HNS Best Practices: Clinical Quality & Documentation Standards

HNS' mission
is to make health care more
accessible, more effective, and more affordable.

I. Introduction

We all have a responsibility to help make our health care system more efficient.

HNS' large network of physicians improves access to affordable and effective conservative treatment options for neuromusculoskeletal and other conditions. Through our quality and educational initiatives, we help improve treatment outcomes and the effectiveness of care we provide. To assist providers in providing the highest quality of care to their patients, HNS has developed practice standards which promote the delivery of safe, timely, effective, and cost-efficient health care.

These standards were developed with guidance from HNS' Professional Affairs Advisory Boards, and are consistent with industry standards, federal and state laws, and the policies of our contracted payors.

These standards represent HNS' performance expectations for contracted health care professionals; accordingly, providers are expected to consistently utilize these standards, relative to care provided to members whose health care plans contract with HNS.

The standards are divided into 5 sections:

- Clinical Care & Provider Responsibilities
- HNS/Payor Policies
- Documentation Standards
- Confidentiality of Healthcare Records
- Health Care Records

Non-Compliance
HNS monitors for non-compliance to these standards and reserves the right to conduct investigations relating to non-compliance to these standards, at any time, which may include requesting copies of health care records, and/or conducting site visits to review records.

Failure to comply with these standards and/or correct identified deficiencies in a timely manner may result in termination from the network. If standards are not met, HNS may take one or more of the following actions:

1. Require the provider to review all HNS standards, policies and the policies of HNS contracted payors and submit an attestation indicating his/her agreement to comply.
2. Require the submission of a written corrective action plan.
3. Require the submission of copies of patient health care and financial records for review.
4. Require the provider to obtain additional continuing education.
5. Place the provider on probationary status.
6. Terminate the provider's Practitioner's Participation Agreement.
7. Report the issue to appropriate state and/or federal authorities, including but not limited to, state licensing boards and NPDB.
8. Other such actions as deemed appropriate by the HNS Quality Management & Improvement (QMI) Committee.

II. Clinical Care & Provider Responsibilities

HNS physicians are expected to consistently provide safe, timely, effective, and cost-efficient health care to members of HNS' contracted health care plans. The following guidance is provided to help you meet this expectation.

1. Maximum Medical Improvement (MMI)

Understand MMI.

MMI occurs when a patient with an illness or injury reaches a state where additional, objective, measurable improvement cannot reasonably be expected from additional treatment and/or when a treatment plateau in a person's healing process is reached.

2. Supportive Care

Understand supportive care.

"Supportive Care:

Long-term treatment/care for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral, have been considered and/or attempted." (*American Chiropractic Association*)

(Most health plans do NOT cover supportive care.)

3. HNS' Philosophy of Care

Apply HNS Philosophy of Care.

Treat and Release:
Provide care to correct the presenting condition, bring the patient to maximum medical improvement (MMI), and discharge the patient from active care with appropriate instructions regarding maintenance/supportive care, self-care, and prevention of future occurrences.

4. Core Standards

The following are considered essential "key" standards to help improve treatment outcomes and cost-efficiency.

i. Establish and document the patient's chief complaint.

ii. Based on the chief complaint and clinical exam findings, establish specific treatment goals for each patient which are objective, measurable, reasonable, and intended *to improve a functional deficit.*

iii. Ensure your initial examination includes the use of standardized outcome assessment tools to establish a functional baseline *against which progress towards treatment goals can be objectively measured*.

iv. Re-evaluate the patient every 4 weeks or 12 visits (whichever comes first).

v. Always use outcome assessment tools and other objective measures at each re-exam, to measure progress toward treatment goals, the effectiveness of treatment, and the appropriateness of additional care.

vi. Use the comparison of the results of the outcome assessments, and other measurable objective findings, to determine when MMI has been reached, *then release the patient to maintenance/supportive care*.

vii. Ensure all diagnoses, all services provided, the rationale for those services, and all treatment recommendations are properly documented in the health care record.

viii. Ensure that all treatment billed to payors is consistent with the chief complaint, objective clinical findings, diagnoses, and payor corporate medical policies.

III. HNS/Payor Policies

HNS has developed policies relating to clinical care and contracted health care professionals must be familiar with and comply with these policies.

Most contracted health plans have specific corporate medical policies for chiropractic care and contracted health care professionals must be familiar with and comply with these policies.

(HNS and most contracted payor corporate medical policies are posted on the HNS Website under “HNS/Payor Policies”.)

IV. Clinical Record - Documentation Standards

Excellent clinical care should be evidenced through excellent clinical documentation. Proper documentation in the clinical record is essential for sound clinical decision-making, which improves quality of care and treatment outcomes and is paramount to appropriate continuity of care, while lack of appropriate documentation can lead to negative treatment outcomes and potential quality of care and patient safety issues.

Clinical records, or health care records, are records created by a provider of health care services rendered to a patient. Records include information that the patient may provide concerning personal identification, demographics, social history, symptoms and medical history. Information entered into the medical record by the provider includes the history reported by the patient, the results of examinations, diagnostic studies, consultations, diagnoses, clinical assessments, treatment plans,

and treatments rendered including modalities, instructions, advice and recommended follow up.

The clinical record is a legal document substantiating health care services provided to the patient. It also serves as a method of communication among health care providers caring for a patient and provides supporting documentation for reimbursement sought for services provided to a patient. Thorough, precise and timely documentation of services provided is in the best interests of you, your patients, and of the payors responsible for the payment of those services.

1. Basic Standards for Documentation

a) The clinical record will be clearly legible to someone other than the writer.

b) Clinical records will be maintained in English.

c) Records that are not electronically generated will be typewritten or written in ink.

d) Each patient will have a centralized record containing all clinical records for that patient.

e) The clinical record will be clearly labeled with the patient's name or other unique patient identifier.

f) A clinical record will be created at the time of the patient's first visit.

g) Contents of records will be organized in date-order; entries will be added chronologically.

h) Each page of the health care record will include the patient's name and date of birth (or other unique identifier).

i) Each page of the health care record will include the signature (or electronic equivalent) of the rendering provider, including the professional designation "DC". If entries are made on the same page by more than one provider, *the author of each entry must be identified*.

j) Entries into the record will be contemporaneous with the encounter.

k) Each entry in the record will be dated with day, month and year.

l) No entries should be erased, deleted, or "whited out". Corrections or changes will be made by marking a single line through the original entry.

Both the entry that is marked through and the corrected entry will be dated and initialed.

m) The clinical record will include all correspondence and evidence of all communication from other sources regarding the patient, including the rationale for any referrals to other providers and all communications to/from the provider to whom the patient was referred.

n) The patient's clinical record will include **S.O.A.P**. notes.

o) The record will include all dates of service and should reflect any missed or canceled appointments.

p) All services provided and all treatment recommendations (DME, exercise, etc.) will be documented in the clinical record, including but not limited to, examinations, diagnostic studies, manipulations, therapies/modalities.

q) All patient education and home care instructions will be documented in the clinical record.

r) Other than maintenance care, the clinical record will reflect that all services provided and all treatment recommendations are consistent with the patient's chief complaint, clinical examination findings, diagnoses, and treatment plan.

s) Primary language and/or linguistic service needs for patients with limited English proficiency, or patients with disabilities requiring special assistance, should be prominently noted in the healthcare record.

t) If abbreviations are utilized, only standard abbreviations common to all health care providers will be used.

u) Abbreviations in the health care record should be legible.
(The abbreviation key (or legend) should be maintained in the provider's office and produced in response to requests for healthcare records from HNS, contracted payors, and all regulatory bodies.)

v) Patient non-compliance should be clearly documented in the clinical record.

2. Clinical Care – Documentation Standards

A. Informed Consent

The clinical record will include *written evidence* that the provider obtained informed consent from each patient prior to initiating treatment.

Providers shall obtain new informed consent when presented with a new condition that was not addressed when the previous informed consent was obtained.

While HNS recommends the use of the *HNS Informed Consent Form*, any similar form is acceptable, *provided the form clearly addresses the specific risks discussed with the patient*.

All informed consent forms shall be dated and signed by the patient, and maintained as part of the healthcare record.

B. History

The clinical record will include past history, family history, and social history (occupation, recreational interests, hobbies, use of drugs, etc.) and the date histories are taken.

The clinical record will include past and present medical or chiropractic treatment for this condition and results of that treatment.

C. Patient Safety

Current and significant past medication (including Rx, OTC and natural products) use will be documented.

Allergies, medication allergies, intolerances, adverse reactions, and contraindications to potential treatments are clearly noted.

The record will reflect any health risk factors that have been identified.

D. Preventive Health Care

There is documentation of routine preventive health measures such as exercise habits, screening for obesity, cholesterol and hypertension, routine mammography, etc.

E. Integrated Care

Other health care providers are identified (PCP, specialists, etc.)

Permission to contact patient's other care providers is documented.

There is evidence of continuity and coordination of care. The record will include any referrals to other health care providers and the rationale for the referral. All communications (written, telephone, etc.) to and from other health care professionals shall be included in the clinical record.

F. Consultations

The clinical record will reflect all consultations. Consultation codes will only be reported on insurance claims when another physician, insurer, employer, or other appropriate source has requested the opinion or advice of the physician. If a consultation has been requested:

- The clinical record will include evidence of the request (whether verbal or written), including the name of the provider or organization requesting the advice or opinion, and the date it was received.

- The clinical record will include a copy of the provider's written report to the requesting physician or appropriate organization, including his opinion, advice and/or any services ordered or performed.

G. Chief Complaint

The clinical record will include the patient's chief complaint(s).

The clinical record will include onset, duration, frequency, location, and radiation of symptoms, as well as aggravating or relieving factors.

The clinical record will include causation, accident, injury, or other etiology.

The documentation in the health care record will indicate that covered services included in the treatment plan are consistent with the patient's chief complaint.

H. Outcome Assessments (OAs)

The use of valid and reliable outcome assessment tools in the management of neuromusculoskeletal disorders is generally considered a "best practice".

In order to make a valid and reliable determination of meaningful progress toward treatment goals, and whether maximum medical improvement (MMI) has been reached, it is essential that the patient health care record includes relevant standardized outcome assessments. **HNS requires the use of outcome assessment tools as part of the initial examination to establish a functional baseline, and at each re-exam to evaluate and monitor progress towards treatment objectives *and to determine when MMI has been reached (or not reached).***

HNS requires the use of generally accepted outcome assessment tools, such as Oswestry, Roland Morris, etc. Several outcome assessment forms, as well as other clinical resources, are available under the “HNS Forms” section of the HNS website.

The clinical record shall include outcome assessments for each examination and re-examination, and evidence that each subsequent OA was compared to the OA from the initial examination, to evaluate and monitor progress towards treatment objectives *and to determine when MMI has been reached (or not reached).*

I. Evaluation (Initial and Re-evaluations)

i. The clinical record shall include evidence of all examinations.

ii. The clinical record will include sufficient documentation to substantiate the specific level of the E/M code reported.

iii. The clinical record will include all clinical examination findings (objective and subjective).

iv. The clinical record will include evidence that outcome assessments were used both during the initial exam, and at each re-evaluation.

v. The health care record must clearly indicate the specific tests performed during all examinations, as well as the results of those tests.

vi. The clinical record will indicate appropriate imaging and diagnostic studies were performed to determine the extent and severity of the injury or condition and the results of those studies.

vii. The clinical record will indicate that all imaging or other diagnostic studies ordered are consistent with the patient’s chief complaint and clinical examination findings.

viii. The clinical exam findings must include specific segments and location of subluxations, which must be documented in the clinical record.

ix. The clinical record will substantiate that vitals were obtained during each examination *for which an E/M code is reported* (at a minimum weight, height, and blood pressure).

Initial

The record will include written evidence of examination for presenting symptoms, including examination of area involved in chief complaint.

The examination should include a consultation to ascertain history and such relevant orthopedic, neurological, and chiropractic tests as are necessary to establish the extent and severity of the injury or condition.

Each initial examination will include the use of outcome assessment tools to establish a functional baseline.

Re-examinations
The clinical record shall include evidence that re-examinations were performed approximately every 4 weeks or 12 visits (whichever came first).

Documentation for each re-exam must include *evidence the patient's progress was objectively measured against the objective goals of the treatment plan.*

The clinical record shall include evidence that outcome assessments, and other objective measures, as applicable, were used, at EACH re-examination, to evaluate the effectiveness of treatment, whether MMI has been reached, and to determine the appropriateness of further care.

J. Assessment

The clinical record includes the provider's initial assessment of the patient's condition.

The clinical record shall support that initial and ongoing assessments are consistent with the history, chief complaint, and objective examination findings.

K. Diagnostic Impression

The clinical record will include all diagnostic impressions.

Diagnoses in the record will be consistent with the patient's chief complaint and objective clinical findings.

All services/DME documented in the clinical record will be supported by an appropriate diagnosis.

Any changes in diagnoses will be documented in the clinical record.

All diagnoses reported on the insurance claim will be documented in the clinical record.

L. Treatment Plans

I. The patient's health care record will include a treatment plan for each episode of care.

II. Each treatment plan should be *individualized* and specific to each patient's presenting complaints.

III. Treatment plans must be consistent with the chief complaint, clinical findings and diagnoses documented in the health care record.

IV. Each treatment plan must include **objective, measurable, reasonable** treatment goals *intended to improve a functional deficit related to the patient's present condition*. Obstacles to recovery and strategies to overcome them will be noted.

V. The treatment plan must include expected outcomes.

VI. The treatment plan will include the specific treatment recommended, including but not limited to, manipulations, modalities, DME, exercises, and home care instructions.

VII. The treatment plan will include anticipated duration of treatment, including frequency of visits.

VIII. The treatment plan will include objective measures to evaluate treatment effectiveness.

IX. The treatment plan will include recommended modalities/therapies/DME, *the rationale for each*, and as applicable, areas of application, frequency, and duration.

X. The clinical record will include patient’s progress as it relates to treatment goals.

XI. The record will include any changes to a treatment plan and rationale for those changes.

M. Spinal Manipulation

The clinical record will include all manipulations performed and will include the location and specific segments or regions manipulated.

The clinical record will substantiate that manipulations reported to payors are consistent with the patient's chief complaint, clinical findings, diagnoses, and treatment plan.

If manipulations are performed, the record will include documentation to demonstrate subluxations existed, relative to the manipulations, and are evidenced by either radiographs or physical examination. If subluxation is demonstrated by physical examination, the clinical record will establish that two of the four P.A.R.T. criteria are met (pain, asymmetry, range of motion, tissue changes); one of which must be range of motion or asymmetry.

The clinical record will support the level of CMT code reported on insurance claims.

N. Extra-spinal Manipulation

The clinical record will include all extra spinal manipulations performed and will include the specific joints manipulated.

The clinical record will substantiate that extra-spinal manipulations are consistent with the patient's chief complaint, clinical findings, diagnoses and treatment plan.

O. Therapies/Modalities/DME

The clinical record will include all DME/modalities/therapies performed, the rationale for each, duration of each and areas of application, as applicable.

The clinical record will substantiate that therapies/modalities/DME are consistent with the patient's chief complaint, clinical findings, diagnoses and treatment plan.

During the initial phase of care, no more than two therapies or modalities per visits are considered usual or customary.

The clinical record will indicate a reduction in the number of therapies as the patient's condition improved.

If time-based therapies are performed (constant attendance or therapeutic procedures), the record will reflect the actual time the therapy was performed. (Ex: 15 minutes or 1 unit)

P. Subsequent Visits

I. All services and DME provided or recommended to a patient will be documented.

II. The clinical record will reflect that services and DME are consistent with the patient's chief complaint, clinical examination findings, diagnosis, and treatment plan.

III. The record will include changes in subjective complaints including, but not limited to, frequency and intensity of pain or discomfort and review of ADL deficit.

IV. The record will include response to treatment, any changes in treatment and the rationale for the change.

V. The clinical record will indicate patient's progress as it relates to objective treatment goals.

VI. Changes in diagnosis will be documented.

VII. If applicable, the patient's health care record will include notes regarding patient compliance.

VIII. The patient's health care record will include prognosis, final diagnoses, and discharge date.

IX. The record will indicate when maximum medical improvement has been reached.

X. The record should reflect a gradual decline in the frequency of visits until the patient reaches the point of discharge or converts to maintenance/supportive care.

Q. Maximum Medical Improvement (MMI)

Maximum Medical Improvement occurs when a patient with an illness or injury reaches a state where additional, objective, measurable improvement cannot reasonably be expected from additional treatment, and/or when a treatment plateau in a person's healing process is reached.

Once Maximum Medical Improvement (MMI) has been reached, the patient *should be discharged to maintenance/supportive care*, or referred.

The clinical record should clearly reflect if and when MMI was reached and if / when the patient was moved to wellness/supportive care, discharged or referred.

> ***Reminder****:* Supportive care is treatment/care for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively deteriorate when there are periodic trials of

treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications. Supportive care is appropriate when alternative care options, including home-based self-care or referral, have been considered and/or attempted.

***Note**: Very few health plans and/or employer groups provide coverage for supportive care.* As with all services, HNS providers must verify benefits for each member prior to providing services.

R. Medically Necessary Care

The medical necessity of covered services billed through HNS must be *clearly evident in the clinical record*; and must be consistent with:

- HNS' Core Standards; and
- The policies of HNS' contracted payors; and
- The practice guides issued by applicable state licensing boards.

The clinical record must *objectively* substantiate the medical necessity of the covered services provided and should be consistent with the patient's chief complaint, diagnoses, and treatment plan.
(Exception: maintenance care)

All medically necessary care provided to patients whose health care plans contract with HNS must be billed through HNS, UNLESS the patient signed, prior to the beginning of care, one of the HNS *Election Not to File* Forms, and the form is on file in the patient's health care record.

It is important to remember that *clinically appropriate care* does not always meet the definition of medically necessary care, as defined by payor corporate medical policies. While physicians should always provide clinically appropriate care to their patients, not all clinically appropriate care is covered under a member's health care plan, *and only benefits covered under a member's health care plan should be billed to the payor.*

V. Records

1. EHR - Electronic Records

HNS highly recommends the use of Electronic Health Records (EHR) and electronic documentation software programs.

If electronic records are utilized, there must be appropriate back-up and recovery procedures in place. Recovery procedures should be tested at least annually to assure recovery is possible within a reasonable period of time.

2. Confidentiality of Health Care Records

Providers have legal, professional and ethical obligations to protect patient confidentiality, and Protected Health Information (PHI), which includes information in the clinical record. (HNS Compliance Policies for Contracted Health Care Professionals include policies relating to HIPAA/HITECH. Those policies are posted under the "Compliance" section of the HNS Website.)

It is essential that the confidentiality of the information in the clinical record be safeguarded and shared only as necessary to protect the interests of the patient.

Providers shall:

- Ensure the privacy and security of the patient's health care information in a manner consistent with state and federal laws.

- Develop and implement practices that protect confidentiality of information and data.

- Ensure that health care records are stored and archived in a secure environment.

- Ensure that those accessing (or seeking to access) health care records have the authority to access it.

- Unless otherwise required by law, ensure that patient-specific health information is only released to:

  The individual to whom the information relates;

  HNS or a health care plan contracted with HNS to perform health care delivery, payment, administration and/or management functions on their behalf;

  A third party only if specific authorization is obtained from the individual to whom the information relates.

- Except as otherwise provided by law, providers will make member's patient-specific health information available to the

member for inspection or copying. (See “Requests for Records” below.)

3. Claims Data

Health care claims shall only be submitted to HNS when the information reported on the claims is supported by documentation in the clinical record, and documentation is consistent with these *Clinical Quality & Documentation Standards*, and HNS’ Fraud, Waste and Abuse (FWA) Policies, and when such documentation is available for audit and reviews.

From *HNS Compliance Policies for Contracted Health Care Professionals* (FWA):

> “The validity, reliability, accuracy and quality of health care data submitted to HNS by contracted health care professionals shall be the ***sole responsibility*** of the health care professional who provided the services (and/or under whose supervision the services were provided), and whose name is on the claim as the rendering provider.”

4. Record Retention

Clinical records shall be organized and stored in a manner that allows for immediate access and easy retrieval.

Clinical records shall be stored in a secure manner that allows access only by authorized personnel.

Complete patient health care records (including billing and payment information, such as EOBs) shall be maintained for a minimum of 10 years from the last date of service OR, if the patient is a minor, for 10 years after the minor patient reaches age 19. Once the patient reaches 19 and is still under care, the provider should retain the patient health care record for 10 years from the last date of service.

5. Requests for Records

Copies of clinical records and associated financial records for patients whose insurance plan contracts with HNS may be requested at any time by a patient, by HNS or a HNS contracted payor and/or by regulatory bodies.

(HNS is a Covered Entity as defined by HIPAA, but acts as a *Business Associate* of each contracted health care professional and a release from a patient is NOT required, when HNS requests health care records)

When clinical records are requested *from those with a right to the health care record, providers will promptly respond to such requests.*

Requests for copies of records will be clearly documented in the health care record and will include the date of the request and the name of the person or entity requesting the records, as well as the date the copies were released.

Original records should never be released; only copies of the records should be released.

If the patient's authorization is required to release records, the clinical record will include a copy of the patient's signed and dated authorization to release, and the name of the person/entity to which the records were released.

If abbreviations are used in the records, copies of records will be accompanied by an abbreviation key (or legend).

A. Requests from Payors or Authoritative Bodies

Network providers must promptly comply with requests from regulatory bodies (such as state licensing board, Department of Insurance).

If a due date is provided in the request, records must be received by the stated due date. *If a due date is not provided, records should be submitted within 10 days of receipt of request.*

B. Requests from HNS

As a business associate of all contracted health care professionals, HNS is authorized to have access to, and review, health care records of patients whose health care plan is contracted with HNS. (A release from a patient is NOT required, when HNS requests health care records)

Network providers are required to submit copies of health care records if requested by HNS and providers will promptly comply with such requests. All requests from HNS for patient health care records will include a due date and records must be submitted to HNS by the due date stated.

C. Requests from Patients

Network providers are required to provide copies of health care records if requested by the patient and providers will promptly comply with such requests. Network providers will provide patient with

copies of the health care record within 10 days of receipt of request from patient.

6. Administrative Record Standards

A. Verification of Benefits Form

The clinical record will include a dated, completed verification of benefits form. (Because benefits may change from year to year, eligibility and benefits should be verified as each plan renews.)

(HNS' Verification of Benefits Form is posted on the HNS Website, under "HNS Forms" - Administrative Forms.)

B. Non-Covered Waivers & ABNs

The clinical record must include, as applicable, signed waivers for all non-covered services provided.

Prior to rendering any non-covered service to an individual with health care coverage, whether the plan is a commercial or federally funded plan, HNS providers must first obtain an executed, appropriate waiver from the patient.

For non-covered services provided by HNS contracted health care professionals, waivers *cannot be generic*, but must be specific to the actual procedure or service to be rendered to each individual member.

(HNS' waivers for non-covered services are posted on the HNS Website, under "HNS Forms" - Administrative Forms)

All waivers must be maintained in the patient's health care record.

Waivers must include:

- Practice and/or provider's name
- Patient's name
- Date waiver obtained
- The specific service the provider recommends
- The cost of the service
- A statement indicating the service is not covered by their healthcare plan
- A statement that indicates, by signing such a waiver, the member agrees to the service or procedure and also agrees to pay for the service or procedure
- The signature of the adult patient, or parent or legal guardian if the patient is a minor

HNS providers cannot bill the patient for non-covered services provided unless they have first obtained the appropriate signed waiver and the waiver is on file in the patient's health care record.

Providers who fail to obtain a signed waiver from the member prior to the rendering of a non-covered service, cannot bill the patient for those services. Additionally, providers will be required to refund any monies collected from the patient for any non-covered services provided for which a signed waiver was not first obtained. So please remember to obtain a signed waiver and be sure that it is maintained in the patient's health care record.

NOTE: The signing of a "waiver" does not allow a provider to "balance bill" a patient for covered services provided.

C. Election Not to File Forms

With few exceptions, contracted health care professionals are required to file claims to HNS, for all covered services provided to patients whose health care plans contract with HNS.

If a personal injury (PI) patient (or his/her parent or legal guardian) specifically requests the provider not to file claims for ***covered*** services to their healthcare plan, the clinical record will include a signed and dated copy of the ***HNS Personal Injury Election Not to File Form.***

If a non-PI patient (or his/her parent or legal guardian) specifically requests the provider not to file claims for ***covered*** services to their healthcare plan, the clinical record will include a signed and dated copy of the standard ***HNS Election Not to File Form.***

Providers must not initiate a conversation with patients regarding not filing claims to their health care plans*. Only requests not to file which are initiated by the patient can be honored, and then only when all of these policies have been followed.*

Discounting Fees

Contracted health care professionals may not discount their fees for any services provided to a patient who has elected not to file. The provider must bill his usual and customary charges for all services provided.

Contracted health care professionals who fail to submit claims to HNS and to comply with these policies may lose their status as a network provider.

(HNS' Election Not to File Forms are posted on the HNS Website, under "HNS Forms" - Administrative Forms)

7. Financial Records

Member's financial records shall reflect:

A. Charges for all services rendered to the patient, consistent with the information in the health care record; and

B. All payments received from all sources (patient, health plans, 3rd party liability payors; and

C. Payment Plans; and

D. The timely collection of applicable co-payments, co-insurance, and/or deductibles.

E. If co-payments, co-insurance and/or deductible are not collected at the time of service *for more than 3 consecutive office visits*, there must be a written payment plan signed by the patient (or patient's legal guardian) included in the health care record; and

F. Payments received from HNS have been posted within 15 days of receipt; and

G. Contractual adjustments (the write-off of the difference between the provider's charges and the allowed amount); and

H. The member's current balance.