep PHI private and secure such as employee training, encrypted systems and other relevant measures.

15. The Practice and other entities performing services on behalf of the Practice use the HIPAA concept of minimum necessary in evaluating the release of patient information. The Practice and other entities performing services on behalf of the Practice release no PHI to employers or financial institutions without explicit authorization from the patient or legal guardian.

16. Electronic, physical, and logistical safeguards are implemented to secure the confidentiality of all patients' PHI.

17. The Practice maintains secure, electronic access to patient data for its providers.

18. The patient may submit a Request for Limitations and Restrictions of Protected Health Information (see below) which the Practice will recognize so long as it is not contrary to state or federal law, does not interfere with the patient's treatment or payment for medical services and does not require excessive Practice resources to implement. Reasonable modifications must be made to the request to make it practical to implement with the input of the patient.

NOTICE OF PATIENTS' PRIVACY RIGHTS

The Notice of Privacy Practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this Practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Please Review This Notice Carefully

1. Our commitment to your privacy:

Our Practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our Practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Patient's Privacy Rights ("Notice") currently in use by the Practice.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI;
- Your privacy rights in your PHI; and
- Our obligations concerning the use and disclosure of your PHI.

The terms of this Notice apply to all records containing your PHI that are created or retained by our Practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will apply to all of your records that our Practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our Practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time. Our Practice will always follow the Notice that is in effect at the time any action related to PHI is taken.

2. If you have questions about this Notice, please contact:
3. The Privacy and Security Officer at:

   _____

4. The different ways in which we may use and disclose your PHI:

   The following categories describe the different ways in which we may use and disclose your PHI:

   Treatment. Our Practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our Practice—including, but not limited to, our doctors and nurses—may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, with your authorization, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents, collectively called your "Friends and Family List" as documented by you on your Patient Authorization for Use and Disclosure of Protected Health Information" form. To let us know with whom you want your information shared, please be sure to complete this notice. Anytime you

would like to update your Friends and Family List, please call the office. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

Payment. Our Practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your PHI to bill you directly for service and items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts. You have the right to request that our Practice not submit a claim to your insurance company for payment due to privacy concerns. However, you agree to pay for all services in full under the time frame specified by our Practice. Failure to do so constitutes a waiver of this right (see 'Requesting Restrictions' below).

Healthcare Operations. Our Practice may use and disclose your PHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our Practice may use your PHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our Practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

Appointment Reminders. Our Practice may use and disclose your PHI to contact you and remind you of an appointment.

Treatment Options. Our Practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our Practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family and Friends. With your authorization, our Practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information since they brought the child to the appointment and were present during the examination. Generally, we require written authorization to share your PHI with friends and family members.

Disclosures Required by Law. Our Practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

5. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your PHI:

Public Health Risks. Our Practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths;
- Reporting child abuse or neglect;
- Notifying a person regarding potential exposure to a communicable disease;
- Notifying a person regarding a potential risk for spreading or contracting a disease or

condition;

- Reporting reactions to drugs or problems with products or devices;
- Notifying individuals if a medication, product or device they may be using has been recalled;
- Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; or
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our Practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the healthcare system in general.

Lawsuits and Similar Proceedings. Our Practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
- Concerning a death we believe has resulted from criminal conduct;
- Regarding criminal conduct at our offices;
- In response to a warrant, summons, court order, subpoena, or similar legal process;
- To identify/locate a suspect, material witness, fugitive, or missing person; and
- In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity, or location of the perpetrator).

Deceased Patients. Our Practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our Practice may release your PHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our Practice may use and disclose your PHI for research purposes in certain limited circumstances, most often when your information is de-identified in such a way that it cannot be attributed to you. We will obtain written authorization to use your PHI for research purposes except when the Practice's Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

1) The use or disclosure involves no more than a minimal risk to your privacy based on the following:

   a. An adequate plan to protect the identifiers from improper use and disclosure;

b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and

c. Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted.

2) The research could not practicably be conducted without the waiver.

3) The research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety. Our Practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. Our Practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security. Our Practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

Inmates. Our Practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (1) for the institution to provide healthcare services to you; (2) for the safety and security of the institution; and/or (3) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. Our Practice may release your PHI for Workers' Compensation and similar programs.

6. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

Confidential Communication. You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy and Security Officer at:

_____ specifying the requested method of contact and/or the location where you wish to be contacted. Our Practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required

by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy and Security Officer at: _____. Your request must describe in a clear and concise fashion:

- The information you wish restricted;
- Whether you are requesting to limit our Practice's use, disclosure, or both; and
- To whom you want the limits to apply.

Inspection and Copies. You have the right to view, download and/or transmit to a third party online the PHI that may be used to make decisions about you, including your medical records and billing records, but not including psychotherapy notes. You must register with the Practice's patient portal or submit your request in writing to:

_____ in order to inspect and/or obtain a copy of your PHI. If applicable, our Practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our Practice. To request an amendment, your request must be made in writing and submitted to:

_____. You must provide us with a reason that supports your request for amendment. Our Practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (1) accurate and correct; (2) not part of the PHI kept by or for the Practice; (3) not part of the PHI that you would be permitted to inspect; or (4) not created by our Practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our Practice has made of your PHI. To obtain an accounting of disclosures, you must submit your request in writing to:

_____. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our Practice may charge you for additional lists within the same 12-month period. Our Practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact:

_____.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our Practice, contact the Privacy and Security Officer at:

_____. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our Practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care. If you have any questions regarding this Notice or our health information privacy policies, please contact our Privacy and Security Officer at:

_____.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of the Notice of Privacy Practices.

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ Date: _____

REQUEST FOR AN ACCOUNTING OF CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION

As a patient, you have the right to receive an accounting of certain non-routine disclosures of your identifiable health information made by our Practice. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be provided free of charge. For additional lists during the same 12-month period, you may be charged for the costs associated with providing the list; however, the Practice will notify you of the cost involved prior to fulfillment of your request and you may choose to withdraw or modify your request. To request an accounting of disclosures made by the Practice, you must submit your request in writing to the Privacy and Security

Officer at: _____.

Patient name: _____

Date of birth: _____

Patient address:

Street: _____

Apartment #: _____

City, State, ZIP: _____

Signature of patient: _____ Date: _____

Signature of guardian: _____ Date: _____

Printed name of legal guardian: _____

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION (PHI)

Patient name: _____

Date of birth: _____

Patient address:

Street: _____

Apartment #: _____

City, State, ZIP: _____

Type of entry to be amended:

__ Office visit record

__ Hospital visit record

__ Prescription information

__ Patient history

__ Other

Please explain how the entry is inaccurate or incomplete:

_____

_____

Please specify what the entry should say to be more accurate or complete:

_____

_____

Signature of patient:_____ Date: _____

Signature of guardian: _____ Date: _____

Printed name of legal guardian: _____

DISPOSITION OF AMENDMENT REQUEST

Patient name: _____Date of birth: _____

Patient address:

Street: _____

Apartment #: _____

City, State, ZIP: _____

Date of amendment request: _____

Amendment has been:

__ Accepted

__ Denied

__ Denied in part, accepted in part

If denied (in whole or in part),* check reason for denial:

__ PHI was not created by this Practice

__ PHI is not available to the patient for inspection in accordance with the law

__ PHI is not a part of patient's record

__ PHI is accurate and complete

Comments from healthcare provider who provided the service:

_____

_____

Name of employee completing form: _____

Title: _____

Signature of treating provider: _____

Date: _____

* If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the Practice, Attn: Privacy and Security Officer: _____.

If you do not provide us with a statement of disagreement, you may request that we provide you with copies of your original request for amendment, our denial, and any disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Privacy and Security Officer at: _____, or the Secretary of the U.S. Department of Health and Human Services.

PATIENT COMPLAINT FORM

Our Practice values the privacy of its patients and is committed to operating our Practice in a manner that promotes patient confidentiality while providing high-quality patient care.

If the Practice has fallen short of this goal, we want you to notify us. Please be assured that your complaint will be kept confidential. Please use the space provided below to describe your complaint. It is our intent to use this feedback to better protect your rights to patient confidentiality.

_____

_____

_____

_____

_____

_____

_____

_____

Name of patient: _____

Date:_____

Signature of patient: _____

Phone #: _____

PRIVACY AND SECURITY OFFICER'S INCIDENT EVENT LOG

Date Received	Date Completed	Nature of Complaint	Results of Investigation	Sanctions

PRIVACY POLICY TRAINING CHECKLIST

Training conducted on date: _____ by: _____.

Training included: (Please check next to the action item to indicate training completion.)

_____ Introduction to HIPAA and the Privacy Rule

_____ Introduction of Privacy and Security Officer and Overview of Privacy and Security Officer Responsibilities

_____ Explanation of Workforce Confidentiality Agreements

_____ Overview of Practice's Privacy Policies and Procedures

_____ Overview of Practice's Notice of Privacy Practices

_____ Explanation of Privacy Forms

_____ Patient Authorization Form

_____ Form Requesting Restriction on Uses of Disclosures of PHI

_____ Form to Implement Access Denial

_____ Form to Amend PHI

_____ Form to Receive Accounting of Disclosures of PHI

_____ Patient Complaint Form

_____ Explanation of Who Can Disclose PHI

_____ Discussion of Job Responsibilities as it Relates to PHI

_____ Explanation of Minimum Necessary Standard

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize [Practice Name] to use and/or disclose certain protected health information (PHI) about me to:

_____

_____

_____ (Names of friends, family members or others to receive this information.)

This authorization permits [Practice Name] to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on [date]: _____, or defined event.

The Practice will ___ will not ____ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy and Security Officer at: _____

Signed by: _____

Relationship to patient: _____

Patient's name: _____

Date: _____

Print name of patient or legal guardian: _____

HIPAA Training Log

Course Name and Overview of Content: _____

_____

_____

Employee Name	Date Trained	Trainer	Employee Signature

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is made effective _____, by and between The Practice ("Covered Entity") and _____ ("Business Associate"), (individually, a "Party" and collectively, the "Parties").

RECITALS

WHEREAS, the Parties have entered into one or more agreements (each an "Underlying Contract") whereby Business Associate will provide certain services to Covered Entity and Covered Entity may disclose certain information to Business Associate pursuant to the terms of the Underlying Contract, some of which may constitute Protected Health Information ("PHI") as defined below;

WHEREAS, Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate pursuant to the Underlying Contract in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH Act"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws;

WHEREAS, as part of the HIPAA Regulations, the Privacy Rule and the Security Rule, defined below, Covered Entity is required to enter into a contract containing specific requirements with Business Associate prior to the disclosure of PHI as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e), and 164.504(e) of the Code of Federal Regulations ("CFR") and contained in this Agreement.

THEREFORE, in consideration of the Parties' continuing obligations under the Underlying Contract, compliance with the HIPAA Security and Privacy Rule, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Security and Privacy Rule and to protect the interests of both Parties.

1. Definitions

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Security and Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Security and Privacy Rule, as amended, the HIPAA Security and Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Security and Privacy Rule, but are nonetheless permitted by the HIPAA Security and Privacy Rule, the provisions of this Agreement shall control.

The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation and materials, including without limitation, demographic, medical and financial information, that relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. "Protected Health Information" includes without limitation "Electronic Protected Health Information" as defined below.

The term "Electronic Protected Health Information" means Protected Health Information which is transmitted by Electronic Media (as defined in the HIPAA Security and Privacy Rule) or maintained in Electronic Media.

2. Obligations of Business Associate

a. **Permitted Uses.** Business Associate shall not use Protected Data except for the purpose of performing Business Associate's obligations under the Underlying Contract and as permitted under the Underlying Contract and Agreement. Further, Business Associate shall not use Protected Data in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by Covered Entity. However, Business Associate may use Protected Data (i) for the proper management and administration of Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) for Data Aggregation purposes for the Healthcare Operations of Covered Entity.

b. **Permitted Disclosures.** The Business Associate may disclose the PHI received by it in its capacity as Business Associate to properly manage and administer its business or to carry out its legal responsibilities if: (a) the disclosure is required by law, or (b) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it is disclosed to the person and the person immediately notifies Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

c. **Prohibited Uses and Disclosures.** Business Associate shall not use or disclose Protected Data for fundraising or marketing purposes. Business Associate shall not disclose Protected Data to a health plan for payment of healthcare operations purposes if the patient has requested this specific restriction, and has paid out of pocket in full for the healthcare item or service to which the PHI solely relates 42 U.S.C. Section 17935(a). Business Associate shall not directly or indirectly receive remuneration in exchange for Protected Data, except with the prior written consent of Covered Entity as permitted by the HITECH Act, 42 U.S.C. Section 17935(d)(2); however, this prohibition shall not affect payment by Covered Entity to Business Associate for services provided pursuant to the Underlying Contract.

d. **Appropriate Safeguards.** Business Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of PHI while in use, transit or rest, other than as permitted by the Underlying Contract or Agreement. These safeguards include but are not limited to, administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Data, in accordance with 45 CFR Sections 164.308, 164.310, and 164.312. Business Associate shall comply with the policies and procedures and documentation requirements of the HIPAA Security Rule, including but not limited to, 45 CFR Section 164.316.

e. **Written Authorization.** Notwithstanding any other limitation in this Section 2, Covered Entity agrees that nothing in this Agreement prohibits Business Associate from using or disclosing PHI to the extent permitted by a written authorization from the applicable patient.

f. **Reporting of Breach of Unsecured PHI.** Business Associate shall, following the discovery of a Breach of Unsecured PHI, immediately notify Covered Entity of such Breach pursuant to the terms of 45 CFR Section 164.410 and cooperate in the Covered Entity's breach analysis procedures, including risk assessment, if requested. A breach shall be treated as discovered by Business Associate as of the first day on which such breach is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate will comply with breach notification laws with the state of (insert the state in which the Practice is legally organized). Business Associate will provide such notification to Covered Entity without unreasonable delay and

in no event later than ten (10) calendar days after discovery of the breach. Such notification will contain the elements required in 45 CFR § 164.410. Business Associate shall mitigate, to the extent practicable, any harmful effects of said disclosure that are known to it.

g. **Reporting of Improper Access, Use, or Disclosure.** Business Associate shall report to Covered Entity any attempted or successful access, use, or disclosure of PHI that is not in compliance with the terms of this Agreement of which it becomes aware. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

h. **Business Associate Agents**. Business Associate shall ensure that any Agents, including subcontractors, to whom it provides PHI, agree in writing to the same restrictions and conditions that apply to Business Associate with respect to such PHI, and implement the safeguards required by paragraph (2)(d) above with respect to Electronic PHI. Business Associate shall implement and maintain sanctions against Agents that violate such restrictions and conditions and shall mitigate the effects of any such violation. Business Associate shall notify Covered Entity in writing of all subcontractor and agent agreements. Business Associate shall immediately notify Covered Entity in writing of any unauthorized attempted or successful access, use or disclosure of data used, transmitted or stored by its Agents.

i. **Designated Record Set.** If Business Associate maintains a Designated Record Set on behalf of Covered Entity:

i) Business Associate shall make Protected Data maintained by Business Associate or its agents or subcontractors in Designated Record Sets available to Covered Entity for inspection and copying within ten (10) days of a request by Covered Entity to enable it to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.524. If Business Associate maintains an Electronic Health Record, Business Associate shall provide such information in electronic format to enable Covered Entity to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(e).

ii) Within ten (10) days of receipt of a request from Covered Entity for an amendment of Protected Data or a record about an individual contained in a Designated Record Set, Business Associate or its agents or subcontractors shall make such Protected Data available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.526. If any individual requests an amendment of Protected Data directly from Business Associate or its agents or subcontractors, Business Associate must notify Covered Entity in writing within five (5) days of the request. Any approval or denial of amendment of Protected Data maintained by Business Associate or its agents or subcontractors shall be the responsibility of Covered Entity.

j. **Accounting Rights.** Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI under the Privacy Rule, including, but not limited to, 45 CFR Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935(c). Within ten (10) days of notice by Covered Entity of a request for any accounting of disclosures of Protected Data, Business Associate and its agents or subcontractors shall make available to Covered Entity the information required to provide an accounting of disclosures to enable Covered Entity to fulfill its obligations. Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by Business Associate and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from

an Electronic Health Record for treatment, payment, and healthcare operations purposes is required to be collected and maintained for only three (3) years prior to the request, and only to the extent Business Associate maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the person who received Protected Data and, if known, the address of the entity or person; (iii) a brief description of Protected Data disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to Business Associate or its agents or subcontractors, Business Associate shall within five (5) days of a request forward it to Covered Entity in writing. It shall be Covered Entity's responsibility to prepare and deliver any such accounting requested. The provisions of this subparagraph j shall survive the termination of this Addendum.

k. **Governmental Access to Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Data available to Covered Entity and to the U.S. Department of Health and Human Services ("HHS") for purposes of determining Business Associate's compliance with the Privacy Rule. Business Associate shall provide to Covered Entity a copy of any Protected Data that Business Associate provides to HHS concurrently with providing such Protected Data to HHS.

l. **Minimum Necessary.** Business Associate (and its agents or subcontractors) shall request, use, and disclose only the minimum amount of Protected Data necessary to accomplish the purpose of the request, use, or disclosure. Business Associate understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by HHS with respect to what constitutes "minimum necessary."

m. **Breach Pattern** or **Practice by Covered Entity.** Pursuant to 42 U.S.C. Section 17934(b), if Business Associate knows of a pattern of activity or Practice of the Covered Entity that constitutes a material breach or violation of Covered Entity's oblations under the Contact or Agreement or other arrangement, Business Associate must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, Business Associate must terminate the Underlying Contract or other arrangement if feasible, or if termination is not feasible, report the problem to the HHS.

3. Termination

a. **Material Breach.** A breach by Business Associate of any provision of this Agreement, as determined by Covered Entity, shall constitute a material breach of the Underlying Contract and shall provide grounds for immediate termination of the Underlying Contract, any provision in the Underlying Contract to the contrary notwithstanding.

b. **Effect of Termination.** Upon termination of the Underlying Contract for any reason, Business Associate shall, at the option of Covered Entity, return or destroy all Protected Data that Business Associate or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Data. If return or destruction is not feasible, as determined by Covered Entity, Business Associate shall continue to extend the protections of Section 2 of this Agreement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. If Covered Entity elects destruction of the PHI, Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed.

4. General Provisions

a. **Compliance with All Laws and Regulations.** The Parties expressly acknowledge that it is, and shall continue to be, their intent to fully comply with all relevant federal, state, and local laws, rules, and regulations.

b. **Governing Law.** This Agreement shall be governed in all respects, whether as to validity, construction, capacity, performance, or otherwise, by the laws of the State of (Insert the state in which the Practice is legally organized).

c. **Notices.** All notices or communications required or permitted pursuant to the terms of this Agreement shall be in writing and will be delivered in person or by means of certified or registered mail, postage paid, return receipt requested, to such Party at its address as set forth below, or such other person or address as such Party may specify by similar notice to the other Party hereto, or by telephone facsimile with a hard copy sent by mail with delivery on the next business day. All such notices will be deemed given upon delivery or delivered by hand, on the third business day after deposit with the U.S. Postal Service, and on the first business day after sending if by facsimile.

As to Covered Entity:

As to Business Associate:

Either Party may change either or both the address and person to which notices shall be sent by giving notice to the other Party in the manner provided above.

d. **Effect on Underlying Contract.** Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the Underlying Contract shall remain in force and effect.

e. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit the Parties to comply with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule, and other applicable laws relating to the security or confidentiality of PHI.

f. **Validity.** If any provision of this Agreement shall be held invalid or unenforceable, such invalidity or unenforceability shall attach only to such provision and shall not in any way affect or render invalid or unenforceable any other provision of this Agreement.

g. **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 of the same or other provisions of this Agreement.

h. **Counterparts.** This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

i. **No Assignment.** This Agreement shall be binding upon and inure to the benefit of the Parties hereto and their respective successors and assigns. Neither Party shall assign or delegate its rights, duties, or obligations under this Agreement, without the prior written consent of the other Party.

j. **Rules in Effect or As Amended.** A reference in this Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended.

k. **Amendment to Comply with Law.** The Parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Underlying Contract or

Agreement may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule, and other applicable laws relating to the security or confidentiality of PHI.

l. **Independent Contractor.** In the performance of the duties and obligations of the Parties pursuant to this Agreement, each of the Parties shall at all times be acting and performing as an independent contractor, and nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee, or partner, or joint venture, or principal and agent between the Parties.

IN WITNESS WHEREOF**,** the Parties hereto have affixed their hands and seals on the day and date first above written.

_____

("BUSINESS ASSOCIATE") ("COVERED ENTITY")

By: _____

_____

By: _____

_____

Print Name: _____ Print Name: _____

Date: _____ Date: _____

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)

Patient name: _____

Date of birth: _____

Patient address:

Street: _____

Apartment #: _____

City, State, ZIP: _____

Type of PHI to be restricted or limited: (Please check all that apply.)

__ Home phone number
__ Cell phone number
__ Home address
__ Occupation
__ Name of employer
__ Office visit record
__ Hospital visit record
__ Prescription information
__ Patient history
__ Office address
__ Office phone number
__ Parent's name
__ Parent's phone number
__ Spouse's name
__ Spouse's phone number
__ Other: _____

_____

How would you like the use and/or disclosure of your PHI restricted?

_____

_____

Signature of patient: _____ Date: _____

Signature of guardian: _____ Date: _____

Printed name of legal guardian: _____

PRIVACY AND SECURITY • POLICY 16.02

Internet Security

It is the policy of the Practice to secure and protect the health information of its patients. This policy defines roles, responsibilities, and policies for physicians, advanced practice providers, employees, agents, and contractors of the Practice who may use the Practice's communications equipment and facilities to access the Internet. Such individuals will be referred to as "the user."

Security and protection of protected health information (PHI) is everyone's responsibility. All users must be aware of their responsibility in the protection of the electronic information assets of the Practice. This policy is provided to enhance the security awareness of our users and to protect confidential patient and sensitive Practice information.

Employees may have access to various forms of electronic media and services including computers, e-mail, telephones, voice mail, fax machines, and the Internet. The Practice encourages the use of these media and associated services because information technology is a critical part of the service provided to patients and, in many cases, is required to efficiently conduct billing or transactions with outside entities that support patient care. However, the Practice-provided access to electronic media and services are the Practice's property, and their purpose is to facilitate the delivery of medical services and subsequent billing and collection.

Due to the rapidly changing nature of electronic communication, the policy cannot cover every possible situation. Instead, this policy expresses the Practice's philosophy and sets general guidelines for the use of electronic communication.

PROCEDURES

1. Users are accountable and responsible for helping to protect electronic information assets. They should be used in an efficient and economical manner and not in a way that is likely to cause network congestion or significantly hamper the ability of other people to access

and use the Practice's information systems.

2. Any software that is designed to destroy data, provide unauthorized access to the Practice's information systems, or disrupt computing processes is prohibited.

3. Users are uniquely identified and authenticated before accessing sensitive electronic information assets.

4. Users access only what they have been authorized to access.

5. Users do not act in a manner that will defeat the effectiveness of security measures.

6. Users do not install any software on their computers without written permission of the system administrator. This includes software downloaded from the Internet or personally brought into the Practice.

7. All software installed on the server and local computers are fully licensed.

8. All users are assigned a user name and password and are required to use them to log on to the system.

9. Data are transmitted securely between networks as per the security standards set forth in the HIPAA Privacy and Security Rules and based on an appropriate basis.

10. Contracts and agreements with Business Associates will be fully executed to assure security and confidentiality of data to electronically provide information to business partners. (See the Business Associate Agreement form in related policy 16.01 on Right to Privacy.) Agreements shall be renewed every three years. An annual accounting of safeguards taken by all Business Associates shall be conducted by the Privacy and Security Officer.

11. Virus checking software is loaded on all workstations and updated automatically to assure the detection of viruses. If at any time a virus is detected on a computer, users are instructed to immediately notify the system administrator.

12. Users notify the system administrator of any security-related incidents or potential security weaknesses.

13. Users use computer resources in compliance with the confidentiality of information policy rules and the HIPAA Security Rule.

14. Periodic audits are run on users' computers to monitor software installation at the discretion of the Administrator.

15. Use of Practice-provided access to the Internet is intended primarily for the Practice's business-related purposes. Internet access is monitored and recorded. Excessive use of the access provided by the Practice to the Internet for non-business–related purposes may result in loss of access privileges and/or disciplinary action, up to and including termination of employment. Visitors and contractors are not given access to the Practice network. To reinforce network security, any wireless service offered to Patients for their convenience and pleasure is hosted through a separate router.

16. Access to selected Internet hosts or networks that the Practice designates as inappropriate may be denied.

17. The Practice may apply browser filters to the software and/or network as appropriate.

18. Disclosing any information related to the business or information that violates the HIPAA Privacy and Security Rules is prohibited.

19. Use of the Practices user names and passwords or any business information on social networks (e.g., Facebook, Twitter) is prohibited.

20. Use of social networks to harass another employee is prohibited and is subject to termination.

21. Users should always portray the Practice as a reputable company and maintain its reputation and goodwill through their use of the Internet.

22. Users may not conduct Practice-related activities or access any Practice systems or protected health information on personally owned devices, included but not limited to smart phones, tablets and computers, without the written authorization of the Administrator. Users agree to allow Practice to install tracking and encryption software on personal devices in these instances.

PRIVACY AND SECURITY • POLICY 16.03

Security Violations

Note: *While this policy references the term "employees," please note that all members of the workforce, including employees and others under the direct control of the Practice, must comply with this policy.*

It is the policy of the Practice to protect the security and privacy of all protected health information (PHI). The Practice is committed to the implementation of policies and procedures that implement the requirements of the privacy and security regulations published under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the American Recovery and Reinvestment Act of 2009, P.L. 111-5 (ARRA), and regulations and guidance issued in response to ARRA.

These procedures shall apply to assist the Practice in:

1. Detecting breaches of PHI (as defined in 45 C.F.R. §160.103), within the meaning of 45 C.F.R. §164.402;

2. Determining whether a breach of PHI has occurred;

3. Determining whether such breach requires notification under 45 C.F.R. 164.404, 164.406, or 164.408; and

4. Determining the requirements applicable to any such required breach notifications.

PROCEDURES

1. Procedures for detecting breaches of PHI

   The Practice shall implement reasonable systems to detect possible breaches of PHI.

   a. Employee detection

      As part of these systems, the Practice ensures its employees receive adequate training regarding the importance of timely reporting privacy and security incidents. Employees who cause a privacy or security incident or breach or who fail to timely report such incidents will be disciplined. Upon discovery of a privacy or security incident, employees must promptly report such incidents to the Practice's designated HIPAA security officer. The HIPAA security officer documents the initial detection and then follows these procedures to determine whether a breach has occurred and whether notification is required.

   b. Determining whether a breach of PHI has occurred

      A *breach* is an unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA privacy rules (45 C.F.R. §164, Subpart E) ("HIPAA privacy rules"), which compromises the security or privacy of the PHI.

      The Practice should take the following steps to determine whether a breach of PHI has occurred:

      - ***Step I:*** *The Practice must first determine whether a particular unauthorized acquisition, access, use, or disclosure of PHI violates the HIPAA privacy rules.*

        – For example, a use or disclosure of PHI that involves more than the minimum necessary information would violate the HIPAA privacy rules. In contrast, a use or disclosure of PHI that is incident to an otherwise permissible use or disclosure and occurs despite reasonable safeguards and proper minimum necessary procedures would not violate the HIPAA privacy rules.

        – If the HIPAA privacy rules have not been violated, then no breach has occurred and the Practice must document its findings and need not complete the remaining steps in these procedures. If, however, the HIPAA privacy rules have been violated, then the Practice should proceed to Step II below.

      - ***Step II:*** *The Practice must determine whether the unauthorized acquisition, access, use, or disclosure of PHI in violation of the HIPAA privacy rules compromises the security or privacy of the PHI.*

– The security or privacy of PHI is compromised if there is a significant risk of financial, reputational, or other harm to an individual. To determine whether an incident has posed a significant risk to the individual, the Practice must conduct and document a risk assessment. Factors to consider include who impermissibly used or obtained the information, the type and amount of information involved, whether the Practice took immediate steps that eliminated or reduced the risk of harm, and whether the information was returned prior to being used for an improper purpose.

– If the Practice determines that a particular incident does not result in significant risk of harm, the Practice must document this assessment and need not complete the remainder of the steps in these procedures. However, if the Practice's risk assessment results in a finding of significant risk of harm, the Practice should proceed below to *Step 2 Determining whether a breach involves secured or unsecured PHI.*

2. Determining whether a breach involves secured or unsecured PHI

If the Practice determines that a breach of PHI has occurred, the Practice must next determine whether the breach involved secured or unsecured PHI. *Secured PHI* is PHI that has been rendered unusable, unreadable, or indecipherable to unauthorized individuals by the use of a technology or methodology specified in guidance issued by the Secretary of Health and Human Services (HHS). The current methods approved to secure PHI are encryption and destruction.

a. Breaches of secured PHI

If a breach of secured PHI occurs, the Practice must take any steps necessary to mitigate the breach. The Practice is not required to complete the breach notification requirements set forth in Breach notification requirements.

b. Breaches of unsecured PHI

If a breach of unsecured PHI occurs, the Practice must provide notice in accordance with the notification requirements set forth in *3. Breach notification requirements*.

3. Breach notification requirements

a. Timing

1) All notifications required by these procedures shall be made without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.

2) A breach is treated as discovered as of the first day on which it is known or by exercising reasonable diligence would have been known to the Practice (including any person other than the person committing the breach, who is an employee or agent of the Practice).

b. Method

1) Written notice to individuals

Notices to individuals shall be provided promptly by written notification by first-class mail to the individual at the last known address of the individual, or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. If the Practice knows that the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification shall be provided by first-class mail to either the next of kin or personal representative. The notification may be provided in one or more mailings as information is available.

2) Substitute notice to individuals

If there is insufficient or outdated contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual should be provided. However, substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative.

In cases where there is insufficient or out-of-date contact information for fewer than 10 individuals, the Practice may provide substitute notice by an alternative form of written notice, telephone, or other means.

In cases of 10 or more individuals for whom there is insufficient or outdated information, the Practice must provide substitute notice in the form of either a conspicuous posting for a period of 90 days on the home page of the website of the Practice or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. Such notice must include a toll-free number that remains active for at least 90 days where an individual can learn whether his or her unsecured PHI may have been included in the breach. In any case deemed by the Practice to require urgency because of possible imminent misuse of PHI, the Practice may, in addition to the required notices described above, provide information to affected individuals by telephone or other means.

3) Notice to media

In any cases where a breach of unsecured PHI involves more than 500 residents of a state or jurisdiction, the Practice will notify prominent media outlets serving that state or jurisdiction without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.

4) Notice to HHS

The Practice also notifies the Secretary of HHS of any breaches of unsecured PHI. Notice of breaches affecting 500 or more individuals are provided to HHS at the same time individual notice is provided as described above and in the manner specified on the HHS website. For all other breaches, the Practice maintains a log or other documentation of such breaches and notifies the Secretary of HHS within 60 days after the end of each calendar year of the breaches that occurred during the preceding calendar year, in the manner specified on the HHS website.

c. Content of notification

Breach notifications shall be written in plain language and include the following, to the extent possible:

1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

2) A description of the types of unsecured PHI (but not the actual data) that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, or other types of information were involved);

3) Any steps individuals should take to protect themselves from potential harm resulting from the breach;

4) A brief description of what the Practice is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and

5) Contact procedures for individuals to ask questions or learn more information, including a toll-free phone number, e-mail address, website, or postal address.

d. Documentation

The Practice must retain documentation of all notifications provided in accordance with these procedures, including evidence demonstrating the necessity of any delays in providing the required notification.

4. State breach notification requirements

   In addition to these HIPAA Privacy and Security Procedures for Breach Notification, the Practice also complies with any applicable state security breach notification laws.

5. Effective date/amendment

   These procedures shall apply to breaches occurring on or after September 23, 2009. These procedures shall be amended from time to time as necessary to comply with changes in the law and regulations and other guidance issued by HHS.

PRIVACY AND SECURITY • POLICY 16.04

Identity Theft Prevention—Red Flag

Alert: *This is a suggested policy for educational and illustrative purposes only. The particular laws of each state may differ, and this suggested general policy should not be implemented without consulting applicable state law. "Red Flag" does not reference the previous "Red Flag Rule" which was determined to not apply to medical practices as a mandate. However, the guidelines from that rule are helpful in preventing financial identity theft and thus helpful for medical identity theft prevention.*

It is the policy of the Practice to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how the Practice (1) identifies, (2) detects, and (3) responds to "red flags." A "red flag," as defined by this policy, is a pattern, Practice, or specific account or record activity that indicates possible identity theft.

PROCEDURES

1. The Practice collects, uses, transmits and stores data for the purposes of payment.

2. The Practice is compliant with federal and state regulations regarding prevention of identity theft.

3. The policy is published on the Practice's Website and patient portal. It is provided to all employees as a means of informing and educating employees and patients.

4. The Privacy and Security Officer is charged with implementing and maintaining the red flag requirements, as outlined in the Specific Procedures section below. This individual is provided sufficient resources and authority to fulfill these responsibilities.

5. All employees are trained on the policies and procedures governing compliance with federal and state laws related to identity theft. The Practice provides training to new employees on these matters within a reasonable time after they have joined the workforce or prior to processing a financial transaction where the employee would be handling demographic information.

6. Training is conducted with each employee upon hire and periodically (not less than annually) thereafter. Additional training is conducted upon a material change in any policy or procedure related to the red flag requirements.

7. Training is documented, indicating participants, date, and subject matter. Participants acknowledge receipt of training in writing.

8. Pursuant to the existing Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule, appropriate physical, administrative, and technical safeguards are in place to reasonably safeguard protected health information and sensitive personal information related to patient identity from any intentional or unintentional use or disclosure.

9. Business Associates of the Practice are contractually bound to protect sensitive patient information to the same degree as set forth in this policy. The initial violation of a business associate is handled by an investigation and notice to the business associate, followed by an effort to correct the problem. If the correction is not made, the agreement is terminated, and services discontinued. (See related policy 16.01 on Right to Privacy and the related Business Associate Agreement.)

10. Red flag requirements and policies are reviewed and updated regularly and not less than annually.

SPECIFIC PROCEDURES

1. Identify red flags

   The Practice identifies red flags based upon review of the guidelines in Appendix A of the Red Flag Rule.[1] The Practice responds to any inconsistent or suspicious documents, information, or activity that may signal identity theft. The following presents examples of detecting potential red flags. The list provided should not be considered an exhaustive list.

   Examples:

   - A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
   - A notice or inquiry from a fraud investigator for a law enforcement agency.
   - A question from a patient based on the patient's receipt of:
     - A bill for another individual;
     - A bill for a product or service that a patient denies receiving;

  - A bill from a healthcare provider that a patient never patronized; or
  - A notice of insurance benefits (or explanation of benefits) for a healthcare service never received.

- A notice from a third-party payer that a person receiving treatment was deceased prior to the date of service.
- A call to the Practice regarding the disposition of a patient's care, in which the patient indicates that he or she was not treated.
- Records showing medical treatment that is inconsistent with a clinical physical examination or with a medical history as reported by the patient.
- A complaint or question from a patient about the receipt of a collection notice from a bill collector when his or her account is not in collection status.
- A complaint or question from a patient about information added to a credit report by a healthcare provider or third-party payer when the account is not at collection status and never has been.
- A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance and the payer has no record of this patient's coverage.
- A notice or inquiry from an insurance fraud investigator for a private third-party payer or a law enforcement agency including, but not limited to, a Medicare or Medicaid fraud agency.

2. Respond to red flags

If an employee of the Practice detects fraudulent activity or if a patient claims to be a victim of identity theft, the Practice responds to and investigates the situation. If the fraudulent activity involves protected health information covered under the HIPAA Security Rule, the Practice also applies its existing HIPAA security policies and procedures to the response. (See related policies 16.01 on Right to Privacy and 16.03 on Security Violations.)

If a red flag is detected by an employee of the Practice:

- The employee gathers all documentation and reports the incident to the Practice's Privacy and Security Officer. In his or her absence, documentation is given to the Administrator, who follows up with the Privacy and Security Officer.
- The Privacy and Security Officer determines whether the activity is fraudulent or authentic.

- If the activity is determined to be fraudulent, the Practice takes immediate action. Actions may include the following tasks:
  - Cancel the transaction;
  - Change the patient account type in the practice management and electronic health record system(s) to “red flag”;
  - Place an alert in the practice management and electronic health system(s) on the fraudulent account so that anyone in the future will be notified not to use this account;
  - Notify the Administrator immediately of any suspected or confirmed “red flag issues”;
  - Notify appropriate law enforcement;
  - Notify the affected person, once identified;
  - Notify affected physician(s); and
  - Notify the Federal Trade Commission (FTC), if necessary.

If a person/patient claims to be a victim of identity theft:

- The Privacy and Security Officer compares the patient’s documentation with personal information in the patient’s record.
- If following investigation it appears that the patient has been a victim of identity theft, the Practice promptly considers what further remedial acts and/or notifications may be needed under the circumstances.
- The person/patient should be encouraged to file a police report for identity theft if he or she has not done so already. If the patient is not familiar with investigating information compromises, advise the patient to contact the Federal Bureau of Investigations (FBI) or the U.S. Secret Service. For incidents involving mail, contact the U.S. Postal Inspection Service. Contact information can be found in the business section of the phone directory. Other reporting resources include:
  - Federal Trade Commission: 1-877-382-4357; www.ftc.gov
  - Federal Trade Commission/Identity Theft Web Site: www.ftc.gov/bcp/edu/microsites/idtheft/

- Federal Trade Commission/Final Rules on Identity Theft Red Flags and Notices of Address Discrepancy: http://ftc.gov/os/fedreg/2007/november/071109redflags.pdf

- Federal Trade Commission/Filing a Complaint with the FTC: www.ftc.gov/bcp/edu/microsites/idtheft/consumers/know-before-filling.html

- The patient is encouraged to complete the Identity Theft Victim's Complaint and Affidavit form[26] and supporting documentation developed by the FTC.

- If a Social Security number is used fraudulently, as in the case of a deceased person, the U.S. Social Security Administration is notified.

- The physician reviews the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies due to identity theft exist, a notation should be made in the record in the electronic health record (EHR) system to indicate identity theft.

- A letter is sent to the person/patient whose identity has been compromised, if the patient is not deceased. (See the Model Letter for the Compromise of Identity below.)

- If, following an investigation, it does not appear that the patient has been a victim of identity theft, the Practice takes whatever action it deems appropriate for the particular circumstances.

3. Help prevent identity theft

If a document containing credit card or demographic information needs to be destroyed, documents are placed in recycle bins to be destroyed by the Practice's destruction vendor. Documents containing this information are never thrown in the trash, removed from the practice or discarded in any other fashion.

The Practice adheres to the following process when handling patients' sensitive information (e.g., credit card information, address, and patient and/or patient's spouse, guardian, or dependent information):

- All new patients over the age of majority are requested to provide government-issued photographic identification, such as a driver's license or passport, to validate their identity with their insurance card, prior to medical services being rendered. For patients under the age of majority, identification is requested from the

[26] Federal Trade Commission. Identity Theft Victim's Complaint and Affidavit form. Available at: www.ftc.gov/bcp/edu/resources/forms/affidavit.pdf. Accessed February 6, 2016.

parent or guardian escorting them to the appointment. All identification is scanned and documented in the practice management system. If a patient does not have photographic identification, two forms of other identification may be requested. If a patient refuses to provide identification, the Practice may decline to provide medical services in cases where it is not an emergency or urgent care situation.

- All patients are requested to provide a physical health insurance identification card featuring their name on the plan produced document. In certain instances, the patient will be permitted to produce the documentation after medical services are rendered. All health insurance identification is scanned and documented in the practice management system.

- All new employees who have access to sensitive information undergo a background check upon hire. (See related policy 2.15 on Background Checks.)

- Sensitive patient information is kept away from public view in locked cabinets, drawers, or secure electronic files.

- Unnecessary information is destroyed.

- No sensitive information is sent over the Internet (i.e., via e-mail or unsecured website) unless the patient has provided a specific release.

- Patient information—PHI or not—is only given to people specifically authorized by the patient; that which is used for the treatment, payment, or operations (TPO) of the patient; and/or as required based on state or federal law.

- Employees should be alerted for the possibility of identity theft in the following situations:

  – The patient submits identifying information that appears to be altered or forged;

  – Information on one form of identification the patient submitted is inconsistent with information on another form of identification or with information already in the patient's records;

  – An address, telephone number, birth date and/or Social Security number is discovered to be incorrect, non-existent, or fictitious;

  – The patient fails to provide identifying information or documents; and

  – An explanation of benefits, claim denial, or rejection indicates that this patient was deceased at the time of service.

MODEL LETTER FOR THE COMPROMISE OF YOUR IDENTITY

[Date]

[Patient name]

[Patient address]

[City, State, ZIP]

Dear [Patient name]:

We are contacting you about a potential problem involving identity theft. [Describe the information compromise and how the Practice is responding to it.]

We recommend that you place a fraud alert on your credit file. A fraud alert tells creditors to contact you before they open any new accounts or change your existing accounts. Call any one of the three major credit bureaus. As soon as one credit bureau confirms your fraud alert, the others are notified to place fraud alerts. All three credit reports will be sent to you, free of charge for your review.

Equifax	Experian	TransUnion
800-685-1111	888-397-3742	800-680-7289

Even if you do not find any suspicious activity on your initial credit reports, the Federal Trade Commission (FTC) recommends that you check your credit reports periodically. Information about victims sometimes is held for use or shared among a group of thieves at different times. Checking your credit reports periodically can help you spot problems and address them quickly.

If you find suspicious activity on your credit reports or have reason to believe your information is being misused, call your local law enforcement agency and file a police report. Get a copy of the report; many creditors want the information it contains to absolve you of the fraudulent debts. You also should file a complaint with the FTC at www.ftc.gov/idtheft or at 1-877-438-4338. Your complaint will be added to the FTC's Identity Theft Data Clearinghouse, where it will be accessible to law enforcers for their investigations.

Please contact me directly at [Phone Number] if you have any questions or concerns.

Sincerely,

[Administrator]

[Practice Name]

PRIVACY AND SECURITY • POLICY 16.05

Consent to Photograph

It is the policy of the Practice to maintain the security and identity of all patients. The Practice maintains patient demographic and insurance information on its information systems and endeavors to assure that the patients using this data to obtain medical services are who they present themselves to be.

PROCEDURES

1. When patients call for an appointment, they are asked to bring government-issued photographic identification (ID) with them for identity verification.

    a. The photo ID can be a driver's license, passport, student ID, or other authentic photo identification card.

    b. If a patient does not have access to a photo ID, the patient is asked to bring two alternative forms of identification, which includes but is not limited to (1) a credit card signed and in the name of the patient; (2) a library card for the local county; (3) a current check drawn by a US bank showing the current address; or (4) a current utility bill that shows the patient's current address.

2. When the patient arrives, the patient's photo ID is scanned into the Practice's practice management system in the patient's account record.

3. All new patients are requested to take a photograph upon arrival. The photograph is uploaded in the Practice's electronic health record (EHR) system.

4. A consent to photograph form is provided to the patient (see the Patient Consent for Identification Photograph form on p. 586) to assure the patient that the photo is only used for identification purposes and will not be used for publication. The signed consent form is scanned and indexed in the Practice's EHR system for future reference; alternatively, an electronic signature is adequate for the consent.

PATIENT CONSENT FOR IDENTIFICATION PHOTOGRAPH

Patient name: _____ Date: _____

____ Check here if minor or unable to provide consent

I consent for a photograph to be made of me. I understand that the information will only be used for identification purposes and will be stored securely. Refusal to photograph will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact:
_____

By signing this consent form, I confirm that this consent form has been explained to me in terms that I understand.

Signature: _____

Patient's Name: _____

Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____

Date: _____

PRIVACY AND SECURITY• POLICY 16.06

Social Networks

It is the policy of the Practice to allow the use of social networks for business purposes. This policy is intended to set employee expectations and establish guidelines for appropriate use of these applications.

The Practice acknowledges the business value of the use of online social networks for the following purposes:

- To create groups to support physician, advanced practice provider, and employee recruiting;
- To create affinity groups to support Practice marketing (e.g., referral networks, testimonials, focus groups);
- For outreach purposes, especially to provide education, research, and information to groups with special medical needs, or to support philanthropic endeavors;
- To monitor public opinion about the Practice, its products, and service;
- For marketing the Practice;
- For engaging patients and connecting with the community; and
- For professional networking, such as maintaining academic contacts or contacts with members of professional organizations.

PROCEDURES

1. All requests for employee use of external social networks must be submitted to the information technology (IT) systems administrator and must be pre-approved. Once approved, the employee may use the social network site without seeking permission at each use or access.

2. Use of personal social network accounts and user identifications (IDs) for Practice use is prohibited. The systems administrator creates a user ID for Practice use on the targeted social network using the employee's corporate e-mail address and communicates the initial account password to the employee. The employee receives an account activation e-mail directly from the social networking service.

3. If access to public social networking sites is currently blocked for all employees, IT establishes access for the applicable employees to the targeted social network site, bypassing firewall website filters.

4. Use of the Practice's social network user IDs for personal use is prohibited. Examples of prohibited use of the Practice user IDs include downloading and installing plug-ins or helper applications such as those that try to access the Practice's e-mail directory or joining groups using the Practice's user ID for personal reasons.

5. Depending on the social network being used, IT provides a link to the current Terms of Service or Terms of Use for that network and requires employees to acknowledge in writing that they have reviewed it.

6. The creation of "groups" within the social network to support business goals is allowed and encouraged by authorized personnel. However, the Practice, including management, regularly monitors and moderates group activity. It is the responsibility and intention of the Practice to monitor individual group member activity as well as to ensure that the company use of the social network complies with the social network's Terms of Service or Terms of Use, as applicable. Further, no "closed networks" shall be created by Practice staff.

7. Employees who use personal social media accounts that identify them as employees of the Practice, or who can be identified on private social media accounts based on their social media engagement on behalf of the Practice, are advised to conduct private social media activities in a way that does not negatively impact the Practice or any social media engagement on behalf of the Practice.

8. The use of patient photographs, patient names and or patient likenesses, even when authorized for use by the Practice, is strictly prohibited for use in Practice social media activities unless expressly authorized by the patient in a separate authorization explaining the social media channel, timeframes for use and samples of marketing/advertising language and presentation.

PRIVACY AND SECURITY • POLICY 16.07

Security of Electronic Health Records

It is the policy of the Practice to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Practice complies with the HIPAA Security Rule, establishing appropriate administrative, technical, and physical safeguards to protect the integrity, confidentiality, and availability of electronic protected health information (EPHI) that is created, received, and managed by the Practice.

EPHI includes any computer data relating to the past, present, or future physical or mental health, healthcare treatment, or payment for healthcare. EPHI includes information that can be identified as an individual with a combination of personally identifiable information data points, such as name, Social Security number, address, date of birth, medical history, or medical record number, and includes such information transmitted or maintained in electronic format.

PROCEDURES

1. Security measures

   The following security measures address the standards of the HIPAA Security Rule that covered entities need to comply with in respect to EPHI. The standards are as follows:

   - Risk analysis
   - Risk management
   - Sanction policy
   - Information system activity review
   - Assigned security responsibility
   - Workforce security

- Information access management
- Security awareness and training
- Password management
- Security incident procedures
- Contingency plan
- Evaluation
- Facility access controls
- Workstation use
- Workstation security
- Device and media controls
- Access controls
- Audit controls
- Integrity
- Person or entity authentication
- Transmission security

The Practice complies with the regulation that each covered entity must review and modify its security measures as needed to sustain the reasonable and appropriate protection of EPHI's confidentiality, integrity, and availability.

Implementation of control solutions to address the standards should be reasonable and appropriate, taking into account:

- The size, complexity, and capabilities of the Practice;
- The Practice's technical infrastructure, hardware, and software security capabilities;
- The costs of security measures; and
- The probability and criticality of potential risk to EPHI.

2. Administrative safeguards

To address HIPAA Section 164.3 08(a)(1) involving **Risk Analysis,** the Practice performs an annual risk analysis, which provides an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of EPHI managed by the Practice. This risk analysis is to be presented to the Administrator or designee, who provides a documented response, to include remediation steps for any identified risks.

To address HIPAA Section 164.308(a)(1) involving **Risk Management,** the Practice implements measures to reduce computer risks and vulnerabilities, including but not limited to:

- Identifying and documenting potential risks and vulnerabilities that could impact systems managing EPHI on an ongoing basis; and
- Performing annual technical security assessments of systems managing EPHI to identify and remedy detected security vulnerabilities. The documented results of these security assessments are presented to the Administrator or designee, who provides a documented response, to include remediation steps for any identified vulnerabilities. The key elements of this annual security assessment are outlined in the Information Systems Chapter.
- To address HIPAA Section 164.308(a)(1) involving **Sanction Policy,** the Practice adheres to the sanctions statement found in this policy, found under "5. Sanctions" and expressly outlined in the Personnel and Information Systems Chapters.

To address HIPAA Section 164.308(a)(1) involving **Information System Activity Review,** the Practice periodically reviews information system activity records, including audit logs, access reports, and security incident tracking reports, to ensure that implemented security controls are effective and that EPHI has not been potentially compromised. Measures include but are not limited to:

- Mandated unique identification/authentication mechanism on computer systems managing EPHI;
- Review of exception reports and/or logs;
- Documentation of procedures and review of the retention of monitoring data, maintaining log information for up to six years, either locally on the server or through the use of backup media; and
- Periodic review of compliance to security policies and procedures, no less than every 3 years. The documented results of these compliance reviews are presented to the Administrator or designee, who provides a documented response,

to include remediation steps for any identified lapses in compliance.

To address HIPAA Section 164.208(a)(2) involving **Assigned Security Responsibility,** the Practice identifies a Privacy and Security Officer responsible for the adherence to this policy and to the implementation of procedures required to protect the confidentiality, integrity, and availability of EPHI.

To address HIPAA Section 164.308(a)(3) involving **Workforce Security,** the Practice establishes procedures that ensure only authorized personnel have access to systems that manage EPHI. Measures that the Practice should address include:

- Managerial approval before any person is granted access to systems managing EPHI (see related policy 16.01 on Right to Privacy);
- Background checks, of all personnel or any person granted access to systems managing EPHI (see related policy 2.15 on Background Checks);
- Limiting authorized persons' access to EPHI to the extent that access to this information achieves the minimum necessary requirements of the person's job responsibilities;
- Quarterly review of the accounts on systems managing EPHI to ensure that only currently authorized persons have access to these systems; and
- Termination of access to EPHI when the employment of a person ends or the job responsibilities of the person no longer warrant access to EPHI. These procedures include changing of locks/combinations if necessary, removal from logical and physical access lists, account disablement, deletion of personal files, and the return of security items (such as keys, access cards, and laptops).

To address HIPAA Section 164.308(a)(4) involving **Information Access Management,** the Practice establishes procedures that ensure that systems that manage EPHI have authorization controls that allow only authorized personnel access. Measures with which the Practice complies include:

- Using systems—such as workstations, interfaces, applications, processes, or other computer-based mechanisms for accessing EPHI—that provide authorization controls that can ensure appropriate access based on authorized personnel's job role;
- Ensuring that these systems require a unique identification/authentication mechanism with appropriate formats (i.e., Social Security numbers are not used as an identification/authentication mechanism);

- Ensuring that these systems have password management features that enforce the use of passwords as part of the identification/authentication mechanism; and

- Ensuring that controlled privileged user accounts can be established (e.g., system administrators who typically require higher levels of access to EPHI).

To address HIPAA Section 164.308(a)(5) involving **Security Awareness and Training,** the Practice undertakes the following steps:

- The Practice's Privacy and Security Officer receives periodic security updates.

- All employees of the Practice take an annual HIPAA security training course offered by the Practice.

- Procedures and logging mechanisms are in place for the Privacy and Security Officer to receive alerts notifying of failed log-in attempts from unauthorized users.

- Users should be educated to note if unauthorized access has been attempted (such as changed passwords and locked-out accounts, or noticing that a different user name has been entered into a log-on field).

To address HIPAA Section 164.308(a)(5) involving **Password Management,** the Practice ensures the following controls are in place for creating, changing, and safeguarding passwords on systems managing EPHI:

To ensure the greatest security for their passwords, users are instructed to abide by the following guidelines in selecting a password:

a. Use a password that is eight or more characters long (recommended 14).

b. Use a password with a combination of letters (upper and lower case), along with symbols (e.g., @=$) and numbers.

c. Use a password with word combinations instead of just one word.

d. Don't use a password that contains the employee's user identification, user account, or any family member names, pet names, or easily identifiable dates or other information as part of the password. Passwords used for other public systems should not be the same as those for Practice workstations or software.

e. Don't repeat the same letter or number more than twice.

f. Don't use the employee's first or last name in any form.

g. Don't use any information easily obtained about the employee, such as your Social Security number.

- Passwords shall expire every 60 days.

To address HIPAA Section 164.3 08(a)(6) involving **Security Incident Procedures,** the Practice ensures procedures are in place to notify the Practice's Privacy and Security Officer when a system managing EPHI is involved in a security incident (e.g., virus or worm infection, accounts compromised, servers damaged from a denial of service attack).

To address HIPAA Section 164.3 08(a)(7) involving **Contingency Plan,** the Practice establishes procedures to respond to an emergency or other occurrence (e.g., fire, flood, vandalism, and unrecoverable hardware failures) that damages systems managing EPHI (see related policy 13.01 on Disaster Preparation). Measures the Practice addresses include the following:

- Having procedures for creating and maintaining backups of EPHI adequate to both restore EPHI and the systems maintaining this data in a timely manner, minimizing data loss.

- Establishing procedures to restore any loss of data due to a disaster. In the case of a system that maintains EPHI that has been identified by the annual HIPAA risk analysis as critical to business or medical operations, the Practice maintains a documented and tested disaster recovery plan for all critical server-based systems, communications, and infrastructure items (e.g., e-mail, voice mail, fax server). This disaster recovery plan is appropriate in scope, reflects recent system updates, addresses crisis management team changes, and includes the latest results of the Practice's disaster recovery test.

- In the case of a system that maintains EPHI that has been identified by the annual HIPAA risk analysis as critical to business or medical operations, the Practice maintains an emergency mode operation plan that enables continuation of critical process to assure access to EPHI and provide for adequate protection of the security of EPHI while operating in emergency mode.

- In the case of a system that maintains EPHI that has been identified by the annual technology risk assessment as critical to business or medical operations, and thereby requiring a disaster recovery plan, the Practice performs yearly recovery tests to ensure the effectiveness of the plan as well as to provide training and experience to those persons responsible for implementing a disaster recovery plan. A recovery test is also performed following significant changes to systems maintaining EPHI. Results of the testing are presented to the Administrator or designee, who provides a documented response, including remediation steps, for any identified deficiencies with the disaster recovery plan. During

testing, the Practice ensures that appropriate security measures are in place to prevent unauthorized disclosure of EPHI.

To address HIPAA Section 164.308(a)(8) involving **Evaluation,** the Practice performs an annual review to demonstrate its compliance with the Practice's HIPAA Security Rule policy. Results of the review are to be presented to the Administrator or designee, who provides a documented response, to include remediation steps for any identified gaps in compliance with the policy.

3. Physical safeguards

To address HIPAA Section 164.31 0(a)(1) involving **Facility Access Controls,** the Practice ensures that systems that manage EPHI are kept in areas with physical security controls that restrict access (e.g., an "isolated room"). Measures the Practice addresses include the following:

- Ensuring that, at a minimum, servers and network equipment that manage EPHI are kept in an isolated room with controls that prevent unauthorized access to these systems. These controls include entry doors that require a key or combination locks, or those that require a security token (such as magnetic strip ID card with identification information).

- Documenting those persons who are permitted authorized access to the isolated room.

- Requiring unauthorized persons (e.g., vendors, contractors, and visitors) to be escorted and monitored by an authorized person when entering and remaining in the isolated room.

- Providing a log of access to the isolated room. (The log may be a written log or an electronic record from an identification card reader.)

- Ensuring that records of facility maintenance or maintenance to systems managing EPHI are kept, documenting who performed the maintenance, who authorized the maintenance, and details of the maintenance activities, including dates and times.

To address HIPAA Section 164.310(b) involving **Workstation Use,** the Practice ensures that only designated workstations possessing appropriate security controls are used to access and manage EPHI, and that these workstations are not used in publicly accessible areas nor used by multiple users, nor by any user who is not authorized to access EPHI. This security measure extends to the use of laptops and home machines. These workstations have security tools installed, including anti-virus software with updated virus definitions, spyware detection software with updated spyware definitions, and an automated patch management system for operating system updates.

To address HIPAA Section 164.310(c) involving **Workstation Security,** the Practice ensures that physical safeguards are in place to protect workstations that access and manage EPHI, including cable locks (for desktops and laptops), screens that are turned away from unauthorized users, and access authorization mechanisms that require a user identification and password to access the workstation. The workstations are configured with a password-protected screen saver that is evoked after a maximum of 10 minutes of inactivity.

To address HIPAA Section 164.3 10(d)(1) involving **Device and Media Controls,** the Practice ensures that procedures are in place to govern the receipt and removal of hardware and electronic media that contains EPHI into and out of a facility, and the movement of these items within the facility. Media can include hard disks, tapes, floppy disks, CD-ROMs, optical disks, and other means of storing computer data. Measures the Practice addresses include the following:

- Disposing of media with EPHI when it is discarded or reused, using means that prevent its recovery, including erasing and overwriting media before disposal, physically destroying the media, and preventing systems that managed EPHI from being sold or donated before ensuring that EPHI has been fully removed; and

- Ensuring that backups of EPHI are created before systems managing EPHI are moved.

4. Technical safeguards

To address HIPAA Section 164.31 2(a)(1) involving **Access Controls,** the Practice ensures that security controls are in place to protect the integrity and confidentiality of EPHI residing on computer systems, including applications, databases, workstations, servers, and network equipment. Measures the Practice should address include:

- Assigning a unique name and or number of identifying and tracking user identity on systems managing EPHI;

- Establishing procedures for obtaining necessary EPHI during an emergency, in which normally unauthorized personnel require access to EPHI or the systems that manage EPHI;

- Configuring systems to terminate a log-on session after a predetermined time of inactivity (e.g., through password-protected screen savers, automatic log off of the application or network session, and the ability to manually lock out access when leaving a workstation); and

- Encrypting EPHI that is transferred or stored on systems controlled and not controlled by the Practice. This can include e-mail messages, interfaces between applications, data stored on removable media (e.g., thumbdrives), and on

files that are transferred over networks. EPHI is not to be transferred using file transfer protocol (FTP), which is a clear text protocol that can allow the confidentiality and integrity of data to be compromised.

To address HIPAA Section 164.312(b) involving **Audit Controls,** the Practice maintains audit controls that allow an independent reviewer to review system activity. Audit logs are captured by the Practice on the following systems that manage EPHI:

- User access and account activity;
- Exception reports;
- Dormant account reports;
- System resource monitoring;
- Data integrity controls;
- Failed log-in reports;
- Users switching user IDs during an online session;
- Attempts to guess passwords;
- Attempts to use privileges that have not been authorized;
- Modifications to production application software;
- Modifications to system software;
- Changes to user privileges; and
- Changes to logging subsystems.

Logs are securely retained for a minimum of one year using an archiving solution that allows for recovery within 24 hours upon request.

To address HIPAA Section 164.3 12(c)(1) involving **Integrity,** the Practice ensures that systems and applications managing EPHI have the capability to maintain data integrity at all times. Examples of integrity capabilities include error-correcting memory, disk storage with built-in error detection and correction, checksums, and encryption.

To address HIPAA Section 164.312(d) involving **Person or Entity Authentication,** the Practice maintains controls that verify that a person seeking access to EPHI is the one claimed. Access to data is controlled using acceptable authentication measures, to include

user name and password, token-base authentication, biometrics, and/or challenge and response mechanisms.

To address HIPAA Section 164.3 12(e)(1) involving **Transmission Security,** the Practice maintains controls to ensure that the integrity of EPHI is maintained when in transit. Secure transmission mechanisms that encrypt EPHI as well as confirm that data integrity has been maintained (e.g., cryptorouters, Secure Shell [SSH], Secure Socket Layer [SSL], and the use of digital signatures) are used. The Practice strives to maintain all electronic communication with patients or that which regards PHI via its patient portal. The use of e-mail for transmitting EPHI is avoided, except in the event of patient request and consent; if required, e-mail messages with EPHI should be encrypted.

5. Sanctions

The Practice implements procedures to meet the requirements of HIPAA set forth in this policy. Every employee in the Practice with access to EPHI is required to adhere to all HIPAA mandates. Violation of this policy may result in disciplinary action up to and including termination of employment. Under federal law, violation of the HIPAA Privacy Rule may result in civil monetary penalties and criminal sanctions including fines and imprisonment.

APPENDIX

APPENDIX A

Operating Policies and Procedures Policy Matrix

The user should maintain a matrix of policies and procedures and a schedule for updates. A review matrix (see the following pages) helps manage the policy maintenance process. Conventions for numbering and naming policies should be designed to match your preferences.

	POLICY STATUS	REVIEW	DATE
POLICY DEVELOPMENT AND MAINTENANCE			
1.01	Development and Administration of Policies and Procedures		
1.02	Forms		
PERSONNEL			
2.01	Shifts		
2.02	Working Hours		

POLICY STATUS		REVIEW	DATE
2.03	On-Call Program		
2.04	Flex Hours		
2.05	Employee Classifications		
2.06	Per Diem Staff		
2.07	Nepotism		
2.08	Salary Determination		
2.09	Wage and Salary Administration		
2.10	Timekeeping		
2.11	Direct Deposit		
2.12	Equal Employment Opportunity		
2.13	Employment Processing		
2.14	Selection Steps		
2.15	Background Check		
2.16	Orientation and Training		
2.17	Competency Assessment		

POLICY STATUS		REVIEW	DATE
2.18	Confidentiality Agreement		
2.19	Name Tags for Employees		
2.20	Dress Code		
2.21	Uniforms		
2.22	Insurance Benefits		
2.23	Workers' Compensation Claims Management		
2.24	Smoking		
2.25	Smoke-Free Workplace		
2.26	Seminar Reimbursement		
2.27	Tuition Reimbursement		
2.28	Meetings and Training		
2.29	Absenteeism and Tardiness		
2.30	Leaves of Absence		
2.31	Family and Medical Leaves of Absence		
2.32	Provider Time Off		

POLICY STATUS		REVIEW	DATE
2.33	Paid Time Off		
2.34	Paid Holidays		
2.35	Adverse Weather Conditions		
2.36	Bereavement Leave		
2.37	Jury Duty		
2.38	Voting Leave		
2.39	Alcohol Consumption on the Premises		
2.40	Drug and Alcohol Use		
2.41	Tuberculosis Test		
2.42	HIV Infection Screening		
2.43	Drug Screening		
2.44	Use of Practice Property		
2.45	Practice Property Ownership		
2.46	Personal Phone Calls		
2.47	Disciplinary Guidelines		

POLICY STATUS		REVIEW	DATE
2.48	Employee Conduct		
2.49	Harassment and Discrimination		
2.50	Workplace Violence Prevention		
2.51	Safety and Health Rules		
2.52	Grievance		
SCHEDULING			
3.01	Appointment Scheduling		
3.02	Appointment Template		
3.03	Appointment Recalls		
3.04	Self Scheduling Patients		
3.05	Deleting and Appointment		
3.06	Appointment Wait List		
3.07	Appointment Confirmation		
3.08	Cancellations		
3.09	Appointment Template		

POLICY STATUS		REVIEW	DATE
3.10	Delinquent Balance Appointment		
3.11	Patient Wait Time		
3.12	Appointment Status		
3.13	Appointment No-Shows		
3.14	Late Arrivals		
3.15	Walk-Ins		
3.16	Follow-Up Appointments		
3.17	Same-Day Appointments		
3.18	Surgery/Procedure Scheduling		
3.19	Provider Bumps		
3.20	Referral Communication		
3.21	Referral Response		
PATIENT ADMINISTRATIVE SERVICES			
4.01	Patient Arrival Notification		

POLICY STATUS		REVIEW	DATE
4.02	Patient Account Assignment		
4.03	New Patient Registration		
4.04	Patient Check-In		
4.05	Patient Signature		
4.06	Referrals, Preauthorizations, and Precertifications		
4.07	Assignment of Benefits		
4.08	Insurance Verification and Benefits Eligibility		
4.09	Insurance Coverage Waiver		
4.10	Parental Preauthorization for Minors		
4.11	Post-Visit Patient Services		
4.12	Patient Satisfaction Survey		
4.13	Answering Service		
MEDICAL RECORDS			

POLICY STATUS		REVIEW	DATE
5.01	Medical Records		
5.02	Medical Records Standards		
5.03	Access to Medical Records		
5.04	Patient Access to Medical Records		
5.05	Records Transfer		
5.06	Clinical Decision Support		
5.07	Documentation Cloning		
5.08	Signature Log		
5.09	Documentation		
5.10	Medical Record Audits		
5.11	Subpoena Compliance		
5.12	Subpoena Duces Tecum		
5.13	Search Warrants		
5.14	Authorization to Release		
5.15	Medical Record Duplication and Form		

	POLICY STATUS	REVIEW	DATE
	Completion		
5.16	Employee Medical Records		
5.17	Return to Work — Medical Status Report Form		
CLINICAL CARE			
6.01	Patient Rights and Responsibilities		
6.02	Record Preview		
6.03	Questions to Ask the Provider		
6.04	Patient Clinical Intake		
6.05	Consent for Treatment		
6.06	Informed Consent for Procedures		
6.07	HIV Testing		
6.08	Preconscious Sedation Evaluation		
6.09	Procedure Follow-Up		
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POLICY STATUS		REVIEW	DATE
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