Practice Site Requirements

To ensure members have access to healthcare in a clean, safe and professional environment, HNS has developed practice site standards including, but not limited to, patient safety, accessibility, physical appearance, adequacy of waiting room and examination room space, and adequacy of clinical record keeping, as well as thresholds for acceptable compliance to these requirements.

All participating providers are expected to ensure compliance to each of these standards.

Non-compliance
HNS monitors for non-compliance to these requirements and reserves the right to conduct random practice site visits to assure compliance, for any reason, including but not limited to response to complaints or concerns raised by patients, contracted payors or regulatory or quality improvement agencies.

All complaints/concerns relating to these requirements are tracked and investigated by HNS. HNS will notify the provider of any complaint or concerns and will work with the provider to correct deficiencies.

Failure to comply with these requirements and/or to correct deficiencies in a timely manner may result in sanctions by HNS. If requirements are not met, HNS may take one or more of the following actions:

1. Conduct a site visit.
2. 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.
3. Require the submission of a written corrective action plan.
4. Require the submission of copies of patient health care and financial records for review.
5. Require the provider to obtain additional continuing education.
6. Place the provider on Probationary Status.
7. Terminate the provider’s Practitioner’s Participation Agreement.
8. Other such actions as deemed appropriate by the HNS Medical Director and/or the HNS Credentialing and/or Quality Management & Improvement (QMI) Committees.

Site Visits

While HNS may conduct a site visit in response to a concern or complaint relating to HNS Practice Site Requirements, please note that HNS does not view site visits as punitive. HNS' objective in performing site visits is to assist the provider in meeting HNS' high standards.

HNS reserves the right to conduct site visits at any time (upon 24 hours' notice to the provider). If HNS receives a concern about an office, an HNS representative will contact the provider to review the concern and, if applicable, schedule a site visit.

During the site visit, an HNS representative will tour the facility. In addition to the concern which prompted the site visit, the HNS representative may also address other HNS requirements.

Following the visit, the HNS representative will follow up with the provider to alert them of the outcome - either that there are no concerns about the office, or will provide a listing of any outstanding concerns and a time-frame for correcting any deficiencies. HNS appreciates that every office is unique and the representative will work with the provider to resolve any concerns as a result of the visit.

HNS has developed thresholds regarding when a site visit is mandatory. While HNS reserves the right to conduct a site visit at any time, a site visit will be conducted if HNS receives more than 2 complaints regarding the same provider within any 3 month period or if HNS receives more than 3 complaints during a calendar year regarding the same provider. If a site visit is necessary, the site visit will be performed within 30 days from the time the established threshold has been met.

If a site visit identifies any concerns, the provider will be required to submit a written corrective action plan outlining his/her plan to correct the deficiencies. This action plan must include a time line and all deficiencies must be corrected within six (6) months or less, depending on the type of complaint and the work required to correct the deficiencies. The written action plan will be reviewed and a follow up site visit for re-assessment will be scheduled within six (6) months to assure correction of deficiencies.

HNS Practice Site Standards:

I. Patient Safety:

The office maintains written procedures for medical emergencies.

Emergency evacuation routes are posted and emergency exits are clearly visible.

A fire extinguisher is maintained with current inspection sticker.

At least annually, all personnel are briefed on emergency procedures and emergency drills are held.

A first aid kit is at the site and is restocked as supplies are used.

A pregnancy reminder sign is prominently displayed in the x-ray room.

If x-ray equipment is on-site, protective equipment (lead apron, etc.) is readily available.

If x-ray equipment is onsite, a radiation caution is prominently displayed in the x-ray room.

If x-ray equipment is onsite, if applicable, x-ray chemical tanks are properly marked with hazardous material warning labels.

II. Accessibility

1. Access to Practitioner:

Network providers are available to members of HNS contracted health care plans 24 hours a day, seven days a week OR the provider’s voice mail/answering machine message includes instructions for how to obtain care in the event of an emergency and the provider is unavailable.

Telephone Requirements

Consistent with good professional practice, network providers’ voicemail messages and/or a telephone answering machine provides important information to the patient when no one is available to take the patient’s phone call.

The voicemail/answering machine message is used during all non-business hours of operation as well as during business hours at times that the phones will not be answered by clinic personnel.

The following information is included on all voicemail and answering machine messages:

- The name of the practice.
- The days and hours the practice is open.
- How to obtain care in the event of an emergency and the office is closed.

In-Office Waiting Time:

In general, patients are seen by the provider within 15 minutes of the time of their appointment.

Routine Appointments:

Network providers schedule patients for routine, non-urgent appointments within 14 days from the time the patient calls for the appointment.

Urgent Appointments:

During normal business hours, network providers schedule patients for urgent appointments within 24 hours of the time the patient calls for the appointment.

Walk-In Patients:
There is a procedure in place for handling emergency walk-ins.

Missed Appointments:
There is a procedure in place for following up on missed appointments.

2. Physical Facility (Access):

Regulatory Requirements
The provider's practice site meets all applicable regulatory requirements including, but not limited to, requirements of the Americans with Disabilities Act.

Office/Location:
The provider provides professional services to members of HNS contracted health care plans only in a permanent, fixed professional office setting located in a traditional commercial office site.

HNS defines a traditional commercial office site to include, but is not limited to, a medical office building, a free standing office or clinic, a facility whose primary purpose is the delivery of healthcare services, or a house converted entirely to a professional office for the provision of healthcare services.

A traditional commercial office site *does not include* mobile chiropractic offices, practices located within health clubs, gymnasiums or other athletic facilities, salons/spas, or within business facilities with one primary function if that function is not the delivery of healthcare services.

Exceptions to these requirements may be made if the provider will be practicing in an underserved area and no other office sites are available and/or if there are other circumstances which are found acceptable by HNS, and provided the physician first obtains prior authorization from HNS.

Exterior Requirements:
Entry to the building accommodates the physically disabled.

The office provides adequate parking for patients and staff.

Provisions are made for proper snow/ice removal.

Interior Requirements:
The interior of the building accommodates the physically disabled.

Exits, corridors, doors, and hallways are free of obstruction and allow for navigation of wheelchairs.

Patient areas are well lit during all hours of operation.

There is at least one handicap-accessible restroom with grab bar.

III. Appearance

Exterior Facility Requirements:

The exterior of the office is neat, well-kept and professional in appearance.

The landscaping is neat and free of debris and trash.

There is appropriate exterior signage so that the practice can be easily identified.

The entrance to the office is easily identified.

The grounds are well lit in the early morning and evening if the clinic is open during those times.

Office hours are clearly posted.

Interior Requirements:

The interior of the office is clean, neat, well-kept and professional in appearance.

Patient areas are well lit during all hours of operation.

Restrooms are clean and well-stocked.

IV. Adequacy of Space and Personnel

1. Waiting Area(s):

The waiting area(s) has adequate lighting.

The waiting area(s) provides comfortable seating.

The seating allows easy access for those with orthopedic difficulties or disabilities.

There are a minimum of five chairs for each physician practicing in the facility.

The actual number of chairs is sufficient to handle the clinic's current average number of patient visits per hour and to accommodate projected growth in the upcoming six-month period.

2. Examination/Treatment Room(s):

The exam/treatment rooms allow easy access for those with orthopedic difficulties or disabilities.

Exam/treatment rooms should have adequate lighting.

There is a minimum of one treatment room per provider.

There are an adequate number of examination/treatment rooms to handle the clinic's current average number of patient visits per hour and to accommodate projected growth in the upcoming six-month period.

There is adequate equipment in each room to satisfy the current patient volume and projected growth in the upcoming six-month period.

Equipment is maintained and serviced regularly and updated/upgraded, as indicated.

3. Business Office:

There is a procedure in place for handling complaints relating to safety and quality of care.

There is an established procedure for communication with a primary care physician or specialist.

There is an established procedure for telephone messages and triage policy.

There are written HIPAA policies and procedures in place to ensure the confidentiality and security of protected health information.

Private area(s) are provided in which the patient can discuss confidential issues with the physician/staff.

Patient information is only displayed in a manner not identifiable to the general public.

The business office is adequately equipped to handle all administrative tasks necessary for current practice volume and projected growth in the upcoming six-month period.

4. Personnel:

There are a sufficient number of staff members to adequately handle the needs of the clinic.

Office personnel are knowledgeable and properly trained.

Personnel maintain respect for patient confidentiality at all times.

The personnel are courteous, respectful, and maintain professionalism when dealing with patients.

V. Clinical Records

The following documentation standards are HNS' minimum clinical record standards.

HNS has developed Best Practices for clinical record keeping (HNS' *Clinical Records Quality Standards*). These standards further clarify HNS' performance expectations for contracted providers. These standards are posted on the HNS website under the Healthcare Professionals tab, under "Clinical Resources". These best practices should be reviewed prior to providing care to members of HNS contracted health care plans.

1. HNS recommends, but does not require, the use of electronic health records (EHR). If electronic records are utilized, there are appropriate back-up and recovery procedures in place.

2. Clinical records are organized and stored in a manner that allows for immediate access and easy retrieval and in a manner that ensures the confidentiality of patient health information.

3. Clinical records are stored in a secure manner that allows access only by authorized personnel.

4. Each patient has a centralized record containing all clinical records for that patient.

5. The clinical record is clearly labeled with the patient's name or other unique patient identifier.

6. Contents of records are organized in date-order; entries will be added chronologically.

7. Each entry in the record is dated with day, month and year.

8. No entries are erased, deleted, or "whited out".

9. All documentation in the clinical record is clearly legible to someone other than the writer.

10. If abbreviations are utilized, only standard abbreviations common to all health care providers are used, and are legible to someone other than the writer.

11. Clinical records are maintained in English.

12. Records that are not electronically generated are typewritten or written in ink.

13. The clinical record includes a copy of the practice's HIPAA Privacy Policy signed by the patient (or legal guardian).

14. Each page of the clinical record includes the name of the patient and date of birth (or other unique identifier).

15. Each page of the clinical record includes the signature of the treating provider.

16. The clinical record includes relevant patient demographic information.

17. The clinical record includes who to contact in the event of an emergency.

18. The clinical record includes past history, family and social history and the date histories were taken.

19. Primary language and/or linguistic service needs for patients with limited English proficiency, as well as significant hearing impairments, are prominently noted in the healthcare record.

20. Current and significant past medications (including Rx, OTC and natural products) are documented.

21. The record reflects any health risk factors that have been identified.

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

23. Patient's other health care providers are identified (PCP, specialists, etc.)

24. The clinical record includes documentation of chief complaint, objective clinical exam findings, the results of outcome assessments, all imaging and diagnostic studies performed or recommended, and the results of those studies.

25. The clinical record includes all diagnostic impressions, and any changes to the diagnosis must be documented.

26. The clinical record includes a treatment plan for each patient, for each episode of care, which includes specific, reasonable, objective, measurable goals (exception: Maintenance care).

27. The clinical record includes written evidence that informed consent was obtained prior to initiating treatment.

28. The clinical record includes the results of outcome assessments from the initial examination.

29. The clinical record includes S.O.A.P. notes.

30. The clinical record indicates that re-exams were performed approximately every 4 weeks or every 12 visits, whichever comes first.

31. The clinical record indicates outcome assessment tools were utilized at each re-exam and includes the results of the outcome assessments.

32. The clinical record indicates the results of the outcome assessments were compared to the initial (or most recent) outcome assessment, on order to evaluate treatment effectiveness.

33. The clinical record indicates evidence that patient’s progress was objectively measured against treatment goals.

34. The clinical record clearly indicates the when maximum medical improvement (MMI) has been reached.

35. The clinical record clearly established the medical necessity for covered services billed to HNS contracted payors.

36. The clinical record includes a waiver signed by the patient, indicating the patient has agreed to pay for any non-covered services provided.

37. The clinical record includes evidence of all services provided on each date of service.

38. The clinical record reflects any missed or canceled appointments.

39. All services provided and the dates of service, as well as all treatment recommendations are documented in the clinical record.

40. The record includes any referrals to other health care providers

41. The patient’s health care record includes prognosis, final diagnoses and discharge date.