HNS
Health Network Solutions

Practice Protection Plan

(HNS Provider Manual)

HNS

Making health care more accessible, effective, and affordable

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I. Introduction

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

We welcome you to our network of health care professionals.

Committed to a more efficient health care delivery system, HNS' programs, policies, and best practices seek to ensure the delivery of safe, quality, cost-effective health care.

As a clinically integrated IPA, HNS is organized in a manner to create efficiencies for contracted managed care plans, their members or beneficiaries, and its contracted health care practitioners and to provide various administrative and support services to both physician participants and the health plans which contract with HNS.

As a clinically integrated IPA, HNS:

- Establishes mechanisms to monitor and control utilization of health care services provided by its contracted health care practitioners designed to control costs and ensure quality of care, and

- HNS only selects those providers who meet HNS' strict selection criteria for participation. HNS seeks to ensure a network of clinically competent, appropriately trained, cost-effective providers who meet or exceed member needs for quality, accessibility, effectiveness, safety, and who are committed to achieving HNS' objectives.

- Invests significant capital, both monetary and human, in its infrastructure, on order to achieve its efficiency objectives.

Participation in the HNS network is not guaranteed. HNS reserves the right to determine which physicians it will accept and maintain within its network and the terms by which it will allow participation.

At all times, contracted health care plans reserve the right to deny, or terminate the network participation of any provider.

HNS leaves treatment decisions in the hands of the provider and their patients. To achieve accountability, we rely primarily on sharing objective and actionable information about your practice that we obtain from submitted claims data and reviews of clinical records.

This is your network and only by working together can we meet our objectives. Please contact us with any questions you may have about your network. We look forward to a long and successful relationship with you.

II. Overview

The information in this manual is intended to:

- Promote the delivery of safe, timely, effective, cost-efficient care
- Familiarize you with HNS' programs and initiatives
- Promote physician collaboration and involvement
- Assist you in understanding your responsibilities as a HNS Contracted Health Care Professional
- Assist you in complying with HNS policies, standards, and program requirements
- Assist you in complying with HNS contracted payor policies
- Assist you in minimizing your malpractice risk

Proprietary Information

The information in this manual is confidential and proprietary and may not be shared or reproduced in whole or in part unless authorized in writing by an authorized representative of HNS.

Amendments

HNS reserves the right to periodically review and revise its policies and standards. This manual may be amended periodically, and the current manual may not reflect HNS' most current policies.

Disclaimer

The material in this manual is provided for educational purposes only. It is not guaranteed to be current, complete, or up to date. The information is not offered as and does not constitute legal advice or opinions.

Contracted health care professionals should attempt to comply with all HNS policies included in this manual, provided they do not conflict with any state or federal laws. *Policies should not be followed if doing so could adversely affect the delivery of appropriate patient care.*

III. Philosophy of Care

HNS believes patients deserve care that is accessible, safe, effective, cost-efficient, considerate of their values and preferences, and respectful of their time and resources.

HNS believes contracted health care professionals should be able to make treatment decisions based on their own clinical judgments.

Contracted health care professionals have an obligation to provide medically necessary health care services to health plan members. This implies care that is necessary and appropriate for the condition, is within generally accepted standards of good care, and is for the benefit of the patient, not the caregiver. However, contracted providers also have an obligation to ensure that care is provided in the most cost-efficient manner.

Further, health care plans/insurers that pay for care have a right to expect services rendered by contracted providers to their members to be consistent with individual plan benefits and corporate medical policies and to be delivered in the most cost-efficient manner.

HNS has explicit targets (standards) for provider accessibility, patient safety, clinical care, and cost efficiency. Treatment recommendations are expected to be consistent with these standards.

To meet these expectations, HNS has developed a philosophy of care that can be summarized as follows:

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

While HNS believes maintenance (wellness) and supportive care are essential to good health, in most instances HNS contracted payors do not cover such care.

IV. Collaboration

HNS is your network, and your active involvement is essential to achieving our efficiency objectives.

HNS' Professional Affairs Advisory Boards and standing committees provide opportunities to be involved in the future direction of HNS and its programs, services, and initiatives.

Professional Affairs Advisory Board
To ensure provider involvement and collaboration in HNS initiatives, HNS maintains Professional Affairs Advisory Boards in key cities throughout our service area. Advisory boards provide guidance to the HNS management team regarding HNS' programs, policies, and services.

Each Professional Affairs Advisory Board consists of approximately eight network physicians from each geographic region. HNS is represented by at least two members of HNS' Board of Directors or senior management team. Boards meet quarterly for a working dinner and HNS picks up the tab.

HNS Credentialing Committee
HNS Credentialing Committee members are actively involved in selecting providers who apply for initial or continued participation in the HNS network and in the development of HNS' credentialing criteria.

During monthly committee meetings, committee members approve and deny applicants for participation in the HNS network and recommend changes to the HNS Credentialing Program.

At least 50% of HNS' Credentialing Committee members are participating providers in the HNS network who have no role in HNS management. HNS attempts to ensure a diverse group of providers serve on the Credentialing Committee with regards to age, gender, geographic location, years in practice, and education.

HNS Quality & Utilization Management Committee
HNS defines its Quality & Utilization Management program as those HNS initiatives designed to positively influence the access to, and the delivery of, safe, effective, and cost-efficient health care in our service area.

If you are interested in serving on one of our advisory boards or the HNS Credentialing Committee, please contact your HNS Service Representative.

V. Communication

Open and ongoing communication between HNS and our contracted health care professionals is essential to the success of the network.

We provide a variety of mechanisms and opportunities to ensure clear and timely communication, including but not limited to:

- HNS Chiropractic Medical Directors
- HNS Service Representatives
- “Current News” (HNS website)
- Email, phone, and fax support

Chiropractic Medical Directors (CMD)

HNS’ Chiropractic Medical Directors are HNS’ primary points of contact for clinical questions and concerns. CMD’s provide peer-to-peer support and guidance and strive to assist contracted health care professionals in improving safety, quality of care, cost efficiency, and compliance and reducing malpractice risk. Please contact them any time they can assist you.

Dr. Richard Armstrong
(919) 747-7933

Dr. Steve Binder
(704) 873-2831

HNS Service Representatives

To enhance communication between HNS and our contracted health care professionals, each provider is assigned a personal HNS Service Representative as the provider’s primary point of contact with HNS. HNS Service Reps work with you and your staff to provide education and administrative support and will assist you with any issues related to HNS claims or payments.

HNS has provided you with your service representative’s email address, telephone, and extension number. Please contact them any time they can assist you.

Email is the preferred method of communicating with your HNS Service Representative.

Please be sure to contact us if there is a change to your email address.

If you need assistance reaching your HNS Service Representative, please contact the Provider Services Department at (877) 426-2411, ext. 117.

HNS News and Information

HNS knows that your time is extremely valuable and sends you only information that is important.

HNS communicates in several ways:

- **Email**
  HNS utilizes email as our primary method of communicating important information. Please be sure to contact us if there is a change to your email address.

  You may add additional email addresses or change your email address via the "Current Account Info" section of the HNS secure website.

- **"Current News" (HNS website**)
  Important news and information are posted in the "Current News" section of the HNS website, located under the "News/Events" tab. We encourage you to check this section often for news and updates.

- **Fax**
  While email is our primary means of communicating with our providers, HNS uses fax to send claims-related information, so please notify us of any changes to your fax number.

- **U.S. Mail**
  If the information we are sending is lengthy, we use U.S. mail, so please make sure HNS always has your current mailing address.

Please carefully review ALL information provided by HNS and notify us promptly of any changes to your email address, phone, fax number, or your practice's mailing address.

In order to fulfill HNS' responsibilities to its contracted health care professionals and contracted health care plans, it is essential that HNS, when necessary, be able to reach contracted health care professionals.

VI. Communications from HNS

Clear communication between HNS and our contracted health care professionals is essential to the success of the network. Accordingly, when HNS contacts a contracted health care professional via telephone or email, he/ she is expected to respond in a timely manner.

VII. HNS Contact Information

Contact Information for HNS Service Representatives
Each contracted health care professional is assigned a personal service representative and has been provided with his/her telephone extension and email address. Because our Service Representatives are on the telephone much of the day with contracted health care plans, the best way to communicate with Service Representatives is via email. HNS strives to respond to all emails within 3 business days of receipt of the email.

Should you need assistance in identifying or reaching your HNS Service Representative, please contact the Provider Services Department at (877) 426-2411, ext. 117.

Telephone

Toll-free number: (877) 426-2411
Local number: (704) 895-8117

Administration
(877) 426-2411, ext. 2

Claims Department
(877) 426-2411, ext. 117

Compliance Hotline
(877) 426-2411, ext. 2

Complaints and Grievances
(877) 426-2411, ext. 2 or ext. 117

Credentialing
(888) 712-6488 or
(877) 426-2411, ext. 118

Provider Services
(877) 426-2411, ext. 117

Quality and Utilization Management
(877) 426-2411, ext. 2

Chiropractic Medical Directors

Dr. Richard Armstrong
cpdrarm@gmail.com
(919) 747-7933

Dr. Steve Binder
sbinder@binderchiropractic.com
(704) 873-2831

Fax: (877) 329-2620

Email: support@healthnetworksolutions.net

Addresses:

Mailing address: P.O. Box 2368, Cornelius, NC 28031

Physical address: 20476 A Chartwell Center Drive, Cornelius, NC 28031

VIII. Claim Inquiries

HNS Service Representatives will be happy to assist individual providers in checking the status of claims submitted though HNS.

Please allow 30 days from the date the claim was submitted to HNS before requesting claim status.

For information regarding secondary, corrected and voided claims (as well as other important and helpful information), please review the ***HNSConnect User Manual***. This manual is posted on the website under "HNS Documents".

To request claim status, please email your HNS Service Representative, and provide all of the information below:

- Provider name
- Patient name
- Patient date of birth
- Subscriber ID number
- Date of service
- Any relevant information regarding the issue

Prior to requesting the status of a claim, please:

- Ensure all EOBs have been posted to patient accounts.
- If filing claims through HNSConnect®, ensure the claim was successfully accepted when transmitted. (Always check the status of your claim file 24 hours after uploading the file to HNSConnect®.)

IX. HNS Initiatives

As a contracted health care professional, it is important that you become familiar with HNS initiatives. HNS' programs, initiatives, and services are designed to promote the delivery of safe, effective, and cost-efficient health care; reduce administrative costs; and improve efficiencies for our contracted health care professionals, contracted payors, and their members.

1. Promoting Safe, Effective, Cost-Efficient Care

Below is a list of HNS programs and initiatives designed to promote the delivery of safe, effective, and cost-efficient health care.

Additional information about each initiative is provided elsewhere in this manual or on the HNS website.

- Credentialing
- Accessibility and Practice Sites Standards
- Clinical Quality & Documentation Standards
- Cultural Competency Program
- Compliance Program
- Continuing Education
- Complaints and Grievance Resolution
- Peer-to-Peer Support
- Educational Reviews of Clinical Records
- Comparative Practice Patterns Review (CPR) Program
- Clinical and Administrative Resources

2. Chiropractic Advocacy

HNS seeks to strengthen the chiropractic profession in our service area and to enhance the perception of the field by maintaining a network of qualified chiropractors who meet HNS' strict credentialing requirements and promoting patient safety, quality, and cost-effective chiropractic care.

HNS supports and promotes legislation to protect and strengthen the chiropractic profession.

HNS works to expand the scope of chiropractic services covered by contracted payors and their employer groups and to ensure fair and reasonable reimbursement for covered services provided by contracted health care professionals.

HNS seeks to ensure contracted payors adjudicate claims pursuant to negotiated rates.

HNS advocates for its contracted health care professionals, whenever possible, with regard to complaints and grievances reported by members and/or payors and aims to quickly resolve issues to prevent escalation of the complaint to payor SIU/fraud departments.

HNS advocates for its contracted health care professionals, whenever possible, whose practice patterns or health care records are under scrutiny by contracted health care plans and seeks to ensure records are appropriately and fairly reviewed.

HNS seeks to promote and advance the chiropractic profession through financial and other support to state and national chiropractic associations and by encouraging membership in these associations.

HNS seeks to promote and advance the chiropractic profession through financial support of various chiropractic research projects, including projects designed to establish the cost effectiveness of chiropractic care for low back pain, neck pain, and headaches compared to the costs of care by M.D.'s and physical therapists.

3. Marketing/Practice Growth

Participation in the HNS Network promotes a more stable patient base through continuous steerage of new patients to your practice. HNS continues to promote growth to your practice by seeking new contracts and network marketing opportunities.

4. Support Services

Our health care executives and service representatives understand your market, business, and challenges and provide ongoing support to you and your staff. In addition to peer-to-peer counseling offered by HNS Chiropractic Medical Directors, each provider is assigned a personal HNS Service Representative who provides ongoing administrative support for issues related to HNS claims/payments and to help you reduce administrative costs. Services they provide include, but are not limited to, tracing claims, researching denials/resolution of unpaid claims, review and research of aging reports, coding/billing, compliance support, and administrative complaint resolution.

5. Administrative Efficiencies

HNS promotes administrative efficiencies through:

- Single signature contracting and credentialing
- Advanced information systems, which capture data needed for centralized claims/payment administration and performance management
- Innovative electronic solutions that streamline the claims/payment process, improve data integrity, reduce denials, expedite claims closure, and improve cash flow.
- Free electronic claims submission through our proprietary software, HNSConnect, and through Office Ally®
- Custom edits in HNSConnect specific to HNS contracted payors to reduce denials and expedite claims closures
- Production and delivery to providers of ANSI 835 files, which interface with a provider's billing software to automatically post EOP information to the individual patient's account, eliminating the time-consuming task of manually posting payments
- Electronic Funds Transfer (EFT), in which HNS expedites payment to providers via direct deposit, promoting improved cash flow

6. Post-Payment Audit Assistance Program

HNS provides assistance to contracted health care professionals undergoing a payor post-payment audit. The program includes step-by-step assistance and guidance through the entire audit process, including but not limited to peer-to-peer review and analysis of requested health care records prior to submission to the payor. The program is designed to ensure records of our contracted health care professionals are appropriately and fairly reviewed and to reduce the amount of any recoupment resulting from post-payment audits.

7. Staff Training

HNS offers orientation and training to contracted health care professionals' staff members to improve practices' efficiency and productivity and to promote compliance with policies, health care laws, and regulations.

X. Quality Management and Improvement (QMI)

HNS is committed to improving the quality of services both provided directly by HNS and by the health care professionals contracted with HNS. HNS' Quality Management and Improvement Program is the foundation of all HNS initiatives and services.

The goals of the QMI program are to promote a safe, effective, cost-efficient health care delivery system in our service areas, to objectively and systematically monitor and evaluate the quality and appropriateness of services provided by our contracted health care professionals and HNS, and to pursue opportunities for improvement.

It is important to note that by executing the HNS Practitioner's Participation Agreement, contracted health care professionals have agreed to comply with all HNS programs and policies, including quality programs and those established by HNS' contracted health plans.

HNS maintains a written Quality Management and Improvement (QMI) Plan that describes the QMI Program. HNS' quality improvement activities emerge from a systematic and organized framework. This framework, adopted by HNS leadership, promotes HNS' accountability for its quality of services and the accountability of contracted health care providers for the quality, safety, and cost-effectiveness of services provided to members.

QMI activities include, but are not limited to:

- Credentialing
- Education
- HNS Best Practices
- Clinical Quality and Documentation Standards
- Safety and Accessibility (Practice Site Standards)
- Cultural Competency Standards
- Compliance with Laws and Regulations
- Complaints and Grievances Resolution

The QMI program is assessed annually to determine its effectiveness and the effectiveness of the services provided by HNS and our contracted health care professionals.

1. Credentialing

HNS' credentialing program promotes the delivery of safe, quality chiropractic care by: (1) selectively choosing providers who meet our strict credentialing requirements and who have demonstrated their commitment to HNS' efficiency objectives and agreed to comply with HNS programs that promote safe, quality, and cost-effective care; (2) ensuring the ongoing monitoring of provider credentials, complaints, and grievances to address safety and quality of care concerns; and (3) implementing remedial action when necessary.

The HNS credentialing program is accredited by the National Committee for Quality Assurance (NCQA). The Program is also consistent with Utilization Review Accreditation Commission (URAC's) high credentialing standards.

Network participation begins when the credentialing process has been completed, the provider's Practitioner's Participation Agreement has been accepted and executed by HNS, and the provider has been notified in writing of the Credentialing Committee's decision.

HNS Credentialing Committee
The HNS Credentialing Committee develops HNS' credentialing criteria, approves the HNS credentialing plan and policies, and selects providers for initial or continued participation in the HNS network. The committee includes physicians from the HNS network as well as HNS staff.

Participation in the HNS network is not guaranteed. All applicants requesting initial or continued participation are evaluated in accordance with the HNS credentialing plan, policies, and procedures.

Contracted health care plans reserve the right to approve or deny participation in the HNS network.

Except as noted above, HNS has the sole right to determine which physicians it will accept and maintain within its network and the terms on which it will allow participation.

HNS Credentialing Policies are posted on the HNS Website.

2. Education

HNS believes a strong and effective ongoing physician education and outreach program can significantly and positively influence the network's ability to consistently deliver safe, effective, and cost-efficient care.

HNS' physician education and outreach programs include, but are not limited to, the following:

A. Initial Provider Orientation

To familiarize newly credentialed providers with HNS programs and initiatives and to foster compliance with HNS and contracted payor policies, HNS requires newly credentialed providers to complete an initial provider orientation. Each HNS contracted health care professional is assigned a personal HNS Service Representative to serve as liaison between the provider, his/her staff, and HNS. Initial orientations are provided by the assigned service representative. Orientations include, but are not limited to, a brief review of HNS' programs and an overview of the HNS website, including the location of HNS Documents, HNS and contracted payor policies, and the importance of complying with those policies. HNS encourages staff members of the contracted provider to participate in the orientation process.

B. Educational Website

HNS maintains a comprehensive, user-friendly educational website that contains clinical and administrative policies, best practices and outcome assessment tools, and other resources to improve patient quality and treatment outcomes.

C. Online CE

The HNS website also includes free, online CE Programs, most of which have been approved by both the NC and SC licensing boards.

D. Quarterly Videos

Each quarter, HNS provides evidenced-based videos from Dr. Ron Feise of the Institute of Evidence-Based Chiropractic. These videos are intended to help chiropractors achieve greater clinical success, are easy to digest, and address issues affecting our profession.

E. Additional Annual CE Opportunities

In partnership with the NCCA and SCCA, HNS offers up to 18 free hours of board-approved CE for HNS Providers who are members of their trade association.

F. Educational Reviews of Health Care Records

HNS has developed well-defined, objective indicators of physician performance for health care record keeping. As part of our efforts to ensure

that services provided by contracted health care professionals are delivered in a safe, effective, and cost-efficient manner, HNS provides educational reviews of providers' health care records for compliance to HNS and payor corporate medical policies and the practice guides issued by applicable state licensing boards. Health care record reviews are conducted by appropriately licensed health care professionals and in accordance with the HNS peer review process. HNS provides a comprehensive analysis of the contracted health care professional's compliance to HNS' Clinical Quality and Documentation Standards, the corporate medical policies of contracted health care plans, and recommendations for improvement, if applicable.

G. Peer-to-Peer Counseling

As part of our physician outreach initiative, HNS provides peer-to-peer counseling to our contracted health care professionals. Counseling is provided by licensed DCs and includes safety and quality of care issues, improving clinical outcomes, proper documentation, coding and compliance to payor corporate medical policies, and risk management.

H. Staff Training

HNS offers orientation and training to contracted health care professionals' staff members to improve efficiency and productivity in the providers' practices and to promote the practice's compliance to policies, health care laws, and regulations.

I. HNS Professional Service Representatives

HNS professional service representatives provide ongoing physician education regarding appropriate documentation, coding, and compliance to HNS payor corporate medical policies. Service representatives also provide ongoing administrative support designed to reduce administrative costs for issues related to HNS claims/payments.

3. HNS Best Practices

HNS has developed practice standards that promote the delivery of safe, accessible, timely, effective, and cost-efficient health care.

HNS' Best Practices
establish performance expectations
for contracted health care professionals.

HNS' best practices are posted on the HNS website and were developed with guidance from network physicians who have served on HNS Professional Affairs Advisory Boards. These best practices are consistent with industry standards, federal and state laws, and the policies of our contracted payors.

By executing the HNS Practitioner's Participation Agreement, contracted health care professionals agree to comply with all HNS policies, procedures, program requirements, and policies of the health plans and managed care organizations which contract with HNS. Accordingly, compliance with these standards is required for continued participation in the HNS network.

Best practices include:

- Acute Low Back Pain
- Cervical Pain
- Headache
- Shoulder Pain
- Thoracic Pain
- Clinical Quality and Documentation Standards

In addition to the above clinical Best Practices, HNS has developed the following Best Practices:

Safety and Accessibility (Practice Site Standards)

These standards are intended to improve access to health care and to ensure care is delivered in a safe and professional environment to all patients, including those with disabilities.

Cultural Competency Standards

These standards are intended to improve access to safe, quality, cost-effective care for those with limited English proficiency, regardless of race, ethnicity, or cultural background.

Cultural competence is defined as the ability of health care professionals and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. HNS' Cultural Competency Program can help provide the highest quality of care to every patient, regardless of race, ethnicity, or cultural background.

Improving practitioners' ability to more effectively interact with patients of different cultures and socioeconomic backgrounds, particularly those with limited English proficiency, allows for more effective communication, which directly affects patient safety, treatment, and treatment outcomes.

In-office Interpretive Services

The program also includes in-office interpretive services in over 200 languages, paid for by HNS, to ensure effective communication with patients with limited English proficiency.

For information regarding this service, please see the “Cultural Competency” section of the HNS website.

(The HNS provider directory includes the names of physicians who speak a language other than English and which languages they speak. Additionally, all patient administrative and clinical forms are provided in Spanish; these are also available on the HNS website.)

4. Clinical Care & Provider Responsibilities

HNS physicians are expected to consistently provide safe, quality, cost-efficient health care to members of HNS’ contracted health care plans.

The following guidelines are provided to help meet these expectations:

A. HNS Compliance Policies for Contracted Health Care Professionals

B. Standard of Conduct

Each of us is expected to act with the highest degree of integrity and professionalism.

All contracted health care professionals shall at all times conduct business with fairness, honesty, integrity, professionalism, and respect for the laws applicable to the health care industry. Even in cases where interpretation of the law of this Standard could be ambiguous, permissive, or lenient, HNS expects its contracted health care professionals to **always do the right thing, in the right way,** and choose the course of honesty and integrity.

C. HNS Philosophy of Care

Apply the 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.

D. “Key” Core Standards

The following are considered essential "key" standards from HNS' *Clinical Quality & Documentation Standards* to help improve treatment outcomes and cost efficiency.

1. Establish and document the patient's chief complaint;

2. Develop an individualized treatment plan for each patient;

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

4. 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*;

5. Re-evaluate the patient every four weeks or 12 visits (whichever comes first);

6. 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;

7. Compare 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*;

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

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

E. Maximum Medical Improvement (MMI)

Understand MMI.

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

F. 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.)

5. Compliance with Laws and Regulations

HNS is committed to conducting business in accordance with the highest ethical standards and in accordance with federal and state laws and regulations that govern our industry. *HNS expects that same commitment from our contracted health care professionals.*

HNS' compliance program seeks to promote awareness among contracted health care professionals of our legal environment, compliance with laws relevant to the health care industry, and the prevention of accidental or intentional non-compliance to those laws. The program includes initial and annual compliance training for all contracted health care professionals.

As a requirement for continued participation in the HNS Network, each provider must complete ***annual compliance training****.*

(The compliance training module (2 CEUs) can be found on the secure section of the HNS Website.)

HNS has developed compliance policies (the HNS Compliance Policies for Contracted Health Care Professionals) that establish HNS' performance expectations for all contracted health care professionals. These policies enumerate which compliance responsibilities are the sole responsibility of contracted health care professionals, those that are the responsibility of HNS, and those that are shared.

These policies are consistent with state and federal laws. They are included in the HNS compliance training and are posted on the HNS website in the "Compliance Section."

Compliance with the *HNS Compliance Policies for Contracted Health Care Professionals* is required for continued participation in the HNS network.

These policies are posted on the HNS website in the "Compliance Section."

6. Complaints and Grievance Resolution

HNS views complaints and grievances as key indicators of the safety, quality, and accessibility of health care services provided by contracted health care professionals. Complaints and grievances provide an excellent mechanism for identifying safety issues, suboptimal care, or suboptimal compliance to HNS' standards.

HNS maintains rigorous processes for monitoring, investigating, and resolving all safety and quality of care complaints lodged against contracted health care professionals and investigates all complaints received from all sources, including but not limited to, patients, providers, payors, regulatory, and quality improvement agencies.

HNS tracks all quality complaints and evaluates both the specific complaint and the contracted health care professional's history, if any, of complaints and takes action as necessary to improve patient safety and quality of care.

HNS' complaints/grievance process provides for fair, timely, and appropriate resolution for all parties.

Contracted health care professionals
must fully cooperate in the timely resolution
of any complaint or grievance,
regardless of the source of the complaint.

HNS shall report certain complaints to authoritative bodies, including, but not limited to, licensing boards and the National Practitioner's Data Bank (NPDB).

As part of the complaint resolution process, copies of health care and associated financial records for patients whose insurance plan contracts with HNS may be requested at any time by HNS, by an HNS contracted payor, or state and federal regulatory bodies. If requested, submission of records must be pursuant to HNS records policies.

XI. HNS Policies

General Policies
To assist contracted health care professionals in ensuring the delivery of safe, quality, cost-efficient health care and in compliance with laws applicable to our industry, HNS has developed the following policies, which, together with HNS' "best practices," establish HNS' performance expectations for contracted health care professionals.

These policies were developed by the HNS QMI Committee in conjunction with contracted managed care organizations and are consistent with industry standards and federal and state laws.

HNS reserves the right to periodically review and revise its policies, and changes may have been made since this document was published. If there is a discrepancy between information in this manual and the most current HNS policies, HNS shall rely on the most current policy.

By executing the HNS Practitioner's Participation Agreement, each contracted health care professional agrees to comply with all HNS policies, procedures and program requirements and the policies of the health plans and managed care organizations that contract with HNS. Compliance with HNS and HNS contracted payor policies is required for continued participation in the HNS network. *However, HNS policies and program requirements should not be followed if doing so could adversely affect the delivery of appropriate patient care.*

Should a policy violation occur or should HNS or a HNS contracted payor suspect a policy violation, HNS may take one or more of the following actions:

- Require the contracted health care professional to submit a signed attestation statement indicating he/she has read, understands, and agrees to comply with HNS and HNS payor policies
- Require the submission of a written corrective action plan
- Require the submission of copies of patient health care and financial records for review
- Require the contracted health care professional to obtain specific continuing education
- Place the contracted health care professional on probationary status
- Terminate the contracted health care professional's Practitioner's Participation Agreement
- Perform other such actions as deemed appropriate by the HNS Quality Management and Improvement (QMI) Committee

Five (5) Core Policies

Compliance to HNS and HNS policies and the terms of the HNS Practitioner's Participation Agreement is required for participation in the HNS network.

1. All contracted health care professionals shall seek to ensure the delivery of safe, quality, cost-efficient care for all patients.

2. All services billed through HNS shall be consistent with HNS standards and policies, HNS payor policies, the practice guides issued by the relevant state licensing board, and all state and federal statutes and regulations.

3. With the exception of maintenance care, all services billed through HNS shall be medically necessary and consistent with the documented chief complaint, clinical findings, diagnoses, and treatment plan (exception: maintenance/supportive care).

4. All services shall be properly documented and properly coded with the most accurate CPT codes (*and appropriate modifiers, if applicable*), HCPCS, and diagnosis codes.

5. Claims for all covered services provided must be filed through HNS. This includes personal injury (PI) claims and claims for secondary coverage if the payor contracts with HNS.

Exception: If a patient *specifically* requests that the provider not file claims to their health care plan, providers may ONLY comply with such requests provided the applicable "HNS Election Not to File Form" is signed and dated by the member, or legal guardian, and is maintained in the health care record, and available for review by HNS, or by the patient's healthcare plan representative.

Other HNS Policies are listed alphabetically on the following pages and are posted on the HNS website.

Acupuncture

HNS Policy:
The medical necessity for all acupuncture services provided and billed through HNS must be clearly documented in the patient's health care record. The services must be reported using the most appropriate codes and must be consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan.

All acupuncture services provided and billed through HNS must be consistent with all HNS and HNS contracted payor policies, the policies of applicable state licensing boards, and state and federal laws.

Only those contracted health care professionals who have met the appropriate state Board of Examiner's continuing education requirements for acupuncture and have submitted evidence of such continuing education to that board may provide acupuncture services to patients whose claims are filed through HNS.

Contracted health care professionals rendering acupuncture services are required to use only FDA-approved disposable needles (no autoclavable, reusable needles) and ensure proper hazardous waste removal.

Documentation for acupuncture services must include:

- Type of modality
- Specific meridian and specific points
- The number of needles applied
- Specific anatomical areas where needles are applied
- Any use of electrical stimulation
- Duration of the service time (reported in 15-minute increments)

Note: Service time includes pre-service, intra-service, and post-service work.

Many insurance companies do not cover acupuncture, so it is imperative to verify coverage prior to treatment. When verifying acupuncture coverage, please be sure to clarify whether coverage applies if the acupuncture services *are provided by a chiropractor.*

Adverse Events

HNS Policy:
An adverse event is an injury that occurs while a patient is receiving health care services from a contracted health care professional.

Contracted health care professionals must notify HNS within five days, in writing, if an adverse event occurs in their practice. The written notification must include the following:

- The name of the contracted health care professional;
- The date the event occurred; and
- A summary of the event.

Advertising

HNS understands and respects our providers' desire to market their practices, but we do require that all advertising and marketing is done consistent with both HNS advertising policies and any applicable requirements issued by licensing boards.

HNS Policies:
All information in all advertisements must be true and factual.

As a general rule, it is inappropriate for HNS providers to advertise for free covered services or covered services at a reduced fee, in any manner, to any member of an HNS contracted payor plan, ***for any covered services for which a provider normally charges a fee.***

All covered services must be provided at the physician's usual and customary fee.

If you wish to advertise to patients who do not have insurance with a health care plan that contracts with HNS for services that would normally be covered for patients with health insurance that does contract with HNS, such advertisements must include the specific disclaimer shown below. The disclaimer must specifically state:

For NC Providers:

This offer does not apply to patients with the following insurance plans:

Blue Cross Blue Shield of North Carolina (BCBSNC)
BCBS Advantage
BCBS Options
BCBS Care
BCBS Choice
BCBS Select
Federal Employees Program (FEP)
All BCBS PPO Plans
All BCBS Out-of-State Plans
Blue Medicare Supplement Plans

CIGNA Healthcare

HealthSpring

HealthTeam Advantage

HealthTeam Advantage Diabetes and Heart Care Plan (CSNP)

MedCost

Medicare/Medicaid

This disclaimer must be **prominently displayed** on the same page, *either directly above or immediately below,* as the text that references free or reduced services. (There can be no other verbiage between the offer itself and the disclaimer.)

The text for this disclaimer **must be in the same font size** as the font used in the body of the advertisement.

For SC Providers:

This offer does not apply to patients with the following insurance plans:

Absolute Total Care
- Absolute Total Care (Medicaid)
- WellCare by Allwell (Medicare Advantage & D-SNP)
- WellCare Prime by ATC (Medicaid/Medicare)

CIGNA Health Care

HealthSpring

MedCost

Select Health of South Carolina
- First Choice (Medicaid)
- First Choice VIP Care (D-SNP)
- First Choice VIP Care Plus (Medicaid/Medicare)
- First Choice Next (Individual Plans)

WellCare Medicare Advantage

This disclaimer must be **prominently displayed** on the same page, *either directly above or immediately below,* as the text that references free or reduced services. (There can be no other verbiage between the offer itself and the disclaimer.)

The text for this disclaimer **must be in the same font size** as the font used in the body of the advertisement.

Balance Billing

HNS Policy:
HNS-contracted health care professionals may only collect the applicable copayment, deductible, and/or coinsurance for any covered service provided.

HNS-contracted health care professionals may not collect, from any applicable sources, more than the HNS-contracted allowable for any covered service provided.

For this policy, balance billing is defined as the practice of billing a member *in excess of any applicable copayment or coinsurance/deductible for any covered service provided.* While contracted health care professionals can and should collect all applicable copayments, coinsurance, and deductibles, contracted health care professionals cannot "balance bill" the patient for the difference between the contracted health care professional's usual and customary charge and the contracted allowable amount.

The signing of a "waiver" does not allow a contracted health care professional to "balance bill" a patient for covered services provided.

"Balance billing" should not be confused with billing for services that are not covered under the member's plan. All contracted health care professionals may provide and collect their usual and customary fee for any non-covered services, *provided they have first obtained a signed waiver from the member.* Please remember the waiver cannot be generic and must specifically state the service/supply recommended as well as the actual costs of the services. All waivers must be maintained in the member's health care record.

HNS has created a sample template, **"Patient Waiver – Non-Covered Services,"** which can be customized for use by any HNS-contracted health care professional. This form is available as a Word file on the HNS website under **"HNS Documents"**.

Chief Complaint

The Chief Complaint is a concise statement describing the symptoms, problems, conditions, or other factors that are the reason for the encounter. It is usually stated in the patient's own words.

Please review HNS' Best Practices (*Clinical Quality and Documentation Standards)* for additional information regarding the chief complaint.

HNS Policy:
Details of the complaint must be clearly documented in the health care record.

Timing and intensity of complaint must be clearly documented.

Causation of the complaint must be documented, including accident, injury, and etiology.

Diagnoses reported in the health care record should be supported by the chief complaint/clinical exam findings.

Services provided and billed to the payor should be clearly related to the chief complaint/clinical exam findings.

Closing Practices to New Patients

HNS Policy:
HNS contracted health care professionals cannot close their practices to new patients whose health care plans contract with HNS.

Clinical Examinations

Please review HNS' Best Practices for Clinical Quality & Documentation Standards for additional information.

For additional important information regarding examinations, please see the ***"Evaluation and Management***" section in this manual.

Initial Examination

HNS Policy:

1. *All initial examinations must be billed to HNS using the most appropriate E/M Code.*

2. Clinical examination findings must *objectively* substantiate the medical necessity of the services provided and should be consistent with the patient's chief complaint, diagnoses, and treatment plan (exception: maintenance care).

3. The history, examination, and all clinical findings must be properly documented in the patient's health care record.

4. 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.

5. HNS requires the use of standardized outcome assessment tools as part of the initial examination to establish a baseline and as part of each reexamination to evaluate and monitor progress toward treatment objectives.

6. The health care record must clearly indicate the specific tests performed as well as the results of those tests.

7. Vital signs must be obtained as part of *every* examination for which an evaluation/management (E/M) code is billed, and results must be documented in the health care record. At a minimum, HNS requires the following:

   Weight
   Pulse
   Blood Pressure

   Other vitals may be appropriate but are left to the discretion of the contracted health care professional and the level of examination performed.

   When a new patient presents requesting only maintenance care, vitals should be taken as part of the initial evaluation. The contracted health care professional may exercise clinical judgment as to the frequency of repeating them.

8. Clinical examinations should include an examination of the area(s) indicated in the patient's chief complaint.

9. Written clinical exam findings must include specific segments and location of subluxations.

10. The health care record must include appropriate documentation to support the type and level of E/M services reported to the payor.

Reexaminations

Please review HNS' Best Practices for Clinical Quality & Documentation Standards for additional information.

Note: Per the ACA Coding and Compliance Manual, the CMT codes include a pre-manipulation patient assessment. Additional evaluation and management (E/M) services may be reported separately using the modifier -25 if the patient's condition requires a significant separately identifiable E/M service above and beyond the usual pre-service and post-service work associated with the procedure.

Contracted health care professionals must be mindful of the submission of an E/M code on the same date a CMT code is reported. It **IS** appropriate to report the applicable E/M code for reevaluations performed pursuant to HNS policies (every four weeks or 12 visits when evaluating effectiveness of treatment, patient progress towards treatment goals, and the appropriateness of additional care). Additionally, it may be appropriate to report an E/M code if a reevaluation is needed when the patient presents with a different complaint, condition, or injury.

HNS Policy:

1. In order to evaluate the effectiveness of treatment and the appropriateness of further care, HNS-contracted health care professionals must perform

reexaminations after approximately 12 office visits or four weeks, whichever comes first (i.e., one treatment cycle).

2. For services provided and billed to HNS-contracted payors, clinical reexamination findings must *objectively* substantiate the medical necessity of the services provided and be consistent with the patient's chief complaint, diagnoses, and treatment plan (exception: maintenance care).

3. The reexamination and all clinical findings must be properly documented in the patient's health care record.

4. The reexamination should include such relevant orthopedic, neurological, and chiropractic tests and outcome assessments that objectively evaluate the patient's progress.

5. Generally accepted outcome assessment tools—such as Ostwestry, Roland-Morris, etc.—must be utilized at each reexamination to measure progress towards treatment objectives.

6. The health care record must clearly indicate the specific tests performed at each reexamination as well as the results of the tests.

7. Documentation for the reexamination must include evidence the patient's progress was objectively measured against the objective goals of the treatment plan to determine if maximum medical improvement has been reached.

8. If reevaluation fails to demonstrate improvement after two treatment cycles the contracted health care professional must assume maximum medical improvement has been reached and the patient should be switched to maintenance care, referred, or released from care.

9. The health care record must include documentation to support the type and level of E/M service reported to the payor.

10. Vital signs must be obtained as part of every *examination for which an E/M code is billed,* and results must be documented in the health care record. Mandatory vitals include:

    Weight
    Pulse
    Blood Pressure

    Other vitals may be appropriate but are left to the discretion of the contracted health care professional and should be consistent with the level of examination performed.

When a new patient presents requesting only maintenance care, vitals should be taken as part of the initial evaluation. The contracted health care professional may exercise clinical judgment as to the frequency of repeating them.

HNS Exam Forms
HNS has created exam forms to assist you in clinical evaluations of patients. All forms are available on the HNS website under **"HNS Documents"**. They are provided in Microsoft Word format so practitioners may download and customize the form(s) with their name and/or practice name.

Chiropractic Manipulative Treatment (CMT)

Please review HNS' Best Practices (*Clinical Records Quality and Documentation Standards)* for additional information regarding chiropractic manipulative treatment.

Per the *ACA Chiropractic Coding Manual*, CMT codes include:

Pre-Service:
- pre-manipulation patient assessment
- documentation and chart review
- image review
- test interpretation and care planning

Intra-service:
- pre-manipulation (e.g., palpation, etc.)
- manipulation
- post-manipulation procedures (e.g., assessment, etc.)

Post-service:
- chart documentation
- consultation
- reporting

HNS Policy:
Unless the member's health care plan includes maintenance care as a covered benefit, the medical necessity for chiropractic manipulation treatment must be clearly documented in the patient's health care record and must be consistent with the chief complaint/clinical findings, diagnoses, and treatment plan.

All CMT services provided and billed through HNS must be consistent with HNS and contracted payor policies, the policies of applicable state licensing boards, and state and federal laws.

CMT documentation must include clinical information that clearly supports the medical necessity for the *level of manipulation* reported to the payor.

CMT documentation must include appropriate diagnoses for each region manipulated.

CMT documentation must indicate the specific segments/areas manipulated. There are two ways in which the level of subluxation may be specified:

- The exact bones may be listed, for example: C5, C6, etc.
- The area may be reported if it implies only certain bones such as: occipital-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and sacrum), sacro-iliac (sacrum and ilium).

To report CMT the record must clearly substantiate a subluxation exists.

Subluxations must be documented and demonstrated by one of two methods: x-ray or physical examination.

Specific documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination.

To demonstrate a subluxation based on a physical examination, two of the four criteria below are required, one of which must be asymmetry/misalignment or range of motion abnormality.

- Pain/tenderness evaluated in terms of location, quality, and intensity
- Asymmetry/misalignment identified on a sectional or segmental level
- Range of motion abnormalities (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility)
- Tissue changes in the characteristics of contiguous or associated soft tissues; including skin, fascia, muscle, and ligament

CMT documentation must clearly reflect the CMT service rendered.

Regardless of how many manipulations are performed in a given spinal region (cervical, thoracic, etc.), it counts as only one region under the CMT codes.

Spinal Manipulations

Includes CPT codes:

- 98940 – spinal, one to two regions
- 98941 – spinal, three to four regions
- 98942 – spinal, five regions

The five spinal regions are:

- **Cervical Region** – includes all manipulations performed to the atlanto-occipital joint and C1–C7 on any visit.
- **Thoracic Region** – includes all manipulations performed to T1–T12, including posterior ribs (costovertebral and costotransverse joints) on any visit.
- **Lumbar Region** – includes all manipulations performed to L1–L5 on any visit.
- **Sacral Region** – includes all manipulations performed on the sacrum, including the sacrococcygeal junction, on any given visit.
- **Pelvic Region** – includes all manipulations performed to the sacro-iliac joints and other pelvic articulations on any visit.

Extraspinal Manipulations

Includes CPT code:

- 98943 – extraspinal, one or more regions

The five extraspinal regions are:

- **Head** – includes all manipulations performed to the head, including TMJ, but excludes atlanto-occipital joint.
- **Lower extremities** – includes all manipulations performed to the hip, leg, knee, ankle, and foot during any visit.
- **Upper extremities** – includes all manipulations performed to the shoulders, arm, elbow, wrist, and hand during any visit.
- **Rib cage** – includes all manipulations performed to the anterior rib cage on any given visit but excludes costovertebral and costotransverse joints.
- **Abdomen**

Coding (ICD, CPT, HCPCS, and Modifiers)

HNS Policy:
Only valid ICD, CPT, and HCPCS codes should be reported on insurance claims submitted through HNS.

All services must be properly coded with the most appropriate ICD, CPT, and/or HCPCS codes.

All ICD, CPT, and HCPCS codes reported on insurance claims must be consistent with HNS and HNS payor policies, the policies of applicable licensing boards, and state and federal laws.

Unlisted modality codes should not be billed through HNS (including, but not limited to, 97039, 97139, 97799, 20999). If practitioners need assistance with determining the appropriate code for a particular service, they should contact their HNS Service Representative.

ICD Codes

All diagnoses reported on the insurance claim must be documented in the health care record.

The patient's health care record must reflect ALL diagnoses/clinical impressions.

All ICD codes reported to a HNS contracted payor must be properly documented in the health care record, consistent with the patient's chief complaint/clinical findings and treatment plan, and support the services billed.

Contracted health care professionals must use the most accurate and appropriate ICD code(s) for services reported on an insurance claim.
The health care record must reflect an appropriate diagnosis associated with each region adjusted.

Any changes in diagnosis must be documented in the patient's health care record.

If the diagnosis code requires the inclusion of laterality (left/right), the documentation in the health care record must clearly substantiate the laterality reported in the code.

For services billed to an HNS-contracted payor, as a general rule, the diagnosis must be related to a neuromusculoskeletal condition and/or the condition must be improved or resolved through standard chiropractic treatment. (See individual payor corporate medical policies for which chiropractic services are covered.)

CPT Codes

Contracted health care professionals must ensure the CPT codes reported on the insurance claim accurately reflect the services provided and that those services are properly documented in the health care record.

Only CPT codes that reflect services that are medically necessary and consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan should be reported on claims filed through HNS (exception: maintenance care).

Contracted health care professionals must use the most accurate and appropriate CPT codes for services reported on an insurance claim.

Number of Units

For all CPT and HCPCS codes reported on a health care claim, contracted health care professionals must assure the accuracy of the number of units reported. The number of units reported must be supported by appropriate documentation in the health care record.

Maintenance/Supportive Care

Contracted health care professionals must bill using code S8990 when reporting maintenance/supportive care to an HNS-contracted payor. This includes manipulations *and therapies* provided as part of the maintenance/supportive care.

HCPCS

HNS-contracted health care professionals must report the most appropriate HCPCS codes on all insurance claims filed through HNS.

HCPCS codes can only be billed to an HNS-contracted payor if the service is medically necessary and consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan. (**Exception**: maintenance care. Contracted health care professionals must report maintenance care using S8990.)

Many HCPCS codes are not covered by HNS-contracted payors. In addition to verifying benefits, providers should check the applicable payor corporate medical policy and/or contact their HNS Service Representative with any questions.

Modifiers

When applicable, contracted health care professionals must use appropriate modifiers when reporting and billing chiropractic services to an HNS-contracted payor.

The use and/or need for the modifier must be supported by appropriate documentation in the health care record.

> **Note:** At this time, HNS-contracted payors cannot accept more than one modifier per code; accordingly, HNS-contracted health care professionals should only report one modifier per service line.

Modifier -59 – Distinct Procedural Service
Indicates that a procedure or service is distinct or separate from other services performed on the same day.

Payors require the use of modifier -59 with certain codes, and without this modifier the claim cannot be correctly adjudicated. For this reason, it is important to understand which codes require modifier -59.

> **Note:** If you perform an **extraspinal manipulation** on the same date as a spinal manipulation, the extraspinal manipulation should be appended with modifier -59 to indicate a separate and distinct service from the spinal manipulation.
>
> **Note:** If you perform a time-based service together with an E/M and/or CMT service, and you also provide the service for less than 15 minutes, you must append the code with modifier -59, not with modifier -52. However, your documentation must reflect the actual time you provided the service (i.e., 10 minutes).

HNS-contracted health care professionals must use modifier -59 for each of the following CPT codes when these codes are billed with E/M and/or CMT codes:

- 97112
- 97140
- 95832
- 95834
- 97124
- 95831
- 95833
- 97760

Modifier -25 – Significant, Separately Identifiable E/M Services
This modifier is only to be used with E/M codes and should not be added to any other code.

If you are billing an E/M service in addition to a chiropractic manipulation code (98940, 98941, 98942) for the same patient on the same date of service, you should append the E/M code with the modifier -25.

Modifier -52 – Reduced Services
If you are reporting a time-based procedure and you provide the service for less than the full unit (15 minutes) but at least 8 minutes, in general you should append the code with a modifier -52.

> **Exception:** If the service is reported with CMT or E/M service and requires the use of modifier -59 to prevent bundling, then always append with the modifier -59. However, your documentation must reflect the actual time you provided the service (i.e., 10 minutes).

Modifier -26 – Professional Component
This modifier indicates the provider is reporting the professional component only for a service. *This code would be appropriately reported by a chiropractic radiologist, for example, who did not actually see the patient but interpreted the study.* If the study is performed in your office and you interpreted the study, the CPT code for the study should not be appended with any modifier.

> **Note:** The pre-service work included in the CMT codes includes imaging review. The review of imaging studies included in the CMT service applies regardless of whether the studies were performed in your office or if the patient brings films to you that were taken elsewhere.

Complaints/Grievances

HNS Policy:
Contracted health care professionals must cooperate fully in the investigation of all complaints and must promptly respond to any HNS (or payor) requests for information needed to resolve the complaint.

Certain substantiated complaints are reported to authoritative bodies, including, but not limited to, licensing boards and the National Practitioner's Data Bank (NPDB).

Requests from Payors or Regulatory Authorities

If requested, contracted health care professionals are required to submit all information requested by contracted payors or regulatory bodies to resolve complaints, including, but not limited to, copies of health care records. If a "due date" is provided in the request, information must be received by the stated due date. If a "due date" is not provided, information must be submitted to the payor within 10 days of receipt of request.

Requests from HNS

Contracted health care professionals are required to submit all information requested by HNS to resolve complaints, including, but not limited to, copies of health care records. Contracted health care professionals must promptly comply with such requests. All requests from HNS for information needed to resolve a complaint will include a "due date" and information must be submitted to HNS by said date.

Consultations

(Please review HNS' E/M policy for information on consultations.)

HNS Policy:
The clinical record must reflect all consultations.

Consultation codes should only be reported on insurance claims when another physician, insurer, employer, or other appropriate source has requested your opinion or advice.

If a consultation has been requested:

- The clinical record must include the verbal or written request, including the name of the contracted health care professional or organization requesting the advice or opinion and the date it was received.

- The clinical record must include a copy of the contracted health care professional's written report to the requesting physician or appropriate organization, including his/her opinion, advice, and any services ordered or performed.

A consultation initiated by a patient and/or family and not requested by a physician or other appropriate source should not be reported using an E/M consultation code.

> **Note:** "Report of Findings" visits do not meet the requirements of an E/M consultation, so providers should not report their standard "Report of Findings" visits using an E/M CPT code.

HNS has provided a sample **"Consultation Form"** for use when billing for consults. This form is available on the HNS website under **"HNS Documents"** in Microsoft Word format.

Copayments/Coinsurance/Deductibles

HNS Policy:
For covered services provided to a member whose health care plan contracts with HNS, the patient cannot be charged any fees for *covered* services provided, except for applicable copayments, coinsurance, and/or deductibles.
Copayments, coinsurance, and/or deductibles should be collected by contracted health care professionals **at the time of service.**

> **Important Note:** If the member has not paid the applicable copayment, deductible, or coinsurance *for three or more consecutive office visits*, there must be a written payment plan signed by the member or legal guardian included in the health care record.

Contracted health care professionals may not waive or reduce copayments, coinsurance, or deductibles OR offer to waive any patient portion of the patient responsibility. This includes offering discounts and agreeing to accept what is paid by the insurance company.

> **Important Note:** If the amount of the covered service(s) provided on a given date of service is ***less than the co-payment,*** only the sum of the contracted allowables may be collected.

If the sum of the cost of covered services ***exceeds the amount of the co-payment,*** only the co-payment amount may be collected.

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.

Waiving, or offering to waive, co-payments, coinsurance or deductibles will result in immediate dismissal from the HNS Network.

Covered Services

HNS Policies:
Continued participation in the HNS Network requires the consistent compliance to all HNS Policies, and the policies of health care plans contracted with HNS.

1. With the exception of certain requests for restrictions of disclosure of health care information (see information below), HNS providers are contractually required to file claims through HNS for ALL covered service provided.

2. HNS providers may not reduce or discount fees for any covered services provided, at any time, regardless of whether a patient has requested a restriction of disclosure of their health care information and/or signed an ENTF form. (Exception: financial hardship provided evidence of it is consistent with HNS Policies regarding financial hardship)

   Please note: ***Signing an ENTF form does not make the patient a "CASH" patient.***
3. Because fees for covered services may not be discounted or reduced, **for non-PI patients**, <u>there is NO financial benefit to the patient</u> for restricting disclosure of their health care information (i.e., requesting claims not be filed to health care plan), or for signing an ENTF form.

4. HNS providers shall not provide any information to a patient, whether orally or written, which may (or does) suggest a financial benefit to a non-PI patient as a result of signing an ENTF form, and/or which otherwise results in the provider's failure to file claims to HNS for covered services provided.

   To provide any information, whether orally or written, which may (or does) suggest a financial benefit to a non-PI patient as a result of signing an ENTF form is *providing false and misleading information to the patient* and is a *misrepresentation of the facts*.

ENTF forms are ONLY to be discussed or used
IF and WHEN
a patient initiates a conversation
regarding the restriction of disclosure of their
health care information.

5. If, pursuant to above, a patient initiates a conversation regarding restriction of disclosure of their health care information, and should choose to do so, providers must comply with this request. However, such requests may ONLY be honored ***if the patient has first signed the applicable HNS Election Not to File form***. (The appropriate HNS ENTF form must always be used.)

6. ENTFs are only applicable to each episode of care. Once the treatment goals for the episode of care have been reached, **the ENTF is no longer valid**, and further covered services must be billed through HNS unless a new signed ENTF form is obtained and is on file in the patient's health care record.

7. A copy of the signed ENTF form must be provided to the patient, and the original, fully executed form must be maintained as part of the patient's health care record.

8. Because the HNS ENTF forms include facts the member needs in order to make an informed decision regarding whether to file claims to his/her health care plan, ***only the HNS Election Not to File forms may be used***. No other form is acceptable, and with the exception of the provider's name/practice name, no alterations to the form may be made.

9. While both forms indicate they are irrevocable, should the patient request to cancel the form, the decision to honor such a request is up to the treating provider. (While he/she may choose to do so, he/she is under no obligation to revoke the ENTF.)

Failure to comply with these policies will result in the immediate termination of participation in the HNS Network, and "committing deception or misrepresentation" may result in action against your NC license by the NC Board of Chiropractic Examiners.

- **Violation – Terms of the HNS Participation Agreement**
  To provide any information, whether orally or written, which may (or does) suggest a financial benefit to a non-PI patient as a result of signing an ENTF form, and which may impact a patient's decision regarding signing an ENTF form, and which results in the provider not filing claims to HNS, is a violation of HNS Policies and the terms of the HNS Participation Agreement, and will result in the termination of your participation in the HNS Network.

- **Violation of NC GS 90-154**
  (Grounds for Professional Discipline by NC BOCE)
  Because you cannot discount or reduce fees for covered services, there is NO financial benefit to a non-PI patient as a result of signing the ENTF form. To suggest otherwise may be a violation of NC GS 90-154 (b) (9) (*"Committing or attempting to commit fraud, deception, or misrepresentation"*).

ENTF Forms

The two HNS ENTF forms can be found on the HNS website under "**HNS Documents**".

Diagnostic Impression

Please review HNS' Best Practices (*Clinical Records Quality and Documentation Standards)* for additional information on consultations.

HNS Policy:
All diagnoses reported on the insurance claim must be documented in the health care record.

The patient's health care record must reflect ALL diagnoses/clinical impressions.

The diagnosis or diagnostic impression must be reasonable based on the patient's chief complaint(s), results of clinical findings, diagnostic tests, and other available information.

The health care record must reflect an appropriate diagnosis associated with each region adjusted. If the diagnosis code requires the inclusion of laterality (left/right), the documentation in the health care record must clearly substantiate the laterality reported in the code.

Diagnoses reported on insurance claims must be consistent with HNS and HNS Payor Policies, the policies of applicable licensing boards, and state and federal laws.

Any changes in diagnoses must be documented in the patient's health care record.

For services billed to an HNS-contracted payor, as a general rule, the diagnosis must be related to a neuromusculoskeletal condition and/or the condition must be one that can be improved or resolved through standard chiropractic treatment. (See individual payor corporate medical policies for when chiropractic services are covered.)

Discounting Fees

HNS Policy:
HNS contracted health care professionals may not offer discounts for any covered services provided. All covered services provided must be provided at the physician's usual and customary fee.

Documentation

Please review HNS' Best Practices (*Clinical Quality and Documentation Standards)* for HNS' performance expectations for clinical documentation. These standards are posted on the HNS website.

DME Services (Durable Medical Equipment)

Please review HNS' Best Practices (*Clinical Quality and Documentation Standards)* for additional information regarding DME services.

HNS Policy:
All recommended or provided DME must be documented in the clinical record.

For all DME provided and billed through HNS, the services' medical necessity must be clearly documented in the patient's health care record and must be consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan.

All DME provided and billed through HNS must be consistent with all HNS and HNS contracted payor policies, the policies of applicable state licensing boards, and state and federal laws.

HNS-contracted health care professionals must accurately report the correct HCPCS code on all insurance claims filed through HNS.

Documentation in the health care record must include the specific DME recommended, the date the DME was ordered, and the date the DME was delivered to the patient. Proof of purchase, unless rented, must be available upon request if requested by a contracted payor or HNS. If DME is rented, rental agreements must be available upon request if requested by a contracted payor or HNS.
Documentation in the health care record should include all instructions given to the patient regarding the use of any DME. If written standards are maintained for DME that include specific instructions, reference to the written standard is acceptable.

If written standards for DME are utilized, they should include the following statements:

- "The patient's health care record clearly establishes the medical necessity for any DME billed to the payor."

- "The need for any DME billed to a payor is consistent with the patient's chief complaint/clinical findings, diagnoses, treatment plan, and payor policies."

DME Vendors – BCBSNC

HNS Policy:
If referring BCBSNC members to a DME vendor, HNS-contracted health care professionals must refer members only to a BCBSNC-preferred DME vendor.

DME Vendors – CIGNA

HNS Policy:
If referring CIGNA and/or Great West patients, contracted health care professionals must refer members to the approved CIGNA/GWH DME vendor.

If practitioners and/or patients have any questions about the specific plan coverage of the DME, please call Cigna HealthCare at (800) 88-Cigna.

DME – Orthotics
CIGNA/Great West HealthCare will only reimburse network providers for chiropractic services that are listed on the Cigna HealthCare fee schedule and only if those services are covered under the member's specific plan. The current fee schedule does not include any HCPCS codes.

If you have a CIGNA patient that needs orthotics and orthotics are covered under the member's plan, these patients must be referred to Cigna HealthCare's authorized DME orthotic vendor. Please contact your HNS Service Representative for information about this vendor.

DME (other than orthotics)

If DME is covered by CIGNA

- When DME is covered, the contracted health care professional must refer the patient to the approved CIGNA DME vendor and may not provide the DME directly to the patient.

If DME is NOT covered by CIGNA

- There must be evidence if the DME is not covered in the member's health care record via a completed Verification of Benefits Form. This form must include all relevant information, including the name of the member, the date of the call, the

name of the CIGNA representative that verified the benefit(s), a reference number, and the specific codes/services verified.

- Practitioners must obtain a signed waiver from the member prior to providing services that attests to the member's agreement to receive and pay for the specific DME recommended.

- Both the waiver and the verification of benefits form must be maintained in the patient's health care record.

ONLY if you have obtained the information outlined above may contracted health care professionals bill the member directly for the DME.

Election Not to File (ENTF) Forms

HNS Policies:
Continued participation in the HNS Network requires the consistent compliance to all HNS Policies, and the policies of health care plans contracted with HNS.

1. With the exception of certain requests for restrictions of disclosure of health care information (see information below), HNS providers shall file claims through HNS for ALL covered services provided.

2. HNS providers may not reduce or discount fees for any covered services provided, at any time, regardless of whether a patient has requested a restriction of disclosure of their health care information and/or signed an ENTF form. (Exception: financial hardship provided evidence of it is consistent with HNS Policies regarding financial hardship)

   Please note: ***Signing an ENTF form does not make the patient a "CASH" patient.***

3. Because fees for covered services may not be discounted or reduced, for **non-PI patients**, there is NO financial benefit to the patient for restricting disclosure of their health care information (i.e., requesting claims not be filed to health care plan), or for signing an ENTF form.

4. HNS providers shall not provide any information to a patient, whether orally or written, which may (or does) suggest a financial benefit to a non-PI patient as a result of signing an ENTF form, and/or which otherwise results in the provider's failure to file claims to HNS for covered services provided.

   To provide any information, whether orally or written, which may (or does) suggest a financial benefit to a non-PI patient as a result of signing an ENTF form is *providing false and misleading information to the patient* and is a *misrepresentation of the facts*.

ENTF forms are ONLY to be discussed or used
IF and WHEN
a patient initiates a conversation
regarding the restriction of disclosure of his/her
health care information.

5. If, pursuant to above, a patient initiates a conversation regarding restriction of disclosure of their health care information, and should choose to do so, providers must comply with this request. However, such requests may ONLY be honored ***if the patient has first signed the applicable HNS Election Not to File form***. (The appropriate HNS ENTF form must always be used.)

6. ENTFs are only applicable to each episode of care. Once the treatment goals for the episode of care have been reached, **the ENTF is no longer valid**, and further covered services must be billed through HNS unless a new signed ENTF form is obtained and is on file in the patient's health care record.

7. A copy of the signed ENTF form must be provided to the patient, and the original, fully executed form must be maintained as part of the patient's health care record.

8. Because the HNS ENTF forms include facts the member needs in order to make an informed decision regarding whether to file claims to his/her health care plan, ***only the HNS Election Not to File forms may be used***. No other form is acceptable, and with the exception of the provider's name/practice name, no alterations to the forms may be made.

9. While both forms indicate they are irrevocable, should the patient request to cancel the form, the decision to honor such a request is up to the treating provider. (While he/she may choose to do so, he/she is under no obligation to revoke the ENTF.)

Failure to comply with these policies will result in the immediate termination of participation in the HNS Network, and "committing deception or misrepresentation" may result in action against your NC license by the NC Board of Chiropractic Examiners.

- **Violation – Terms of the HNS Participation Agreement**
  To provide any information, whether orally or written, which may (or does) suggest a financial benefit to a non-PI patient as a result of signing an ENTF form, and which may impact a patient's decision regarding signing an ENTF form, and which results in the provider not filing claims to HNS, is a violation of HNS Policies and the terms of the HNS Participation Agreement, and will result in the termination of your participation in the HNS Network.

- **Violation of NC GS 90-154**
  (Grounds for Professional Discipline by NC BOCE)
  Because you cannot discount or reduce fees for covered services, there is NO financial benefit to a non-PI patient as a result of signing the ENTF form. To suggest otherwise may be a violation of NC GS 90-154 (b) (9) (*"Committing or attempting to commit fraud, deception, or misrepresentation"*).

ENTF Forms

The two HNS ENTF forms can be found on the HNS website under "**HNS Documents**".

Electrodes

HNS Policy:
Electrodes are considered incidental to electrical stimulation and separate reimbursement is not allowed for incidental supplies. Accordingly, HNS-contracted health care professionals must not bill separately for electrodes when billing for electrical stimulation.

Electronic Fund Transfers (EFT's)

HNS utilizes electronic fund transfers (EFT's) to issue payor funds to participating providers.

HNS will electronically transfer your funds via EFT to our bank by 5 p.m. on the day HNS issues payments (10th, 20th of each month or the next business day, and the last business day of each month). HNS banks with Wells Fargo. Wells Fargo will transfer the funds to your bank within two business days. HNS will send an email notification to all network providers each time we electronically transfer funds to our bank account for distribution.

> **Note:** Practitioners' EFT is linked to their Tax ID (EIN). If this number changes, practitioners must immediately contact HNS and submit a new EFT registration using their new username and password.

Practitioners should contact their HNS service rep concerning all changes within their practices.

HNS Policy:
All HNS contracted health care professionals must accept HNS funds electronically from HNS.

For contracted health care professionals in group practices, each contracted health care professional must register separately for EFT.

Practitioners must immediately contact HNS and submit a new EFT registration if there are any changes to their EIN.

If practitioners change bank account information, they must immediately contact HNS and submit a new EFT registration.

Evaluation and Management Services (E/M)

HNS Policies:

New Patient:
An appropriate examination must be performed on each new patient and must be performed prior to rendering any treatment to the patient.

All initial examinations *must be billed to the payor*, regardless of whether the plan pays for the examination, and *must be billed using the most appropriate E/M Code*.

Documentation in the clinical record must clearly support the E/M service level billed.

E/M services reported to an HNS-contracted payor must be properly documented in the patient's health care record.

Established Patient:
A re-examination must be performed every 4 weeks or 12 visits (whichever comes first), and *all such required re-examinations must be billed to the payor*, regardless of whether the plans cover re-examinations, *and must be billed using the* most appropriate E/M code.

Documentation in the clinical record must clearly support the E/M service level billed.

E/M services reported to an HNS-contracted payor must be properly documented in the patient's health care record.

> **Note:** Per the ACA Coding and Compliance Manual, the CMT codes include a pre-manipulation patient assessment. Additional evaluation and management (E/M) services may be reported separately using the modifier -25 if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.

Despite the above, it is both appropriate and required to perform and report the applicable E/M code for reevaluations performed pursuant to HNS policies (every four weeks or 12 visits, whichever comes first I, in order to evaluate effectiveness of treatment, patient progress towards treatment goals, and the appropriateness of additional care. Additionally, it may be appropriate to report an E/M code if a

reevaluation is needed when the patient presents with a different complaint, condition, or injury.

A. E/M Services – New Patient

A new patient is one who has not received any professional services from the provider (or another chiropractor in the same group practice) within the past three years.

> **Note:** The provider may need to indicate, by CPT code, that on the day a procedure or service was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual pre-service and post-service care associated with the procedure that was performed. This should be reported by adding modifier **-25** to the appropriate level of E/M service.

B. E/M Services – Established Patient

An established patient is one who has received professional services from the provider (or another chiropractor in the same group practice) within the past three years.

To determine the appropriateness of further care, E/M services should be performed approximately every four weeks or every 12 visits (whichever comes first) unless, in between the four week/12 visit protocol, there has been significant change to warrant a reexamination that results in a change to the treatment plan.

> **Note:** The provider may need to indicate, by CPT code, that on the day a procedure or service was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual pre-service and post-service care associated with the procedure that was performed. This should be reported by adding modifier **-25** to the appropriate level of E/M service.

C. 99211 – Established Patient -Brief (Do not use!)

Providers should not report this code. This is a low complexity code which does not require a physician or other qualified health care professional to be present in the exam room with the patient. For all re-evaluations, report the most appropriate code (99212-99215).

D. E/M Services – Consultations

As noted under HNS "Consultation" policies, consultation E/M codes may only be billed when another physician, insurer, employer, or other appropriate source has requested a practitioner's opinion or advice. If such a consultation has been requested:

- The verbal or written request must be clearly documented in the patient's health care record, including the name of the contracted health care professional or organization requesting the advice or opinion and the date it was received.

- The contracted health care professional's written report to the requesting physician or appropriate organization, including his/her opinion, advice and any services ordered or performed, must be clearly documented in the patient's health care record. A copy of this report must be maintained in the patient's health care record.

A consultation initiated by a patient and/or family and not requested by a physician or other appropriate source should not be reported using an E/M consultation code.

> **Note:** "Report of Findings" visits do not meet the requirements of an E/M consultation; contracted health care professionals should not report their standard "Report of Findings" visits using an E/M CPT code.

HNS has provided a sample **"Consultation Form"** we recommend for billing for consultations. This form is available in Microsoft Word format on the HNS website under **"HNS Documents"**.

> **Note:** The provider may need to indicate using CPT code that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond other services provided or beyond the usual pre-service and post-service care associated with the procedure that was performed. This should be reported by adding modifier **-25** to the appropriate level of E/M service.

Family Members

(Treatment of family members)

HNS Policy:
HNS-contracted health care professionals may not bill HNS-contracted payors for chiropractic services provided to immediate family members, including:

- Spouses
- Children
- Siblings
- Parents

Fee Schedules (Physicians)

HNS Policy:
1. Each physician shall establish a fee for each service offered by the practice.

2. Once a fee has been established for each service offered, physicians shall bill the same fee to each payor/healthcare plan contracted with HNS.

(i.e., for any service provided, physicians shall not charge one healthcare plan a fee different than the fee charged to another healthcare plan contracted with HNS.)

3. *Payor contracted allowables (as shown on fee schedules) shall not be used as a charge for services provided.*

   Physicians have complete authority to set their own prices for the services they provide.

   As with any business, fees should reflect the value of the products and services provided. Fees should take into consideration the costs of providing each service, and the total costs of running your business.

While each provider can decide what fees he/she wishes to charge, when determining what fees to charge, it is helpful to be aware of what each payor has agreed to pay for each covered service provided. **For each payor with which you contract, carefully review each fee schedule**. (All HNS Fee Schedules are available on the secure section of the HNS Website.) When setting your fees, keep in mind that most health care plans pay the *lessor of* the billed charge and the contracted "allowable".

Filing Claims to HNS

The ***HNSConnect User Manual*** includes important and valuable information regarding filing claims to HNS. This manual is posted on the website under "HNS Documents". Please keep this handy and refer to it often!

HNS Policy:
Claims for all covered services provided to members whose health care plans contract with HNS must be filed through HNS. This includes PI claims as well as secondary coverage if the secondary payor contracts with HNS.

Exceptions (PI Cases)

In cases of personal injury when a third-party payor is involved and the patient instructs the contracted health care professional not to file claims to his/her health care plan, the contracted health care professional may ONLY comply with this request if the patient has signed and dated the ***HNS' Personal Injury Election Not to File Form***. A copy of this form must be provided to the patient and the original must be maintained in the patient's health care record.

Exceptions (Other Exceptions)

In cases other than PI, if a patient does not wish to have their claims filed to their health care plan, the contracted health care professional may ONLY comply with this request if the patient has signed and dated the ***HNS' Election Not to File Form***. A copy of this form must be provided to the patient and the original must be maintained in the patient's health care record. (**This specific form must be used for services provided on or after May 1, 2017.)**

Before utilizing one of the HNS Election Not to File forms, please carefully review all of the information regarding this form. Please see **Election Not to File Form** section of this manual.

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.

How to File:

Electronic Claims Filing Policy
HNS will accept electronic claim files via the following methods:

1. **HNSConnect®**
   HNS accepts HIPAA compliant ANSI 5010 837p claim files submitted through HNSConnect® *directly from the physician's practice management software.* HNS cannot accept 837p claim files submitted in version *4010.*

2. **Office Ally™**
   If your software system cannot produce the required HIPAA compliant 837p 5010 claim files, effective April 1, 2014, you may submit your claims to HNS through Office Ally™. HNS cannot accept claim files from any other clearinghouse. For more information about enrolling with Office Ally™, please review the Office Ally™ section of the HNS website.

3. **Manual Entry via HNSConnect®**
   You may file claims to HNS by manually entering claim data into HNSConnect®.

Primary Claims
With few exceptions, all primary claims must be submitted *electronically* to HNS.

Corrected Claims
A corrected claim is a claim that has *already been adjudicated* and needs to be filed for correct processing. In other words, to file a "corrected claim" you must already have received an EOB/NOP from the payor.

Please review the *specific requirements for filing corrected claims* in the **HNSConnect User Manual**, which is available on the HNS website, under 'HNS Documents".

All health care providers are charged with reporting accurate information on insurance claim forms. Information submitted on claim forms to HNS-contracted payors that is

inaccurate or erroneous *must be corrected as soon as the contracted health care professional becomes aware of the error.* HNS contracted health care professionals must promptly correct the inaccurate information by filing a corrected claim to revise the information previously submitted and per the instructions noted above.

Secondary Claims
HNS-contracted health care professionals are required to file all secondary claims through HNS if the secondary coverage is provided by an HNS-contracted payor. Please review the *specific requirements for filing secondary claims* in the **HNSConnect User Manual**, which is available on the HNS website, under 'HNS Documents".

Claims with Attachments
Claims with attachments, such as office notes, must be filed through HNS. Such claims must be submitted on a CMS 1500 paper claim form and mailed, emailed, or faxed to HNS.

Who Can File:

Providers:
Only providers who have been credentialed with HNS and are active HNS-contracted health care professionals can provide and bill for care as an "in-network" provider on behalf of a member who has insurance with a health care plan that contracts with HNS.

> **Exception:** If services were provided by a *locum tenens* ("fill-in") provider working for the HNS-contracted health care professional, and *all locum tenens requirements have been met,* services provided by the "fill-in" provider may be submitted under the name of the HNS in-network provider who contracted with the "fill-in" provider.
>
> Please refer to the policy on *locum tenens* providers for requirements regarding *locum tenens* billing.

If Patients File Claims
Claims submitted by the patient to HNS or directly to the health care plans will not be processed and/or will be incorrectly adjudicated. Contracted health care professionals are required to file claims on behalf of patients who have health insurance with a health care plan that contracts with HNS.

New Associate/Employee Chiropractors
Claims cannot be submitted *in a practitioner's own name* for services provided by an associate physician who is not yet credentialed with HNS (Exception noted above for *locum tenens*).

If a practice has hired a new associate, they must contact HNS immediately so we can assist with credentialing the provider. Until the provider is credentialed by HNS, he/she must not provide any physician services to a patient whose insurance processes through HNS.

Name of Provider on Claim Form (Rendering Provider)
All claims submitted to HNS must include the name and the Type I NPI number of the provider that *actually rendered the services that are reported on the claim form.* The provider's signature on the health care claim form is an attestation that he/she actually provided the services.

> **Exception:** If services were provided by a *locum tenens* ("fill-in") provider and all *locum tenens* requirements have been met, services provided by the "fill-in" provider may be submitted under the name/NPI number of the provider who contracted with the "fill-in" provider. Please refer to the policy on *locum tenens* providers for requirements regarding *locum tenens* billing.

If practitioners are in a group practice or share call coverage with other providers, they should take special care to assure the accuracy of the rendering provider's name on each claim submitted.

If practitioners discover that a claim (or claims) was submitted incorrectly with the wrong rendering provider's name, they must promptly file corrected claims to correct the error. Prompt recognition of this and immediate correction can reduce payor concerns of fraud and/or abuse.

Financial Hardship

HNS Policy:
Despite financial hardship, network providers may not waive or reduce copayments, coinsurance, or deductibles.

If true financial hardship exists and has been clearly established and supporting documentation is maintained in the health care record, the provider may reduce or waive *their charges but may not reduce or waive copayments, deductibles, and/or coinsurance.*

In order to reduce or waive charges for financial hardship, contracted health care professionals must have written policies that specifically outline the practice's criteria for reducing or waiving charges, relative to financial hardship.

Financial Hardship Policies must include:

1. Written standards for providing reductions or waivers of charges with specific, objective criteria for determining financial hardship.

2. Written standards that the practice's financial hardship policies are consistent with community standards, HNS and HNS Payor Policies, the policies of applicable state licensing boards, and all state and federal laws.

3. A clear statement that should charges be reduced or waived as a result of a financial hardship, the waiver or reduction shall be applied to all services/supplies required to provide the care needed by the patient (i.e., waivers or discounts may not be applied to some services but not to others).

4. A printed financial worksheet that such patients must complete to provide the information needed to determine if the patient's financial position meets the criteria of the policy.

5. A single designated person in the practice with authority to grant the discount.

The contracted health care professional must maintain a complete list of all patients who received discounts or waivers of charges.

> **Important Note:** To assist in determining if financial hardship exists and meeting HNS' requirements, HNS has developed a "Confidential Financial Hardship Worksheet" for use in establishing true financial hardship. This helpful tool is included in the **"HNS Documents"** section of the HNS website.

HRA/HSA Plans

HNS Policy:
For Health Reimbursement Accounts (HRA) and Health Saving Accounts (HSA), providers may require the member to pay for covered services provided in full at the time of service but *may not collect from the member more than the contracted allowable for any covered service*.

The contracted health care professional must provide the member with a receipt reflecting the services provided, the amount charged for each service, and the amount paid by the member.

Should the contracted health care professional subsequently receive payment for those services directly from the HRA/HSA plan administrator, the contracted health care professional must promptly refund any amounts paid by the member *to the member.*

Independent Contractors

HNS Policy:
To prevent confusion for members seeking care from “in-network” providers, all chiropractors practicing in the same physical location must participate in the HNS network or none of those chiropractors can participate in the HNS network. This includes chiropractors in a group practice filing claims under the same EIN *as well as independent contractors.*

Chiropractors in the HNS network may choose to add an independent contractor to their practice but the independent contractor must participate with HNS or none of the chiropractors practicing at that physical location may participate with HNS.

What is an independent contractor?
The definition of an independent contractor has been outlined by common law principles, the Fair Labor Standards Act, and some court decisions.

The IRS, along with many individual states, has adopted common law principles to define an independent contractor. These rules focus primarily on the level of control an employer has over a service or product, meaning how the employer defines what is being done and how it will be accomplished.

Common law principles further define independent contractor status by the method of compensation. If a person is on an employer’s payroll and receives a steady paycheck, clearly the person is an employee rather than an independent contractor, who likely receives payment in a different manner.

Considerations in identifying someone as an independent contractor may include:

- Whether the provider supplies his/her own equipment, materials, and tools
- Whether all necessary materials are supplied by the employer
- Whether the provider can be discharged at any time and can choose whether to come to work without fear of losing employment
- Whether the provider can control his/her hours of employment, thus indicating he/she is acting as an independent contractor
- Whether the provider is leasing the space he/she uses to practice
- Whether the provider employs his/her own staff

When the services being performed are integral to the business, it is more likely that the person is an employee. On the other hand, work that is temporary and non-integral may imply independent contractor status.

These courts also use the “right to control” test. When the hiring party controls the manner in which work is carried out and a product is delivered, the relationship between the parties is that of an employer/employee.

Employer Tax Liability
An employer’s tax liability is determined by the worker’s employment status. When a worker is an employee, employers must pay state and federal unemployment tax, social security tax, and workers compensation/disability premiums to a state insurance fund. When a worker is an independent contractor, the hiring party is not required to make any of these payments.

Should employers incorrectly define a worker as an independent contractor, they may find themselves liable for past taxes, including FICA and federal unemployment tax. Safe harbors, which allow employers to use the independent contractor status and avoid penalties, including prior practice of treating similar employees as independent contractors and the existence of prior IRS audits where no taxes were required to be paid.

Informed Consent

HNS Policy:
Prior to initiating treatment for any condition, informed consent must be obtained from the patient and evidenced in writing.

HNS Network Physicians must utilize a written informed consent form, and the form must be dated and signed by the patient (or legal guardian) and maintained as part of the healthcare record. However, because of the fact-specific nature of the informed consent process, HNS does not endorse nor offer opinions as to the sufficiency of a physician’s overall informed consent process, including, but not limited to, the substance of any informed consent form used in that process.

Overall, HNS Network Physicians should keep in mind that informed consent is a process, which may or may not be satisfied with a written form. Importantly, a signed written consent form is not a valid substitute for, nor does it replace, a discussion between doctor and patient. Ultimately, it is the doctor’s responsibility to make sure the patient is properly informed, understands, and consents to the treatment to be provided.

Generally, informed consent arises from the principle that a patient has the right to exercise control over his or her body by making an informed decision concerning whether to consent to a particular course of treatment or procedure. A patient also has the right to withdraw consent at any time.

For a patient to truly consent, it is generally held that they should know and completely understand the following:

a) Nature of their condition;

b) Nature of the treatment to be rendered;
c) All material risks attendant to that treatment;
d) The possibility of an occurrence of said risks;
e) Alternative treatment available and the risks attendant to those treatments; and,
f) The consequences of allowing the condition to remain untreated.

Even though the principles above have been generally accepted throughout the United States, it is up to each individual state to define the necessary elements to establish informed consent within their jurisdiction.

As such, considering all factors involved in the informed consent process, HNS recommends that HNS Network Physicians contact attorneys who practice healthcare-related law in their state to obtain guidance concerning the informed consent process used in his/her practice, including, but not limited to, what specific information to include in the informed consent form.

That said, HNS does make available sample informed consent language on the HNS Website under "**HNS Documents**", which HNS Network Physicians and their counsel may consider should they choose to do so.

Insurance ID Cards

HNS Policy:
HNS-contracted health care professionals must always ask if a patient has health care coverage.

If the patient has coverage, the contracted health care professional must obtain a current copy of the member's ID card.

Copies of the member's current ID card must be maintained in the health care record.

At each visit, the contracted health care professional should ask if there have been any changes to the patient's insurance information.

HNS service reps will gladly assist in determining if claims for a specific plan should be sent to HNS. Providers should email a legible copy of the member's ID card to their HNS Service Representative.

Locum Tenens/Reciprocal Billing

On occasion, a contracted health care professional may arrange for a *locum tenens* (substitute) physician to see patients if he/she is out of the office and unavailable to provide chiropractic services.

HNS Policy:

Other than claims-reporting services by a *locum tenens* (substitute) provider, all claims filed to HNS-contracted payors must accurately reflect the name of the contracted health care professional that *actually rendered services*.

If a *locum tenens* (substitute) physician is utilized, claims reporting services provided by the *locum tenens* provider may be submitted under the name of the contracted health care professional who has contracted with the *locum tenens* provider if all of the following requirements are met for all covered services provided:

- The substitute physician is either in practice for himself/herself, part of another group practice, or works solely as a *locum tenens* or "substitute" provider. In other words, the "substitute" physician cannot be an employee of the regular physician nor have a partnership or associate relationship with the "regular" physician.

- The regular physician is unavailable to provide the services on the dates the "substitute" physician is used (i.e., out of the office).

- The patient has arranged or sought out services from the contracted health care professional.

- The substitute physician does not provide the services over a continuous period of time longer than 60 days.

- The health care record properly reflects the name of the provider that rendered each service.

- The "regular" physician must maintain thorough and accurate records indicating the name and NPI number of the "substitute" physician, the dates the "substitute" physician provided services, and the names of all patients who received services by the "substitute" physician. This information must be readily available to HNS and our contracted payors.

  Note: A physician may have reciprocal arrangements with more than one physician.

If providers have any questions regarding the appropriate employment of a *locum tenens* provider and/or associated billing requirements, they can contact their HNS Service Representative for assistance.

Maintenance/Supportive Care

More and more plans are now covering wellness visits. (Please see list below of some plans that DO cover wellness.)

It is very important when verifying benefits to specifically ask if code S8990 is covered by the member's plan. (To ensure you get accurate information, do not ask if wellness/maintenance is covered; ***specifically ask if S8990 is covered!***)

If Maintenance Care is Covered:

The AMA defines S8990 as "Physical or manipulative therapy performed for maintenance rather than restoration."
If maintenance/supportive care is covered by the member's plan, the service(s) must be accurately reported using HCPCS code **S8990**. (Never use CMT codes if billing for maintenance/supportive care – even if the services are covered by the member's plan.)

Therapies and Manipulations:
As noted in the AMA definition for S8990, this code includes ***both therapies and manipulations***, so providers should report S8990 when providing only a manipulation and/or when therapies are done in conjunction with the manipulation.

If Maintenance Care is **NOT** Covered:

If maintenance/supportive care is not covered by a member's health care plan, with few exceptions, it should not be billed to the payor.

If a patient insists that you file a claim, do the following:

1. Provide the patient with the **HNS Maintenance/Supportive Care Letter to Patients** and ask them to read it.

2. Have the patient sign the **HNS Maintenance/Supportive Care Waiver** and explain that while you are confident the insurance plan won't cover it, you will be happy to file a claim provided they first agree, in writing, to pay for the service if the plan does not cover it.

3. Then file the claim, accurately reporting the care as maintenance by using code **S8990**. The plan will deny the claim and the patient will receive an EOB showing the service is not covered.

If Maintenance Care is Covered by Secondary Payor:

When maintenance care is not covered by the primary payor but is covered by the secondary payor, you must report S8990 to both the primary and secondary payor. Billing the correct code (S8990) will result in a denial from the primary payor and an appropriate EOP denial to send to the secondary payor.

Additionally, a patient may need a receipt/super bill or EOP denial in order to seek reimbursement under a flexible spending account or HSA/HRA account. Always ensure the receipt includes the S8990 code.

The ACA has published the following definitions:

"Preventive/Maintenance Care:
Elective health care that is typically long-term, by definition not therapeutically necessary but is provided at preferably regular intervals to prevent disease, prolong life, promote health, and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration, or it may be initiated with patients without symptoms in order to promote health and to prevent future problems. This care may incorporate screening/evaluation procedures designed to identify developing risks or problems that may pertain to the patient's health status and give care/advice for these. Preventive/maintenance care is provided to optimize a patient's health."

Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur.

"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. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when risk of supportive care outweighs its benefit, i.e., physician/treatment dependence, somatization, illness behavior, or secondary gain."

The AMA defines S8990 as "Physical or manipulative therapy performed for maintenance rather than restoration."

MMI – Important Note:
The clinical record must clearly indicate when maximum medical improvement (MMI) has been reached. Once MMI has been reached, the patient should be released from care or switched to maintenance/supportive care.

HNS Payor Policies for Maintenance/Supportive Care

Absolute Total Care Members (Medicaid & Medicare – Allwell)
Maintenance and supportive care are not covered.

BCBSNC Members
Maintenance and supportive care are not covered chiropractic benefits for the following members:

- BCBSNC members
- Blue Medicare Supplemental members
- HSA/HRA members (high deductible plans)
- ASO self-funded groups, with the following exceptions:

  Exceptions:
  Several groups for whom BCBS administers their plans DO cover maintenance. For those plans, maintenance must be reported using **S8990**.
  - The City of Cary
  - Piedmont Natural Gas
  - Waste Industries USA, Inc.
  - SAS Institute, Inc.
  - Wake Internal Med Consultants, Inc.

Please note – this list is not all-inclusive, so always verify benefits.

BCBS Out-of-State Plan Members
Benefits for BCBS out-of-state members are determined by the member's home plan. Please contact the home plan directly to determine if maintenance and/or supportive care are covered.

If you are told when verifying benefits that maintenance care is covered, then you may provide maintenance care for that member, but treatment must be correctly reported using **S8990**.

CIGNA HealthCare Members
Maintenance and supportive care are not covered.

Federal Employee Plan Members
Benefits for FEP members are determined by the member's plan. Please contact the FEP plan directly to determine if maintenance and/or supportive care are covered.

If you are told when verifying benefits that maintenance care is covered, then you may provide maintenance care for that member, but it must be correctly reported using **S8990**.

HealthSpring Members
Maintenance and supportive care are not covered.

HealthTeam Advantage Members
Maintenance and supportive care are not covered.

HealthTeam Advantage Diabetes and Heart Care Plan (CSNP) Members
Maintenance and/or supportive care are not covered.

MedCost Members
Many MedCost payors cover maintenance and/or supportive care. Please contact each payor to determine if maintenance and/or supportive care are covered for each of your MedCost patients. If you are told when verifying benefits that maintenance is covered, then you may provide maintenance care for that member, and this must be filed through HNS. If maintenance care is covered, it must be reported using **S8990**.

Select Health of South Carolina
Maintenance and supportive care are not covered.

WellCare Medicare Advantage (effective 12/1/2021)
Maintenance and supportive care are not covered.

Malpractice Coverage

HNS Policy:
At all times, HNS-contracted health care professionals are required to maintain professional liability insurance with minimum coverage amounts of **$1 million/$3 million.**

All contracted health care professionals should contact their malpractice carrier immediately if they suspect a patient may be contemplating a malpractice action.

HNS-contracted health care professionals must contact HNS immediately if they become a defendant in any malpractice action; receive any pleading, notice or demand of claims or service of process relating to alleged malpractice; or if they are required to pay damages in any such action by way of a judgment or settlement.

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 person's healing process reaches a treatment plateau.

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 whether the patient was moved to wellness/supportive care, discharged, or referred.

> ***Reminder***: Supportive care is treatment 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-contracted health care professionals must verify benefits for each member prior to providing services.

Medical Necessity

HNS Policy:
Contracted health care professionals shall only submit claims to HNS for services that are medically necessary and consistent with HNS policies and the policies of contracted payors (exception: maintenance/wellness care).

The clinical record must include documentation which *objectively* substantiates the medical necessity of the covered services billed to payors.

Medically necessary care must be evidenced by all relevant standards included in HNS' Clinical *Quality and Clinical Documentation Standards.*

The following are considered essential "core" standards to help improve treatment outcomes and ensure only medically necessary care is billed to contracted payors:

1. Establish and document the patient's chief complaint

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

3. Ensure the 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*

4. Reevaluate the patient every four weeks or 12 visits (whichever comes first)

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

6. 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*

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

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

(The HNS *Clinical Quality and Documentation Standards* is posted on the HNS website.)

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.*

Repayment to Payors

HNS Policy:

1. Contracted health care providers shall not retain fees received for services provided to which they are not entitled.

2. If a contracted health care professional receives a payment for services that a payor determines is not medically necessary, the provider shall timely repay those monies to HNS or the applicable payor and shall do so in the manner and form specified by HNS or the payor.

This policy survives the termination of the *HNS Practitioner's Participation Agreement.*

Modalities/Therapies

Please review HNS' Best Practices (*Clinical Quality and Documentation Standards)* for additional information regarding modalities and therapies.

HNS Policy:
When performed and billed to a payor, modalities/therapies must be properly documented in the health care record, accurately reported using the most appropriate code, be medically necessary, and be consistent with the chief complaint/clinical findings, diagnoses, and treatment plan.

Unlisted modality codes should not be billed through HNS (including, but not limited to, 97039). If practitioners need assistance with determining the appropriate code for a particular service, they should contact their HNS Service Representative.

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

- There should be a reduction in the use of therapies as the patient's condition improves.

- All therapies/modalities provided and the rationale for each must be documented in the health care record.

- Documentation contained in the health care record must clearly establish the medical necessity for all therapies billed to the payor.

- All therapies provided and billed to the payor must be consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan.

- When reporting time-based codes, the health care record must reflect the actual time the services were performed.

- All time-based therapies (constant attendance and therapeutic procedures) are billed in 15-minute increments. If provided for less than 8 minutes, the service should not be billed to the payor. The time these services are provided must be documented in the health care record.

- Documentation must also include:
    - Type of modality
    - Rationale
    - Area of application (specific areas/regions treated)
    - Setting and frequency (as applicable)
    - If time-based code, actual time service performed

All therapies provided and billed to a payor must be consistent with HNS and contracted payor policies, the policies of applicable state licensing boards and state and federal laws.

Written Standards
HNS-contracted health care professionals may choose to avoid the time constraints associated with repeatedly meeting the requirements for proper modality documentation by establishing written standards for the application of each modality used in the practice.

If practices choose to utilize written standards, the rationale for the use of the therapies included in the health care record must be consistent with the language in the written standards.

Note: If a practitioner incorporates written standards in his/her practice, they should include the following statements:

- "The medical necessity for each modality/therapy I have provided and billed to the payor is clearly documented in the patient's health care record and is consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan."

- "All therapies provided and billed to the payor are consistent with the chiropractic services covered under the patient's health care plan."

If providers choose to utilize written standards for their practice, they must always document the specific service provided, the specific area(s) treated, and, if time-based services are utilized, the actual length of time the service was provided.

HNS has provided a sample template for **"Written Standards for Modalities"**. This form is available on the HNS website under **"HNS Documents"**.

Supervised Modalities

Please review HNS' Best Practices (*Clinical Quality and Documentation Standards)* for additional information regarding modalities and therapies.

Supervised modalities (**CPT 97010-97028**) are defined as the application of a modality that does not require direct (one-on-one) patient contact by the provider. The provider can leave the room while the patient is receiving this service.

The services are not timed codes and may only be billed once per encounter, regardless of the number of applications.

HNS Policies:
When performed and billed to a payor, modalities/therapies must be properly documented in the healthcare record and accurately reported using the most appropriate code.

When performed and billed to a payor, modalities/therapies must be medically necessary and consistent with the chief complaint/clinical findings, diagnoses and treatment plan.

Documentation in the healthcare record must include the rationale for each therapy and must clearly establish the medical necessity for each therapy billed to the payor.

For ALL modalities and therapies, documentation must include:

- Type of modality
- Rationale

- Area of application (specific region treated)
- Setting and frequency (as applicable)
- If time-based code, actual time service performed

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

There should be a reduction in the use of therapies as the patient's condition improves.

All time-based therapies (**constant attendance** and **therapeutic procedures**) are billed in 15-minute increments.

When reporting time-based codes, the healthcare record must reflect the actual time the services were performed. (Ex: 15 minutes)

If a time-based code is provided for less than 8 minutes, the service should not be billed to the payor.

Unlisted modality codes, as a general rule, should not be billed through HNS (including, but not limited to, 97039). If you need assistance with determining the appropriate code for a particular service, please contact your HNS Service Representative.

Constant Attendance Modalities (Time-based)

Please review HNS' Best Practices (*Clinical Quality and Documentation Standards)* for additional information regarding modalities and therapies.

HNS Policy:
Constant Attendance Modality codes (**CPT 97032-97039**) are used to report various physical agents applied to the patient for the purpose of producing therapeutic changes to biological tissue. **The services described by these codes require direct one-on-one contact by the provider.** Throughout the procedure, the provider is required to maintain visual, verbal, and/or manual contact with the patient.

Unlisted modality codes, as a general rule, should not be billed through HNS (including, but not limited to, 97039, 97139 and 97799). If you need assistance with determining the appropriate code for a particular service, please contact your HNS Service Representative.

HNS Policies:
When performed and billed to a payor, modalities/therapies must be properly documented in the healthcare record and accurately reported using the most appropriate code.

When performed and billed to a payor, modalities/therapies must be medically necessary and consistent with the chief complaint/clinical findings, diagnoses and treatment plan.

Documentation in the healthcare record must include the rationale for each therapy and must clearly establish the medical necessity for each therapy billed to the payor.

For ALL modalities and therapies, documentation must include:

- Type of modality
- Rationale
- Area of application (specific region treated)
- Setting and frequency (as applicable)
- If time-based code, actual time service performed

All time-based therapies (**constant attendance** and **therapeutic procedures**) are billed in 15-minute increments.

If a time-based code is provided for less than 8 minutes, the service should not be billed to the payor.

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

There should be a reduction in the use of therapies as the patient's condition improves.

Therapeutic Procedures (Time-based)

Please review HNS' Best Practices (*Clinical Quality and Documentation Standards)* for additional information regarding modalities and therapies.

HNS Policy:
A Therapeutic Procedure (**CPT 97110-97546**) is defined as "a manner of effecting change through the application of clinical skills and/or services that attempt to improve function."

These procedures require direct one-on-one patient contact by a **physician** or **therapist.**

> **Note**: Manual therapy (**97140**) and therapeutic massage (**97124**) can only be performed by the physician or an appropriately *licensed* therapist.

Common components included as part of Therapeutic Procedures include chart reviews for treatment, setup of activities and the equipment area, and review of previous documentation as needed.

When performed and billed to a payor, modalities/therapies must be properly documented in the healthcare record and accurately reported using the most appropriate code.

When performed and billed to a payor, modalities/therapies must be medically necessary and consistent with the chief complaint/clinical findings, diagnoses and treatment plan.

Documentation in the healthcare record must include the rationale for each therapy and must clearly establish the medical necessity for each therapy billed to the payor.

For ALL modalities and therapies, documentation must include:

- Type of modality
- Rationale
- Area of application (specific region treated)
- Setting and frequency (as applicable)
- If time-based code, actual time service performed.

All time-based therapies (**constant attendance** and **therapeutic procedures**) are billed in 15-minute increments.

If a time-based code is provided for less than 8 minutes, the service should not be billed to the payor.

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

There should be a reduction in the use of therapies as the patient's condition improves.

Unlisted modality codes, as a general rule, should not be billed through HNS (including, but not limited to, 97039, 97139 and 97799). If you need assistance with determining the appropriate code for a particular service, please contact your HNS Service Representative.

Manual Therapy (97140)

Please remember that manual therapy should be used the same day as a manipulation *only in certain circumstances, and the rationale must be clearly documented.*

The *ACA Chiropractic Coding Solutions Manual* gives the following example of the appropriate use of 97140 on the same day of a manipulation.

> *"A patient has severe injuries from an auto accident with a neck injury that contraindicates CMT in the neck region. Therefore, the provider performs MANUAL THERAPY to the neck region and CMT to the lumbar region. In this instance, it would be appropriate to report both the 97140 and the CMT."*

If it is appropriate to report 97140 (manual therapy) together with a CMT, the manual therapy code (97140) must be appended with the modifier -59.

At the present time, payors' claim processing systems can accept only one modifier per CPT code. Manual therapy, when performed together with a CMT code, must be submitted with modifier -59 to indicate a "distinct procedural service." Even if the service was reduced and would normally require the use of modifier -52 and modifier -59, always append this code with the modifier -59 or the service will be denied.

Note: If no CMT code is reported on the same date of service as code 97140, and the service was reduced to less than 15 minutes, then append with modifier -52.

Modifiers

When applicable, contracted health care professionals must use appropriate modifiers when reporting and billing chiropractic services to an HNS-contracted payor.

The use and/or need for the modifier must be supported by appropriate documentation in the health care record.

> **Note:** At this time, HNS-contracted payors cannot accept more than one modifier per code; accordingly, HNS-contracted health care professionals should only report one modifier per service line.

Modifier -59 – Distinct Procedural Service
Indicates that a procedure or service is distinct or separate from other services performed on the same day.

Payors require the use of modifier -59 with certain codes; without this modifier the claim cannot be correctly adjudicated. For this reason, it is important to understand which codes require modifier -59.

> **Note:** If a practitioner performs an **extraspinal manipulation** on the same date as a spinal manipulation, the extraspinal manipulation should be appended with modifier -59 to indicate a separate and distinct service from the spinal manipulation.

> **Note:** If a practitioner performs a time-based service together with an E/M and/or CMT service that must be appended by modifier -59, and also provides the service for less than 15 minutes, he/she must append the code with modifier -59, not modifier -52. However, the documentation must reflect the actual time the service was provided (i.e., 10 minutes).

HNS-contracted health care professionals must use modifier -59 for each of the following CPT codes when these codes are billed with E/M and/or CMT codes:

- 97112
- 97124
- 97140
- 95831
- 95832
- 95833
- 95834
- 97760

Modifier -25 – Significant, Separately Identifiable E/M Service

> **Note:** This modifier is only to be used with E/M codes and should not be added to any other code.

If a provider is billing an E/M service in addition to a chiropractic manipulation code (98940, 98941, 98942) for the same patient on the same date of service, he/she should append the E/M code with modifier -25.

Modifier -26 – Professional Component
This modifier indicates the provider is reporting the professional component only for a service. *This code would be appropriately reported by a chiropractic radiologist who did not actually see the patient but interpreted the study.* If the study is performed in a practitioner's office and he/she interpreted the study, the CPT code for the study should not be appended with any modifier.

> **Note:** The pre-service work included in the CMT codes includes imaging review. The review of imaging studies included in the CMT service applies regardless of whether the studies were performed in a provider's office or if the patient brings films to the provider that were taken elsewhere.

Nerve Conduction/EMG Policy

HNS Policy:
Most contracted payors do not cover nerve conduction or EMG studies when performed by chiropractors. Always check when verifying benefits.

BCBSNC Policy:
BCBSNC only provides coverage for nerve conduction studies and EMG's when performed by physicians who are Diplomates of the American Chiropractic Neurology Board (DACNB).

This policy applies to out-of-state BCBS plans as well as in-state plans.

In order to bill BCBSNC for nerve conduction studies and EMG's, the provider's name must be included on the list of certified neurologists on the ACNB website (www.acnb.org). If his/her name is not included on the ACNB website, he/she cannot bill BCBS for these services.

If a provider is not a DACNB and provides nerve conduction studies/EMGs to members whose health care plans process through BCBSNC, these services must be treated as non-covered services and, as such, require a waiver that is signed by the patient *before such services are rendered.* Please remember all waivers for non-covered services must be maintained in the patient's health care record.

New Patients

HNS Policy:
HNS-contracted health care professionals cannot close their practices to new patients whose health care plans contract with HNS.

Non-Covered Services

HNS Policy:
With few exceptions, non-covered services cannot be billed to HNS-contracted payors.

> **Exception**: When practitioners need to report a non-covered service in order to obtain a denial to use for coordination of benefits and/or if a patient needs to obtain a denial from a payor for reimbursement under a flexible spending account or HSA/HRA account, those services may be reported to a payor that does not cover the services provided the patient's health care record includes appropriate evidence to support the need to bill the non-covered service to the payor.

HNS-contracted health care professionals must verify benefits prior to providing services in order to determine if the services planned are covered chiropractic benefits under a patient's health care plan. (When verifying benefits, contracted health care professionals should always ask if the planned services are covered when provided by a *chiropractic physician.*)

In addition to verifying benefits, with respect to non-covered services, HNS-contracted health care professionals must comply with any applicable payor corporate medical policies. Please remember that information received when verifying benefits does not supersede information published in the payors' corporate medical policies.

Waivers for Non-Covered Services

Prior to rendering any non-covered service, HNS-contracted health care professionals must first obtain an executed, appropriate waiver from the patient. This waiver cannot be a generic waiver but *must be specific to the actual procedure or service to be rendered to each individual member*. 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 patient's health care plan
- A statement that indicates that 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-contracted health care professionals 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.

Contracted health care professionals 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, contracted health care professionals 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 contracted health care professional to "balance bill" a patient for *covered services* provided.

HNS has created a sample **"Non-Covered Services Waiver"** form that can be customized for use by any HNS-contracted health care professional. This form is available on the HNS website under **"HNS Documents"**.

NPI Number (Rendering Provider)

HNS Policy:
All claims submitted to HNS must include the name and the Type I NPI number of the provider that *actually rendered the services reported on the claim form.* A health care professional's signature on the health care claim form is an attestation that he/she provided the services reported on the claim.

> **Exception:** If services were provided by a *locum tenens* ("fill-in") provider and *all locum tenens requirements have been met,* services provided by the "fill-in" provider may be submitted under the name/NPI number of the provider who contracted with the "fill-in" provider. For more information, please refer to the policy on *locum tenens* providers for requirements regarding *locum tenens* billing.

If providers are in a group practice or share call coverage with other providers, take special care to assure the accuracy of the rendering provider's name on each claim submitted.

If providers discover that a claim (or claims) was submitted incorrectly with the wrong rendering provider's name, they must promptly file a corrected claim. Prompt recognition of this and immediate correction can reduce concerns of fraud and abuse.

Network Participation (All In/All Out)

HNS Policy:
The following requirements apply to all health care professionals who have chosen to participate in the HNS Network via execution of the HNS Practitioner's Participation Agreement:

- Each HNS provider shall serve as an "in-network" provider for each applicable health care plan with which HNS contracts. (Providers cannot "opt out" of one or more plans with which HNS contracts.)

- Participation in the HNS Network extends to any practice location the provider maintains in the HNS Service area. (Regardless of the number of practice locations or the location itself, the provider must be available to provide chiropractic care to any patient whose health care plan contracts with HNS, at each practice location, during all hours the practice is open for business.)

- While participating in the HNS Network, providers may not close their practices to new patients whose health care plans contract with HNS.

- To avoid confusion for members seeking chiropractic care from an "in-network" provider, all chiropractors practicing at the same physical location must participate in the HNS Network or none of the chiropractors practicing at that location may participate in the HNS Network. This includes, but is not limited to, chiropractors in a group practice, chiropractors renting space from another chiropractor and chiropractors practicing as independent contractors within another chiropractor's office.

- Health care plans with which HNS contracts have various requirements for participating "in-network" providers, such as maintaining current PTAN and/or Medicaid numbers. At all times, all HNS providers must meet all requirements set forth by all applicable contracted health care plans.

Additional policies regarding participation in the HNS Network can be found on the HNS website under "Credentialing Policies".

Orthotics (Foot)

HNS Policy:
Custom foot orthotics should only be billed to a contracted payor when ALL of the following criteria has been met:

The chief complaint/objective clinical findings, and diagnosis documented in the healthcare record must clearly support the need for orthotics; and

There must be an appropriate treatment plan, *which include orthotics,* and which clearly links the need for the orthotics with the goals of the treatment plan; and

There must be clear clinical documentation which explains **WHY** non-custom orthotics would not be appropriate for the condition or diagnosis.

The clinical record provides evidence the foot orthotics have been customized from a mold or scan of the patient's foot.

The custom foot orthotics are medically necessary to support or aid in the treatment of an illness or injury, as described below:

A. When there is a **primary diagnosis** of foot pain or a primary diagnosis of a foot condition (e.g., plantar fasciitis, pes planus, pes cavus, etc.) provided that:

1. Documented objective clinical findings clearly link the prescription of custom foot orthotics to the primary diagnosis and/or chief complaint;

   AND

2. The prescription of custom foot orthotics is consistent with the goals of the treatment plan.

B. *In the absence of a primary diagnosis of foot pain or a foot condition*, custom foot orthotics may be medically necessary when provided concurrent with Chiropractic Manipulative Therapy, provided:

1. Documented objective clinical findings clearly link the prescription of custom foot orthotics to the primary diagnosis and/or chief complaint;

   AND

2. The prescription of custom foot orthotics is consistent with the goals of the treatment plan.

Replacement of Custom Foot Orthotics

Medically necessary replacement of custom foot orthotics is generally provided under the following conditions:

- Following malfunction of the device; or
- After the device's normal life span, provided there are objective clinical findings clearly linking the replacement of custom foot orthotics to the patient's current primary diagnosis and/or chief complaint; or
- For growth adjustments, provided there are objective clinical findings clearly linking the replacement of custom foot orthotics to the patient's current primary diagnosis and/or chief complaint.

CIGNA Healthcare - Orthotics

CIGNA Healthcare contracts with a DME Vendor to provide medically necessary orthotics to members. If your CIGNA patient needs orthotics, please contact the CIGNA DME Vendor. (See CIGNA Orthotic Vendor under the CIGNA Healthcare Guide, which can be found under the heading "Billing / Claim Support".)

Non-Covered Services Waiver for Orthotics

HNS has created a new non-covered services waiver specific to custom foot orthotics.

If there is *ANY doubt* the prescription
of orthotics is not consistent with **ALL** of these policies,
please have your patient sign this waiver.

(The waiver is available under HNS Documents on the HNS website.)

Outcome Assessments

HNS Policy:
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 of whether maximum medical improvement (MMI) has been reached, it is essential that the patient health care record include relevant standardized outcome assessments (OA).

HNS requires the use of standardized outcome assessment tools as part of the *initial examination* to establish a baseline and as part of *each reexamination* to evaluate and monitor progress toward treatment objectives.

HNS recommends 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 **HNS Documents** on the HNS website.

Completed outcome assessment forms/tools must be maintained in the patient's health care record.

Patient Education and Instruction

HNS Policy:
All instructions given to the patient should be documented in the health care record.

Any home care instructions should be documented in the health care record, including specific information given and the rationale.

All recommendations for exercise, dieting, and nutrition/supplements should be documented in the health care record.

Personal Injury (PI) Cases

HNS Policy:
Claims for all covered services provided to patients whose health care plans contract with HNS must be filed to HNS; **this includes claims for covered services provided relative to personal injury cases.**

The only exception to this policy is if the patient has signed and dated HNS' ***Election Not to File*** form. This form includes important facts and information the member needs in order to make an informed decision. As such, only this specific form can be utilized. (The form is available under HNS Documents on the HNS website.)

For additional important information regarding PI cases, please review the information under the sections in this manual titled "Election Not to File" and "Covered Services".

Posting Payments

HNS Policy:
Payments, including zero-dollar payments, received through HNS from HNS-contracted payors must be posted to patient accounts within 15 days of receipt.

Practice Changes

(As previously noted under *Notifications to HNS*)

HNS Policy:
HNS-contracted health care professionals are contractually required to notify HNS, in writing, of any changes to their practice information.

Please do not contact or notify HNS payors with changes to your practice information. To do so may result in a practitioner's inadvertent termination as a network provider. Once received, HNS will notify the payors of any changes to a practice.

HNS-contracted health care professionals must notify HNS, in writing, no later than **15 calendar days** following the occurrence of any of the following events:

- Provider's license to practice in the state is suspended, revoked, terminated, or subject to terms of probation or other restrictions or there are any subsequent changes in the status of any information relating to provider's professional credentials
- Provider has become a defendant in any malpractice action; receives any pleadings, notice or demands of claim or service of process relating to alleged malpractice; or is required to pay damages in any such action by way of judgment or settlement
- Provider becomes the subject of any disciplinary proceeding or action before provider's requisite state licensing agency or a similar agency in any state
- Provider is convicted of a felony relating directly or indirectly to chiropractic practice
- There is a change in the provider's business address
- Provider becomes incapacitated, as that term is defined under the appropriate state practice act for that provider
- An act of nature or any event beyond provider's reasonable control that will likely interrupt all or a portion of provider's practice for a period of 60 consecutive calendar days or that may have a material adverse effect on provider's ability to perform provider's obligations hereunder for such a period
- Any change in the nature or extent of services rendered by provider
- Any other act, event, occurrence or the like that might materially affect the provider's ability to carry out provider's duties and obligations under the HNS Practitioner's Participation Agreement
- The addition of another practice location or the closure of a practice location

- The addition of a provider to the practice and/or if a provider leaves an existing practice.

HNS will notify HNS-contracted payors of any of the above changes within 15 days of receipt of notice of changes.

Radiology

HNS Policy:
The medical necessity for ALL radiology services provided and billed through HNS must be clearly documented in the patient's health care record, properly reported using the most appropriate CPT code, and consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan.

- HNS-contracted health care professionals must document all radiology studies performed and/or interpreted in the office.

- The area(s) initially x-rayed must be medically necessary and consistent with the patient's initial chief complaint.

- Subsequent x-rays must be medically necessary and consistent with the patient's chief complaint, clinical findings, diagnoses, and treatment plan.

- A written radiology report to document the provider's interpretation of the radiograph(s) must be maintained in the patient's health care record. These reports must be signed or initialed by the provider and should include:

    - Patient-identifying information (patient name, DOB, etc.)
    - Date of study as well as an accurate description of the radiological findings
    - Impressions
    - Recommendations for follow-up studies that may be needed to reach a final diagnostic impression

- The specific area(s) x-rayed must be documented.

- The date of the study must be documented.

- The name of the person performing the x-ray study must be documented.

- There should be documented, supporting evidence that clinical findings support the need for repeat x-rays.

- Routine repetitive x-rays within a 90-day period require the following documentation:

- Evidence of a new injury reported in the same area as the initially reported area
- An initially identified pathology or biomechanical aberration requiring further investigation
- A new symptom in the same area appears that was not present initially

To demonstrate a subluxation by x-ray, the x-ray must have been taken at a time reasonably proximate to the initiation of treatment.

An x-ray is considered reasonably proximate if it was taken:

- No more than 12 months prior to the initiation of a course of treatment.

- No more than three months following the initiation of a course of treatment.

Radiographs are generally considered medically necessary only for the purposes of diagnosing specific problem area(s) documented as a chief complaint with supporting objective clinical findings verifying their necessity.

Repeat x-rays must be clinically indicated and the reason(s) clearly documented in the health care record.

For billing purposes, an x-ray "view" is a separate exposure to radiation. Therefore, full spine x-rays cut into sections do not constitute multiple views unless multiple exposures are taken.

Single view x-rays without opposing views are not considered of diagnostic quality. An occasional "spot shot," or single view, may be performed as a follow-up to review a specific area in question.

Other Notes

1. **CPT 76140** – consultation on an x-ray examination made elsewhere. This code is a service to be used by a radiologist or other consultant who performs a subsequent reading of any diagnostic imaging study *but does not actually see the patient.* This code should not be reported by contracted health care professionals when reviewing x-rays brought by a patient that were taken elsewhere.
   The review of imaging studies included in the CMT work service applies regardless of whether the studies were performed in a practitioner's office or if the patient brings films that were taken elsewhere. This code would be appropriately reported by a chiropractic radiologist who did not actually see the patient but interpreted the study (please remember that interpreting the study is not the same as an "over read").

2. **Modifier -26** – Professional Component
   This modifier indicates the contracted health care professional is reporting the professional component ONLY for a service and is often incorrectly reported with

radiology codes. Please note that the pre-service work included in the CMT codes and E/M codes *includes imaging review* and, as such, this modifier should not be reported by HNS-contracted health care professionals who are also reporting a CMT or E/M code on the same date of service.

Radiology Over Reads

Important Note:
Radiology Over Reads – Patients with a health insurance plan that contracts with HNS cannot be billed for radiology over reads. While radiographic over reads are very valuable, the cost for this service cannot be billed to the payor or to the HNS patient. Remember, providers cannot collect more than the patient's copay, deductible, and/or coinsurance for any covered service provided.

HNS has provided a sample "Radiology Report" template that is available on the HNS website under "**HNS Documents**".

Referrals

HNS Policy:
When referrals to other health care professionals are indicated, HNS-contracted health care professionals must make every effort to refer to health care professionals who also participate with the member's health care plan.

Refunds/Overpayments/Underpayments

Payments to which the Provider is Not Entitled

HNS Policy:

1. Contracted health care providers shall not retain fees received for services provided to which they are not entitled.

2. If a contracted health care professional receives a payment:

    a. in excess of the contracted allowable; or
    b. for services that a payor determined were not medically necessary; or
    c. not consistent with payor corporate medical policies or with HNS Policies; or
    d. to which he/she is otherwise not entitled,

    the contracted health care professional shall repay those monies to HNS in a timely fashion or, as applicable, to the contracted payor who paid the funds, and shall do so pursuant to any HNS or payor repayment requirements.

This policy survives the termination of the *HNS Practitioner's Participation Agreement.*

3. If a contracted health care professional becomes aware of a payment to which he/she is not entitled, the contracted health care professional shall take all actions necessary to ensure the timely return of those funds to the applicable party and shall do so in accordance with any directives issued by HNS or the contracted payor.

4. HNS may, at its sole discretion, require the provider to submit a certified check or money order, payable to HNS, to the contracted payor or to a member for the full amount of the overpayment. If repayment is required by HNS, providers shall comply with such requests and shall repay the entire amount of the overpayment in the manner and form specified by HNS.

Provider Errors (Inadvertent)

HNS Policy:
If a provider receives a payment for a service to which he/she is not entitled due to an inadvertent error by the provider and if the filing of a "corrected claim" by the provider is the appropriate course of action to resolve the issue, the provider shall file a "corrected" claim and shall do so within 15 days from the date he/she became aware of the overpayment.

Payor Recoupments

As a general rule, when a payor discovers it has made a payment to a contracted health care professional to which he/she is not entitled, the payor will recoup those monies from future payments owed to the provider.

HNS Policy:
If HNS receives notice from a payor that a refund is due or otherwise determines the provider has received monies to which he/she is not entitled, as a general rule, HNS shall recoup those monies from subsequent payments otherwise due to the provider who received the overpayment. However, HNS, at its sole discretion, reserves the right to require the provider to issue a certified check or money order to HNS or to the payor for the full amount of the overpayment, and providers shall promptly comply with any such request.
Providers shall allow HNS and, as applicable, contracted payors to recoup the total amount of any overpayments from future HNS payments, until the amount due has been repaid. *If the individual provider to whom the overpayment was issued is an employee of another HNS provider, providers shall allow HNS to recoup the funds from the employer physician under whose EIN the payment was reported.*

HNS, in order to recoup the entire amount of the overpayment from the provider, may recoup up to the total amount of the recoupment *from any and all future payments HNS receives from any* payor that would otherwise be owed to the provider.

Recovery of Payments after Provider Termination

HNS Policy:
Providers shall remain liable for overpayments that occur as a result of services provided prior to termination. Should a payor recoup monies from HNS or request the repayment of monies by HNS associated with services provided by a contracted health care professional in the HNS Network who is no longer an HNS participating provider, HNS reserves the right to pursue all remedies available by law it believes necessary or appropriate in connection with collecting those funds from the provider.

Refunds to Patients

HNS Policy:
If HNS or a payor determines a provider has received payments from a patient to which he/she is not entitled and determines those fees must be refunded to the patient, contracted health care providers must refund those monies to the patient within 10 days of the date HNS notifies the provider that a refund must be issued.

HNS may require the provider to provide HNS with a copy of the check issued to the patient and, if so, the provider shall comply with that request.

Refunds to HNS

HNS Policy:
Unless specifically instructed to do so by HNS, providers shall NOT issue refund checks, either directly to HNS or to an HNS contracted payor.

Providers shall resolve repayment of funds to which they are not entitled pursuant to these policies and/or to specific directives issued by HNS.

Underpayments

If the payor incorrectly adjudicates a claim (or claims), and the EOB/NOP reflects less than the contracted allowable, providers should contact their HNS Service Representative for assistance in resolving the issue.

Rendering Provider

HNS Policy:
All claims submitted to HNS must include the name and the Type I NPI number of the provider that actually rendered the services reported on the claim form. Providers' signature on the health care claim form is an attestation that they provided the services.

> **Exception:** If services were provided by a *locum tenens* ("fill-in") provider and all *locum tenens* requirements have been met, services provided by the "fill-in" provider may be submitted under the name/NPI number of the provider who

contracted with the “fill-in” provider. For more information, please refer to the policy on *locum tenens* providers for requirements regarding *locum tenens* billing.

If practitioners are in a group practice, share call coverage with other providers, or have an independent contractor working in their office, they should take special care to assure the accuracy of the rendering provider’s name on each claim submitted.

If providers discover that a claim (or claims) was submitted incorrectly with the wrong rendering provider’s name, they must promptly file corrected claims to correct the error. Prompt recognition of this and immediate correction can reduce payor concerns of suspected fraud and abuse.

Requests for Patient Records

HNS Policy:
Copies of health care and associated financial records for patients whose insurance plan contracts with HNS may be requested at any time by a patient, HNS or an HNS-contracted payor, or the applicable state’s Department of Insurance (DOI).

Requests for copies of health care records should be clearly documented in the health care record and should 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 sent. When health care records are requested, contracted health care professionals *must promptly respond to such requests.*

Requests from Payors or Regulatory Agencies

If requested, contracted health care professionals are required to submit copies of health care records and must promptly comply with such requests. 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 must be submitted to the payor within 10 days of receipt of request.

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.)

Contracted health care professionals 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.

Requests from Patients

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

requests. Contracted health care professionals will provide patient with copies of the health care record within 10 days of receipt of request.

Providers should never release original records; always make copies of the health care records and release only the copies. When copies of records are requested by patients, have the patient sign and date an authorization to release records. This can be a very simple form with the following statement: “I authorize you to furnish (name) or bearer with a complete copy of my chiropractic health care record, including records of office visits and care rendered, diagnostic test results, and x-ray reports.”

Always retain a copy of the patient’s authorization in the patient’s health care record.

Retention of Health Care Records

Please review HNS’ best practices (*Clinical Quality and Documentation Standards)* for additional information regarding patient records.

HNS Policy:
The patient health care record, including associated relevant and/or supporting documents, must be maintained in a safe and secure location.

HNS-contracted health care professionals must retain complete patient health care records (including all EOB’s) in accordance with federal and state laws. Records must be maintained for a minimum of 10 years from 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 contracted health care professional should retain the patient health care record for 10 years from the last date of service.

If electronic records are utilized, contracted health care professionals must ensure there are 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.

Sale of Practice

HNS Policy:
HNS does not interfere with the sale of a contracted health care professional’s practice. HNS-contracted health care professionals may sell their practices to whomever they desire, whenever they desire. However, HNS contracts with individuals, not with practices. Therefore, a sale of a practice does not guarantee the new owner participation in the HNS network.

Taping

According to the AMA CPT Assistant, if Kinesio taping is performed to facilitate movement by providing support and the tape is applied specifically to enable less painful use of the joint and greater function (restricting some movement, facilitating others), then application of the tape is considered part of neuromuscular reeducation (97112) or therapeutic exercises (97110), depending on the intent and the outcome desired. In these cases, the application of the tape would be included in the time spent in direct contact with the patient and would not be appropriately billed using strapping codes. However, if the purpose of the taping is *to immobilize the joint*, then the strapping codes may be appropriate as these codes describe the use of a strap or other reinforced material applied post-fracture (or after another injury) to immobilize the joint. This includes Kinesio tape or McConnell taping techniques.

Any time taping is done the health care record must clearly document the specific reasons for and location of the taping. If the service that includes the taping is billed to a payor, the taping must be consistent with the documented chief complaint/clinical examination findings, diagnosis, and treatment plan.

> **Important Note**: BCBSNC (as well as many other health care plans) considers Kinesio taping investigational, so it is not a covered service for BCBS patients.

Timely Filing

Making sure claims are filed in a timely manner will facilitate prompt payment of the claims and will reduce denials due to timely filing limits.

HNS Policy:
15 Day Timely Filing Requirement

- All primary claims must be filed within 15 days of date of service.
- Secondary claims must be filed within 15 days of the date the primary EOB was received.
- Corrected claims must be filed within 15 days of the date the EOB for the original claim was received.

Payor Timely Filing Policies

The HNS website includes a section titled “Timely Filing” (under “HNS/Payor Policies”). This section includes the timely filing policies for HNS-contracted payors as well as HNS’ best practices for sound A/R management.

Treatment Plans

Please review HNS' best practices (*Clinical Quality and Documentation Standards)* for additional information regarding treatment plan requirements.

HNS Policy:
A properly prepared treatment plan for the improvement of the patient's condition must be included in the patient's health care record.

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

The treatment plan must be consistent with the patient's chief complaint/clinical findings and diagnoses.

The treatment plan must include specific, objective, measurable goals (both short- and long-term) that are expected to improve a functional loss. Obstacles to recovery and strategies to overcome them will be noted.

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

The treatment plan must include the duration and frequency of visits, and frequency of visits must be consistent with the chief complaint, clinical findings, and diagnoses.

The treatment plan must include objective measures to evaluate treatment effectiveness.

The treatment plan must include recommended modalities/therapies, the rationale for each, areas of application, frequency, and duration.

The record must include patient's progress as it relates to the treatment plan.

The record must include any changes to the current treatment plan and rationale for those changes.

The patient's treatment plan must include phases of care pursued.

HNS provides a sample **"Treatment Plan"** template to assist practitioners. This form is available on the HNS website under "**HNS Documents**".

(NC Providers)

Per the NC BOCE Practice Guides
"Each patient is unique, and each patient's complaints, injuries, and circumstances are distinct. It is the physician's responsibility to develop a treatment plan individually tailored to the patient's condition. The goals of the treatment plan should be to restore motion, improve strength and function, and reduce pain.

At the outset of treatment, the physician should provide the patient with estimates of the time within which to expect initial improvement and the time within which to expect maximum therapeutic benefit. The physician should adequately explain to the patient the nature of the patient's condition, the goals of treatment, and the treatment strategy. Because the patient's active participation in the treatment plan is essential to success, the physician should refer or discharge a patient who fails to comply with treatment recommendations."

Verification of Benefits

HNS Policy:
HNS providers are required to verify eligibility and benefits prior to rendering services by contacting the member's health care plan via the payor's preferred method of contact. Written documentation, indicating you have verified eligibility and benefits, and the information obtained during this contact, must be included in the patient's health care record.

Always Use the HNS EIN and NPI

Contracted payors have network providers listed under the HNS EIN and NPI. When verifying benefits, always provide these numbers:

HNS EIN: 56-1971088

HNS NPI: 1093773392

Some payors may also request the physical address associated with the HNS EIN and NPI. If so, please provide the HNS address: 20476 A Chartwell Center Drive, Cornelius NC 28031.

EXCEPTION for SC providers:

When calling Select Health or Absolute Total Care for benefits, you will be asked for the provider's individual NPI number, the last four digits of the HNS EIN (1088), and your provider's practice address.

Corporate Medical Policies

When verifying benefits, please remember the information you receive does not supersede the payor's corporate medical policies.

NOTE: The payor's corporate medical policy does not apply to self-funded employer groups. Self-funded employers determine what services will and will not be covered.

For North Carolina Providers: The Federal Employer Plan (FEP) and out of state BCBS plans are not subject to the BCBSNC Corporate Medical Policy.

Verifying Benefits

When verifying benefits, always clarify that you are verifying coverage for chiropractic services rendered by a Chiropractor in an office setting. Always obtain a reference number for your contact.

Providers should verify and/or document:

- The name of the payor's representative who provided the benefit information.
- A reference number for your verification.
- The date the information was obtained.
- If the patient's coverage includes chiropractic care.
- Effective date of coverage and policy renewal date and/or projected term date.
- The amount of patient's deductible and out of pocket expenses, as well as how much has been met.
- The amount of copay or co-insurance.
- The maximum number of visits allowed and how many have been used.
- If services routinely performed are covered when rendered by a Chiropractor.
- If prior authorization is required for any of the services routinely performed.
- If the plan covers chiropractic maintenance care (S8990).
- If the plan has a pre-existing waiting period.
- If the plan shows the member has any other coverage on record.
- Any other plan limitations or exclusions.

Benefit verification should be completed:

- Prior to rendering services to the patient.
- At the beginning of the patient's plan year.

- If the patient obtains new insurance coverage.
- If a new or different service needs to be performed.

Please remember that information obtained from the payor's representatives does not supersede the applicable corporate medical policy or published plan benefits.

For North Carolina providers calling out of state BCBS plans for benefit verification, please clarify that your provider participates with the local BCBS PPO plans.

HNS provides a sample **"Verification of Benefits"** form. This form is available on the HNS website under "**HNS Documents**".

Vertebral Axial Decompression (VAD) Coverage

BCBSNC and CIGNA Healthcare do not cover Vertebral Axial Decompression, as it is considered investigational.

Visits (Frequency of Visits)

HNS Policy:
The frequency of treatment should gradually decline until the patient reaches the point of discharge or converts to maintenance/supportive care.

The care provided and the frequency of visits billed to HNS-contracted payors must be supported by documented medical necessity and consistent with the patient's chief complaint/clinical findings, diagnoses, and treatment plan.

Additionally, when visit frequency exceeds the following guidelines, *additional, substantial* supporting documentation must be present clearly justifying the need for additional visits in the following cases:

- If visits exceed one per day
- If one visit per day exceeds a one-week duration
- If three visits per week exceeds a four-week duration
- If there are more than 15 visits in the first month of care

Vitals

HNS Policy:

Vital signs must be obtained as part of *every* examination for which an evaluation/management (E/M) code is billed, and results must be documented in the health care record. At a minimum, HNS requires the following:

Weight
Pulse
Blood Pressure

Other vitals may be appropriate but are left to the discretion of the contracted health care professional and should be consistent with the level of examination performed.

When a new patient presents requesting only maintenance care, vitals should be taken as part of the initial evaluation. The contracted health care professional may exercise clinical judgment as to the frequency of repeating them.

Waiving Copays, Deductibles and Coinsurance

HNS Policy:
HNS-contracted health care professionals may not waive or reduce copayments, coinsurance, or deductibles OR offer to waive *any* patient portion of the patient responsibility. This agreeing to accept what is paid by the insurance company.

HNS contracted health care professionals should collect copayments, coinsurance, and/or deductibles at the time of service if any covered services were provided at the office visit.

Important Notes:
If the member has not paid the applicable copayment, deductible, or coinsurance *for three or more consecutive office visits*, there must be a written payment plan signed by the member or legal guardian included in the health care record.

If the amount of the covered service(s) provided on a given date of service is ***less than the co-payment,*** only the sum of the contracted allowables may be collected.

If the sum of the cost of covered services ***exceeds the amount of the co-payment,*** only the co-payment amount may be collected.

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.

No fees may be charged to the patient for any covered services provided, except for applicable copayments, coinsurance, and/or deductibles.

Discounting Fees

HNS contracted health care professionals may not offer discounts for any covered services provided. All covered services provided must be provided at the physician's usual and customary fee.

Waiving, or offering to waive, any portion of the patient's responsibility, or discounting fees for covered services provided, will result in immediate termination from the HNS network.

XII. Comparative Practice Patterns Review (CPR) Program

Introduction
The objective of the HNS Comparative Practice Patterns Review (CPR) program is to ensure the consistent delivery of cost-efficient care. The program promotes the delivery of cost-efficient health care by regularly sharing objective and actionable data regarding a provider's individual practice patterns, the practice patterns of their peers, and the costs of the care provided.

Through the use of performance-based tiers, recognition programs, and administrative withholds, the program offers incentives and rewards the delivery of cost-efficient care.

HNS Policy:
HNS-contracted health care professionals shall ensure the delivery of cost-efficient care, as defined by HNS Comparative Practice Program parameters, to members of health care plans that contract with HNS.

1. Summary of CPR Program and Process

a. The HNS CPR program is based on the core tenet that physicians should be able to make treatment decisions based upon their own clinical judgments. This does not include medically necessary determinations.

   The program does not mandate the number or type of services physicians may provide nor the frequency or length of time in which treatment may be provided. CPRs are statistical reviews of the network and individual physician's performance relative to costs and practice patterns.

b. The program is designed to improve cost efficiency by regularly providing meaningful and actionable cost and utilization data to physicians in the HNS network.

c. Through the use of performance-based tiers, recognition programs, and administrative withholds, the CPR program aligns incentives and rewards the delivery of cost-efficient care.

d. The metrics utilized in the CPR program, against which physician performance is measured, are based on the *collective* costs and practice patterns of the physicians in the HNS network.

e. The CPR program includes the establishment of target performance goals relative to cost efficiency for the individual physician and for the network as a whole.

f. HNS evaluates the physician's and the network's aggregate performance against these goals. The program includes annual and monthly performance reviews.

g. The program utilizes the "average cost per patient" as the primary metric to evaluate physician and network performance for cost efficiency.

h. Because the network's actual "average cost per patient" may fluctuate, to ensure fair and appropriate performance measurement a target "average cost per patient" benchmark is established at the beginning of each calendar year and is used throughout the year. The target benchmark may increase each year but will not decrease.

i. For the target benchmark, HNS utilizes the higher of the actual network average obtained using a trimmed mean approach OR the highest actual network average from the previous five years.

j. CPR's compare the physician's average cost per patient to the target benchmark.

k. Variations in types of practices ("specialty" practices), patient demographics, clinical characteristics, comorbidities, and responses to treatment all impact a physician's "average cost per patient." To appropriately allow for these variations when measuring physician performance, the CPR program utilizes a range of acceptance (ROA) from the target benchmark.

l. HNS conducts an annual review of average "case costs" (using primary diagnoses) to ensure the HNS ROA appropriately accommodates those costs.

m. In January of each year, HNS conducts an annual review of physician and network performance relative to cost efficiency. Annual reviews reflect performance based on data from claims submitted through HNS during the previous calendar year.

n. Based on the physician's "average cost per patient" and the relationship of his/her "average cost per patient" to the HNS target benchmark, HNS assigns a performance measurement ("plan ranking") to each physician for each health care plan reviewed.

o. The combination of "plan rankings" from the *annual review* determines each physician's HNS participation status. This is based on the lowest plan ranking for the review period. With few exceptions, the physician's HNS participation status determines his/her HNS administrative withhold for the remainder of the calendar year and the HNS participation status cannot be changed until the next annual review.

p. When measuring performance, average costs per patient within 151% of the HNS benchmark are considered indicative of cost-effective care, while average costs per patient in excess of 151% indicate suboptimal performance and result in probationary status

Plan rankings and participation status include:

Excellent – Avg. cost per patient is within 115% (within ROA)

Good – Avg. cost per patient is between 115% and 141% (within ROA)

Caution – Avg. cost per patient is between 141% and 151% (within ROA)

Probation – Avg. cost per patient is greater than 151% (**exceeds ROA**)

ID – indicates insufficient data to gauge cost effectiveness.

Performance measurements of **ID** indicate there is **insufficient data** *for the specific review period*, relative to a particular health care plan, to gauge cost effectiveness. Plan rankings of ID, as a general rule, do not negatively impact a physician. However, close attention should be paid to a plan ranking of ID, as this ranking will change as soon as there is a sufficient amount of data to gauge cost effectiveness. To alert the physician to what his/her plan ranking would have been had the data threshold been met, HNS assigns a sub-classification to plan rankings of ID. This sub-classification represents the variation from the physician's average cost per patient to the HNS target benchmark for the specific health care plan during the specific review period.

q. Results of the annual review are provided via the HNS Comparative Practice Patterns Report (CPR). CPRs include the physician's "average cost per patient," compare the physician's "average cost per patient" to the HNS benchmark and range of acceptance for this metric and display the physician's plan ranking for each health plan, the HNS participation status, and the HNS administrative withhold.

r. Top performers (those physicians whose average costs per patient are within 115% of the HNS target benchmark) are generally rewarded via a reduction to their HNS administrative withhold and receive special recognition as an "HNS Center of Excellence" in the HNS online physician directory.

This designation is published with the physician's name in the HNS provider directory and is designed to improve transparency, allowing members to make better-informed health care decisions, and may promote steerage to the most cost-efficient physicians.

The table below is an example of how various plan rankings and HNS admin fees may be impacted by participation status.

Combination of all plan rankings determines HNS Participation Status	HNS Participation Status	HNS Administrative Withhold	"Center of Chiropractic Excellence" Designation
All plan rankings of Excellent OR any combination of plan rankings of Excellent and/or ID	**Excellent**	**Lowest Administrative Withhold**	
All plan rankings of Good OR any combination of plan rankings of Excellent, Good, and/or ID	**Good**	Reduced Administrative Withhold	N/A
All plan rankings of Caution OR any combination of plan rankings of Excellent, Good, Caution, and/or ID	**Caution**	Reduced Administrative Withhold (same % as "Good")	N/A
All plan rankings of ID (Insufficient Data)	**ID**	**Standard HNS Administrative Withhold**	N/A
All plan rankings of Probation OR any combination of plan rankings of Excellent, Good, Caution, Probation, and/or ID	**Probation**	**Standard HNS Administrative Withhold**	N/A

s. In addition to the annual review, HNS conducts monthly performance reviews. With few exceptions, each monthly review is based on *the most recent 12 months of claims data*. If any monthly review indicates underperformance, the physician's participation status may be changed to probation.

t. Because there may be circumstances in which the assigned participation status is not appropriate, physicians have the right to appeal their HNS participation status *within 30 days* of when it is first assigned. However, if a physician chooses not to appeal his/her status, HNS concludes the physician does not dispute the assigned participation status and understands that termination may occur, if applicable, should performance not improve within the specified period.

u. Because continued participation in the HNS network requires the consistent delivery of effective, cost-efficient care, physicians whose practice patterns are inconsistent

with cost-efficient care, as defined by CPR program parameters, are placed on probationary status for a period of 12 months.

v. Physicians on probation are offered peer-to-peer counseling from one of the HNS Chiropractic Medical Directors, provided a specific time frame to improve cost efficiency, and required to successfully complete six hours of a specified continuing education course designed to help improve treatment outcomes and cost efficiency.

w. To ensure a probationary physician's performance is measured fairly during the 12-month probationary period, HNS only reviews data from claims submitted since the onset of the probationary period. HNS generates "interim" CPR reports for the physician each month of the probationary period and each report reflects only data from claims submitted since the onset of the probationary period. During the probationary period, the physician's "average cost per patient" is compared to the *actual HNS network average* for the specific reporting period.

x. While significant efforts will be made to assist physicians in improving cost efficiency, generally speaking, physicians whose average costs per patient are not consistent with cost-efficient care, *as defined by CPR program parameters*, within the time frames established to demonstrate improvement, and who do not appeal their participation status face termination of their participation in the network.

y. In most instances, physicians have the right to appeal CPR decisions to terminate their participation in the network. If a physician appeals either the participation status determination or the termination decision, the physician must submit a notice of appeal, in writing, to HNS. As part of the review process, HNS may review copies of a number of the physician's health care records for compliance to HNS and contracted health care plan policies.

2. HNS Philosophy of Care

Health care plans that pay for care expect services provided by contracted physicians to be provided in an *effective, cost-efficient manner* and to be consistent with corporate medical policies.

As noted previously in this manual, to help meet our obligations, HNS has adopted the following philosophy of care:

Treat and Release

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

3. CPR Probationary Status

CPR's that indicate an "average cost per patient" outside the ROA result in a participation status of probation. The probation period is 12 months.

Counseling
In the first month of the contracted health care professional's probationary period, he/she is contacted by one of HNS' Chiropractic Medical Directors and offered counseling regarding the HNS CPR program, understanding the CPR reports, and the contracted health care professionals and network's responsibility to ensure cost-efficient care.

CE Requirements
Effective January 1, 2017, contracted health care professionals newly on probation are required to complete the six-hour CE program on the HNS website titled "Improving Outcomes with Excellence in Clinical Documentation." This CE must be completed within 20 days of the date shown on the CPR report on which probation status was first assigned.

Interim Reports
To ensure the contracted health care professional's performance is measured fairly while on probation with HNS, during the 12-month probationary period HNS only reviews data from claims submitted since the onset of the probationary period. HNS generates "interim" CPR reports for the contracted health care professional each month of the probationary period, and each report reflects only data from claims submitted since the onset of the probationary period.

Initial 90-Day Probation Period
While the contracted health care professional's probationary period is 12 months, the contracted health care professional is given an initial period of approximately 90 days to improve their "average cost per patient" (CPP) to within the ROA. The three-month period is intended to allow for the completion of one treatment cycle for many of the contracted health care professional's active patients. If the contracted health care professional's average CPP does not improve to within the HNS ROA by the end of the three-month initial probationary period, the contracted health care professional's participation in the network may be terminated.

If, during the initial 90-day probationary period, the contracted health care professional has an insufficient volume of patients to demonstrate improvement, he/she may be granted an additional period of 90 days.

Remaining Nine Months of Probation
If the contracted health care professional's "average cost per patient" improves to within the ROA by the end of the initial 90-day probationary period, but between months 4-12 of the probationary period is again outside the ROA for the same health care plan, the contracted health care professional's participation in the network may be terminated.

Subsequent Performance
Contracted health care professionals are expected to ensure the consistent delivery of cost-effective care. Contracted health care professionals who have been on CPR probation with HNS and again have average per patient costs outside of the HNS ROA may be terminated from the network.

4. CPR Decisions

To ensure fair and consistent decision-making in the CPR program, HNS has developed criteria for use in determining the appropriate course of action regarding health care professionals whose "average cost per patient" is outside the HNS range of acceptance. Criteria are reviewed at least annually and may be modified at any time by the QUM Committee.

The following information clarifies the course of action that HNS may take when under-performance is identified. Any single action, or a combination of actions, may be taken.

a. Place the contracted health care professional on probationary status.

b. Provide an additional period of time to improve performance, of up to 90 days.

c. Provide an additional 12-month probationary period.

d. Change of status to exempt, other, or pending review.

e. Terminate the contracted health care professional's Practitioner's Participation Agreement.

f. Require the contracted health care professional to review all HNS standards, policies, and the policies of HNS-contracted payors and submit attestation including his/her agreement to comply.

g. Require the submission of a written corrective action plan.

h. Require the submission of copies of clinical and financial records for review for compliance to HNS standards and policies.

i. Require the contracted health care professional to obtain specific additional continuing education.

j. Other such actions as deemed appropriate by the HNS QUM Committee.

If HNS requests that the contracted health care professional comply with any of the requirements listed above, HNS will provide specific dates by which the requirement(s) must be met. Failure to comply with the requirements by the dates specified may result in termination of the contracted health care professional's participation.

5. Appeals and Hearings

Please see **Terminations and Appeals,** Section 2 (CPR Program) for information regarding the appeals process related to CPR Program terminations.

XIII. Code Audit Review Program

Introduction
Consistent with the responsibility to promote quality and cost-efficient health care, and to educate providers, on a semiannual basis, HNS conducts reviews of HNS Network Physicians' individual utilization of certain services that may indicate quality of care issues, suboptimal utilization, and which may subject the physician to close scrutiny of the physician's practice patterns by contracted healthcare plans.

HNS Policy:
HNS contracted healthcare professionals shall ensure the delivery of quality, cost-efficient care, as defined by HNS Code Audit Review program parameters.

1. Summary of the Code Audit Program and Process

a. To help ensure statistical relevance, the Code Audit Program generally requires that a Network Physician have a minimum of 50 patients over the previous 12 months before performing a review of the physician's utilization of any code.

b. The CPT/HCPCS codes that are reviewed, and the criteria for review, are chosen based on utilization trends and data from a variety of sources, including, but not limited to, the HNS Network, HNS contracted payors, CMS, and other reputable sources.

c. When high utilization of codes under review are identified per the Code Audit Program, the following occurs:

   Initial High Utilization of Code: Mandatory peer-to-peer counseling between the physician and an HNS Chiropractic Medical Director.

   High Utilization of Same Code in Second Review: If a physician *ever* triggers code criteria *for the same code a second time*, the physician will receive a letter from HNS concerning the code's utilization and next steps if the physician triggers criteria for that code a third time.

   High Utilization of Same Code in Three Reviews: If a physician ever triggers code criteria *for the same code a third time*, HNS will request healthcare records and conduct a review for compliance to HNS policies and Best Practices.

2. Medical Record Review, Probation, and Admin Withhold

a. Finding Compliance: If a medical record review performed pursuant to the Code Audit Program finds that the Network Physician has complied with HNS policies and

best practices, then the physician will be placed on a “No Contact” list for the reviewed code for five (5) years.

b. Non-Compliance & Code Audit Probation: Importantly, if a medical record review performed pursuant to the Code Audit Program finds *substantial non-compliance* to HNS policies and best practices for the code at issue then:

Code Audit Probation: The physician will be placed on *Code Audit Probation*—unrelated to the CPR Program—for 12 months; and,

No Administrative Withhold Reduction: The physician will be ineligible for any reduction in his/her HNS Administrative Withhold (otherwise allowed by the CPR Program) during that probationary period.

3. Code Audit Program Termination

If a Network Physician triggers Code Audit criteria for a code following conclusion of a Code Audit Probation period, which occurred because of that same code, the physician will be presented to the HNS Quality and Utilization Management (QUM) Committee to determine whether the physician's HNS participation should be terminated.

4. Appeals and Hearings

Please see **Terminations and Appeals,** Section 3 (Code Audit Review Program) for information regarding the appeals process related to Code Audit Review Program terminations.

XIV. Non-Compliance

HNS monitors for non-compliance to HNS and contracted payor policies. Complaints or concerns of non-compliance may originate from HNS, patients, contracted payors, regulatory, or quality improvement agencies.

To ensure compliance with these requirements and/or in response to complaints or concerns, HNS reserves the right to conduct telephone interviews and/or random practice site visits (during normal business hours) and to request information from the contracted health care professional related to the concern/complaint.

All complaints and concerns relating to non-compliance are tracked and investigated by HNS. HNS will notify the contracted health care professional of any complaint or concerns. Failure to comply with these standards and/or to correct deficiencies in a timely manner pursuant to HNS requirements 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 contracted health care professional to review all HNS standards and policies and the policies of HNS-contracted payors and to 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 contracted health care professional to obtain additional continuing education

5. Place the contracted health care professional on probationary status

6. Terminate the contracted health care professional's Practitioner's Participation Agreement

7. Other such actions as deemed appropriate by the HNS Quality Management & Improvement (QMI) Committee

HNS reserves the right to conduct site visits at any time (upon 24 hours' notice to the contracted health care professional). HNS has developed thresholds regarding when a site visit is mandatory. HNS shall perform a site visit if more than two complaints regarding the same contracted health care professional within any three-month period or if more than three complaints during a calendar year regarding the same contracted health care professional are received.

If a site visit is mandated because the threshold has been met, the site visit will be performed within 30 days from the time the established threshold has been met. A HNS

Site Visit Survey Form will be completed within 72 hours of each site visit and filed in the contracted health care professional's confidential file.

If a site visit is necessary, the contracted health care professional will be required to submit a written corrective action plan outlining his/her plan to correct the deficiencies. This action plan must include a timeline and all deficiencies must be corrected within six 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 reassessment will be scheduled within six months to assure correction of deficiencies.

XV. Termination and Appeals

HNS seeks to ensure a network of clinically competent, appropriately trained, cost-effective health care professionals who meet or exceed patient needs for quality, accessibility, effectiveness, and safety and who are committed to achieving HNS' objectives.

Participation in the HNS network is not guaranteed. HNS reserves the right to determine which physicians it will accept and maintain within its network and the terms by which it will allow participation.

At all times, contracted health care plans reserve the right to approve, deny, or terminate network participation of any provider.

In deciding on a course of action for contracted health care professionals who do not meet HNS' requirements for continued participation in the HNS network, HNS may, but is not required to, consider courses of action other than termination. Actions to improve compliance and/or performance may include:

- Requiring the contracted health care professional to review the professional and ethical standards of the applicable state licensing board and/or HNS and the policies of contracted health care plans
- Requiring the contracted health care professional to submit a signed attestation statement indicating review of the above and that indicates the contracted health care professional understands and agrees to comply with those policies and/or regulations
- Requiring the contracted health care professional to review HNS' Compliance Training Module, which addresses compliance, fraud, waste and abuse, as well as HIPAA/HITECH regulations, and to submit a signed attestation statement indicating such review
- Requiring the contracted health care professional to obtain additional education approved by applicable state licensing boards and to provide evidence to HNS of completion of such CE
- Requiring the contracted health care professional to review the HNS Practice Site and Accessibility Standards and to submit a signed attestation statement indicating such review
- Requiring the submission of a written corrective action plan
- Other actions as may be determined by the Medical Director, Credentialing Committee, Quality and Utilization Management Committee, or hearing panel

1. General

A. Termination

If the decision is made to terminate a contracted health care professional's participation in the HNS network, termination shall be consistent with the terms of the HNS Practitioner's Participation Agreement and as applicable, HNS credentialing policies and procedures.

If the decision is made to terminate a contracted health care professional's participation in the HNS network, HNS shall seek to notify the health care professional, in writing, provided HNS has a current address for the health care professional.

Unless the termination is without cause, as provided in the HNS Practitioner's Participation Agreement, the notice of termination will include the basis for the termination decision.

The notice of termination shall include the effective date of the termination.

As a general rule, the effective date of all terminations shall be on the 10th or 20th (or next business day) of the month or the last business day of a month.

If the decision to terminate participation is based on a quality issue that potentially jeopardizes the safety or health of patients, the termination may be effective immediately.

B. Appeals

In many instances, contracted health care professionals have the right to appeal decisions resulting in termination from the HNS network. If the termination includes appeal rights, the notice of termination will include those rights.

Appeals of decisions to terminate participation in the HNS network made by HNS' Credentialing Committee shall be in accordance with HNS' credentialing policies and procedures.

If a physician has the right to appeal and wishes to do so he/she must appeal the decision by notifying HNS, in writing, within 30 days of the date of the notice of termination, unless another date is stated in the notice.

The written notice must include the specific reasons why the physician believes reconsideration of the termination decision should occur. Providers may submit written evidence, as applicable, in support of the appeal.

Upon receipt of the written appeal for reconsideration, HNS may request additional information including, but not limited to, copies of specific health care records for patients whose health care plans contract with HNS. If additional information is required, the physician will be notified in writing of the specific information that must be submitted. Any requested information must be submitted to HNS by the date requested. Failure to submit requested information by the due date will result in forfeiture of appeal rights and the decision to terminate shall stand.

In most cases, a determination regarding the appeal will be made within 60 days from the date the written notice of appeal was received or, if additional information was requested, within 60 days of completion of the review of the requested information. The provider shall be notified, in writing, of the final decision.

HNS may, but is not required to, schedule a hearing to review an appeal of participation status. If a hearing is scheduled, HNS shall establish a hearing panel to conduct the review of the appeal. (See Hearing Panel below)

C. Reapplication

While HNS and contracted payors at all times reserve the right to approve or deny participation in the HNS network, in most cases a provider who has previously been terminated from the network is eligible to reapply for participation.

Participation in the HNS network subsequent to termination shall at all times be the decision of the HNS Credentialing Committee, and pursuant to HNS' credentialing criteria.

As a general rule, the following policies shall apply:

- After the initial termination, the provider shall not be eligible for participation until six months after the effective date of his/her termination from the network.

- If the provider's participation has been terminated and he/she subsequently rejoins the network and is again terminated, the provider will not be eligible for participation until 12 months from the effective date of that termination.

- If the provider subsequently rejoins the network and his/her participation is again terminated, the provider will be ineligible for future participation in the HNS network.

2. CPR Program

A. Termination

By executing the HNS Practitioner's Participation Agreement, contracted health care professionals agree to comply with HNS programs and policies.

While there are exceptions, as a general rule continued participation in the HNS network is dependent, in part, upon compliance to HNS' CPR program and policies.

B. Appeals – Participation Status

Health care professionals have the right to appeal the HNS CPR participation status.

If a physician wishes to appeal, he/she must notify HNS, in writing, within 30 days of the date shown on the CPR report in which the participation status was assigned. *If the physician does not appeal his/her HNS participation status within the time frame allowed, HNS concludes the physician agrees with the data included on the CPR and the assigned participation status.*

The written notice must include the specific reasons why the physician believes reconsideration of the HNS participation status should occur. Health care professionals may submit copies of health care records to support their appeal.

- *Promises to improve and maintain an average cost per patient going forward are not acceptable grounds for reconsideration.*

- *Disagreeing with the CPR program parameters and/or the methodology for establishing averages utilized in the CPR program is not considered an acceptable basis for reconsideration of the participation status.*

Upon receipt of the written notice of appeal of the HNS participation status, HNS will change the physician's status to "pending review" until the QUM Committee completes a review, and a final determination has been made.

Upon receipt of the written appeal for reconsideration, HNS may request additional information, including, but not limited to, copies of specific health care records for patients whose health care plans contract with HNS. If additional information is required, the physician will be notified in writing of the specific information that must be submitted. Any requested information must be submitted to HNS by the date requested. If information requested by HNS is not received by the stated due date, the appeal process will terminate, and the original determination will stand.

In most cases, a determination regarding the appeal will be made within 60 days from the date the written notice of appeal was received or, if additional information was

requested, within 60 days of completion of the review of the requested information. When the determination has been made the provider shall be notified, in writing, of the final decision and, as applicable, the provider's participation status will be modified.

HNS may, but is not required to, schedule a hearing to review an appeal of participation status. If a hearing is scheduled, HNS shall establish a hearing panel to conduct the review of the appeal. (See Hearing Panel below)

C. Appeals – CPR Termination Decisions

In most cases, health care professionals have the right to appeal terminations of participation related to non-compliance to HNS' CPR program and policies.

Exception: Provider History
A review of the provider's history of compliance to HNS and payor policies may result in the decision not to allow an appeal of a termination decision.

Exception: Probation 3
If a provider has been assigned a participation status of probation a third time, and did not appeal his participation status, and at the end of the initial 90-day probation period, or at any time during the remaining 9-month period, the provider again has an average cost per patient outside the HNS ROA, the provider's participation will be terminated, and he/she may not be afforded the right to appeal the termination decision.

Exception: Beyond Probation 3
If a provider's average cost per patient has resulted in a status of probation three (3) times and the provider did not appeal any of his participation status, and the provider again has an average cost per patient outside the HNS range of acceptance, the provider's participation will be terminated, he/she will not be afforded the right to appeal the termination decision, *and in general, he/she will be ineligible for future participation*.

Exception: Second Appeals
If the physician previously received a written notice of termination as a result of failure to comply with HNS CPR policies or HNS contracted payor policies, appealed the decision and the appeal resulted in a reversal of the termination decision, and the provider subsequently fails to comply with HNS CPR program requirements and again receives a notice of termination, HNS may, but is not required to, afford the physician appeal rights.

Exception: Previous Audits of Healthcare Records
If HNS has previously audited the physician's health care records and the audit findings indicated lack of compliance to those HNS policies intended to ensure the delivery of effective, but cost-efficient care, and the CPR report which resulted in termination indicates practice patterns which are the same as, or similar to,

practice patterns at the time of the audit, the QUM Committee may, but is not required to, allow the appeal of the termination decision.

If a physician has the right to appeal, and wishes to do so, the physician must appeal the decision, by notifying HNS, in writing, and must do so within 30 days of the date of the Notice of Termination, unless another date is stated in the notice.

The written notice must include the specific reasons why the physician believes reconsideration of the termination decision should occur. Providers may submit written evidence, as applicable, in support of the appeal. *Only relevant reasons for reconsideration will be considered ground for reconsideration of the termination decision.*

- *Promises to improve and maintain an average cost per patient going forward are not acceptable grounds for reconsideration.*

- *Disagreeing with the CPR program parameters and/or the methodology for establishing averages utilized in the CPR program is not considered an acceptable basis for reconsideration of the termination decision.*

Upon receipt of the written appeal for reconsideration, HNS may request additional information including, but not limited to, copies of specific healthcare records for patients whose health care plans contract with HNS. If additional information is required, the physician will be notified in writing of the specific information that must be submitted. Any requested information must be submitted to HNS by the date requested. Failure to submit requested information by the due date will result in forfeiture of appeal rights, and the decision to terminate shall stand.

In most cases, a determination regarding the appeal will be made within 60 days from the date the written notice of appeal was received, or if additional information was requested, within 60 days of completion of the review of the requested information. The provider shall be notified, in writing, of the final decision.

HNS may, but is not required to, schedule a hearing to review an appeal of termination decisions. If a hearing is scheduled, HNS shall establish a hearing panel to conduct the review of the appeal. (See Hearing Panel below)

D. Reapplication

If a provider's participation is terminated due to non-compliance related to the CPR program, as a general rule, the following policies apply:

i. After the initial termination, the provider shall not be eligible for participation until six months after the effective date of his/her termination from the network.

ii. If the provider subsequently rejoins the network and again has a participation status of "probation," he/she shall be provided a 90-day period during which to

comply with CPR program policies. If, at the end of the 90-day period, the provider has not complied with policies, participation will be terminated, and the provider will not be eligible for participation until 12 months from the effective date of the termination.

iii. If the provider subsequently rejoins the network and again receives a participation status of "probation," his/her participation will be terminated, and the provider will be ineligible for future participation in the network.

iv. **Beyond Probation 3 Ineligibility:** Regardless of the number of prior terminations, if a provider's average cost per patient results in a status of probation three (3) times and the provider did not appeal any of his participation status, and the provider again has an average cost per patient outside the HNS range of acceptance, the provider's participation will be terminated, he/she will not be afforded the right to appeal the termination decision, and in general, he/she will be ineligible for future participation.

3. Code Audit Review Program

A. Termination

By executing the HNS Practitioner's Participation Agreement, contracted healthcare professionals agree to comply with HNS programs and policies.

While there are exceptions, continued participation in the HNS network is dependent, in part, upon compliance to HNS' Code Audit Review program and policies.

B. Appeals – Code Audit Termination Decisions

In most cases, healthcare professionals have the right to appeal terminations rendered pursuant to the Code Audit Program.

Exception: Provider History
A review of the provider's history of compliance to HNS and payor policies may result in the decision not to allow an appeal of a termination decision.

Exception: Second Appeals
If the physician previously received a written notice of termination as a result of failure to comply with HNS Code Audit policies or HNS contracted payor policies, appealed the decision and the appeal resulted in a reversal of the termination decision, and the provider subsequently fails to comply with HNS Code Audit Review Program and again receives a notice of termination, HNS may, but is not required to, afford the physician appeal rights.

Exception: Previous Audits of Healthcare Records

If HNS has previously audited the physician's health care records and the audit findings indicated lack of compliance to those HNS policies intended to ensure the delivery of effective, but cost-efficient care, and the Code Audit Review which resulted in termination indicates utilization patterns which are the same as, or similar to, patterns at the time of the audit, the QUM Committee may, but is not required to, allow the appeal of the termination decision.

If a physician has the right to appeal, and wishes to do so, the physician must appeal the decision, by notifying HNS, in writing, within 30 days of the date of the Notice of Termination, unless another date is stated in the notice.

The written notice must include the specific reasons why the physician believes reconsideration of the termination decision should occur. Providers may submit written evidence, as applicable, in support of the appeal. *Only relevant reasons for reconsideration will be considered ground for reconsideration of the termination decision.*

- *Promises to improve going forward are not acceptable grounds for reconsideration.*

- *Disagreeing with the Code Audit Review program parameters and/or the methodology for establishing review criteria is not considered an acceptable basis for reconsideration of the termination decision.*

Upon receipt of the written appeal for reconsideration, HNS may request additional information including, but not limited to, copies of specific healthcare records for patients whose health care plans contract with HNS. If additional information is required, the physician will be notified in writing of the specific information that must be submitted. Any requested information must be submitted to HNS by the date requested. Failure to submit requested information by the due date will result in forfeiture of appeal rights, and the decision to terminate shall stand.

In most cases, a determination regarding the appeal will be made within 60 days from the date the written notice of appeal was received, or if additional information was requested, within 60 days of completion of the review of the requested information. The provider shall be notified, in writing, of the final decision.

HNS may, but is not required to, schedule a hearing to review an appeal of termination decisions. If a hearing is scheduled, HNS shall establish a hearing panel to conduct the review of the appeal. (See Hearing Panel below)

C. Reapplication

If a provider's participation is terminated pursuant to the Code Audit Review program, as a general rule, the following policies apply:

v. After the initial termination, the provider shall not be eligible for participation until six months after the effective date of his/her termination from the network.

vi. If the provider subsequently rejoins the network and again has his/her participation terminated pursuant to the Code Audit Review program, the provider will not be eligible for participation until 12 months from the effective date of the termination.

vii. If the provider subsequently rejoins the network and again goes on Code Audit Probation, his/her participation will be terminated, and the provider will be ineligible for future participation in the network.

4. Hearing Panel

To the extent applicable, the hearing panel is intended to be a medical peer review committee, as that term is defined by the provisions of 90-21.22A and SCGS 40-71 and shall operate consistent with the requirements of those statutes to ensure that its protections apply to the committee's proceedings, records, and materials.

Physician members of the hearing panel must, at a minimum, hold an unencumbered license in the state in which they practice, and must be eligible to participate in all federal health care programs.

All hearings will be held at the HNS offices in Cornelius, NC. The physician will be notified, in writing, of the date and time of the hearing. The physician has the right to be represented at the hearing by an attorney or any other person of the physician's choice but may not be accompanied by more than one individual. The provider must provide HNS with the name of the person who will be attending the hearing on their behalf no less than five days in advance of the hearing. Notification to HNS may be via fax, email, or U.S. mail.

During the hearing, the panel will review the basis of the determination and the physician will be afforded an opportunity to explain his/her reasons for requesting reconsideration. The physician may also present supporting documentation.

HNS' Chiropractic Medical Directors, HNS' legal counsel, and the Chair of the HNS Quality Management and Improvement (QMI) Committee may be present at hearings.

Only physician members of the hearing panel may cast a vote regarding reconsideration of the decision and votes may only be cast by those hearing panel members who were not involved in the initial decision-making and who are not in direct economic competition with the appealing provider.

Compensation paid to members of the hearing panel shall be either an hourly or per diem rate and shall not be related to the final decision or outcome of the hearing.

The Hearing Panel

- Shall conduct appeal hearings and make final determinations;
- Shall uphold, reject, or modify decisions of the QUM Committee and/or Medical Director;
- May require the provider to take certain actions to improve performance; and
- May change the provider's participation status.

The hearing panel considers the following in determining a course of action. During or prior to the hearing, did the provider:

- Provide evidence that he/she is complying with HNS and contracted payor policies;
- Present a corrective action plan; and
- Affirm his/her commitment to consistent compliance with HNS and contracted payor policies.

Should the provider fail to appear at the hearing at the time and date specified, the provider forfeits all rights to the appeal process.

Within 30 days of the date of the hearing, HNS will notify the physician, in writing, of the panel's decision regarding reconsideration. The written notice will include the basis for the decision.

The decisions of the hearing panel are final.

XVI. Prevention and Detection of More Serious Health Issues

As chiropractic doctors, we receive extensive training in identifying patient conditions that enables us to recognize problems. Further, we see our patients on a more routine basis than most health care providers. This gives us the unique opportunity to consistently monitor their overall health and identify small changes that may be indicative of a larger issue. And, of course, many conditions are far easier to treat when they are identified early.

As chiropractors, we know that cancer often gives no signs or symptoms that exclusively indicate the disease is present. Many complaints for cancer also can be explained by a relatively harmless condition. There are, however, **seven symptoms** that should elevate the suspicion of cancer:

1. Persistent cough for a duration of one month or blood-tinged saliva
2. Blood in the stool or any change in bowel habits
3. Unexplained weight loss, fever or night sweats
4. Non-healing sores
5. Change in urinary habits or blood in urine
6. Obvious change in a wart or mole
7. Persistent lumps, especially in the breasts or testicles

When Back Pain May Mean Cancer?

Musculoskeletal pain can be an early symptom of a variety of cancers. For example, pancreatic cancer often initially presents as mid-back pain. Ovarian and colon cancer can present as low-back pain in some patients. Head and neck cancers often cause neck pain and stiffness. Metastatic lung cancer can spread to the scapula, and prostate cancer often spreads to the lumbar spine. When a patient presents with any of these back complaints, it's important to question the mechanism of injury. If there is no apparent explanation and a practitioner cannot duplicate the symptoms, he/she should ask if the patient has experienced any of the seven signs listed above. In addition, if patients being treated for back pain do not show improvement within two to three weeks despite appropriate therapy, they should be questioned about their general health. This is true even if patients were asked about their health as new patients. Patients who haven't been in for three months or more should be asked about the seven signs, either personally or via a patient questionnaire, especially if there is no trauma or mechanism of injury to explain the symptoms. When cancer is detected early, treatment is often

more successful, and chiropractors are in a unique position to aid in early detections because of the frequency with which we see our patients.

Prevention of Medical Errors

The following article was written by Dr. Mario Fucinari, DC, CCSP, MCS-P, a featured NCMIC Speaker. This article was reprinted with his permission.

> Most low back problems that present in chiropractic offices today are biomechanical in nature and do not necessarily signify a dangerous underlying abnormality. However, some back pain indicates a serious condition, such as inflammatory disease, fracture, referred pain, infection, or cancer.[1] To determine whether there is a potentially dangerous cause of back pain, clinicians often seek historical or examination findings that might be "red flags."
>
> The evaluation and management of a case consists of the history, examination and medical decision making. In the medical decision making, the clinician decides if treatment is indicated or if contraindications exist. Treatment and the mode of treatment must take into account several factors. Listed below are assembled various factors that should be taken into consideration before rendering care to the patient.

Red Flags and Yellow Flags

Red Flags – a clinical symptom or sign that may indicate serious pathology as a source of the patient's spinal pain. This may represent a contraindication to treatment.

Yellow Flags – a symptom or sign that should raise the index of suspicion regarding the development of chronicity in a patient with spinal pain.

Red Flags – Serious Spinal Disease

- Spinal pain of unknown origin in patient age <20 or >50
- Trauma related to pain
- History of cancer
- Night pain
- Fever, chills, night sweats, nausea, vomiting, fatigue, diarrhea
- Weight loss
- Pain at rest
- Corticosteroid use
- Recent infection
- Generalized systemic disease (diabetes)
- Failure of 4 weeks of conservative care
- Cauda Equina
- Saddle anesthesia
- Sphincter disturbance
- Motor weakness lower limbs

Waddell Nonorganic Signs also known as "Yellow Flags" do not cause a contraindication to care, but rather indicates a psychosocial consideration for care.

- Superficial tenderness to light pinch
- Nonanatomic tenderness, which is not localized and often extends from the lumbar spine to thoracic or pelvis
- Axial loading pain when low back pain is reported with vertical loading to the patient's head
- Pain with whole body rotation when shoulders and pelvis are rotated in the same plane
- Discrepancy between seated and lying SLR
- Give-way or cogwheel weakness that cannot be explained on a localized neurologic basis
- Sensory disturbances in a stocking rather than a dermatomal pattern of distribution
- Disproportionate verbalization and facial expressions during examination

Contributory Negligence

When care is prescribed for a patient, it is incumbent that the physician rule out all contraindication to the treatment prescribed. Current practice parameters indicate that the patient should be placed into active care, rather than passive care, as quickly as possible.

In cases of malpractice, when negligence is considered, three factors are taken into consideration to determine the extent of liability. These factors are:

- Standard of care
- Causation
- Liability

Cervical Spine Manipulation and Vertebral Artery Dissections – Incidence of Vertebral Artery Injury

NCMIC estimates the occurrence of "serious arterial syndromes" to be less than 1 in 2 million to 1 in 3.8 to 5.8 million cervical manipulations *(NCMIC, Current concepts: Spinal Manipulation and Cervical Arterial Incidents, 2006).*

Analysis of the Data

The Bone and Joint Decade 2000–2010 Task Force on Neck Pain reviewed 32,000 research citations and more than 1,000 relevant studies. They concluded that the risk of suffering a stroke from cervical manipulation was attributable to a patient coming into the office while in the process of a vertebral artery dissection.

The physician must be able to recognize the signs and symptoms of vertebral artery dissection (VAD). The patient will characteristically complain, "I have pain in my head

and/or neck unlike anything I have ever had before." This will not present as a typical headache.

If the patient presents with an atypical headache, the physician must first rule out a vertebral artery dissection. A review with the patient as to the signs and symptoms of a VAD must be documented. The "5 D's and 3 N's" are as follows:

5 D's and 3 N's
Dizziness/vertigo/giddiness/lightheaded
Drop attacks/loss of consciousness
Diplopia (or other visual problems)
Dysarthria (speech difficulties)
Dysphagia
And = Ataxia of gait (walking difficulties), Ataxia of the extremities or falling to one side
Nausea (with possible vomiting)
Numbness on one side of the face and/or body
Nystagmus

The Physical Examination
In the past, provocative tests were done to indicate a propensity to VAD. The use of these tests has been found to be of no predictive value. It is still advisable to take the blood pressure of a patient bilaterally, prior to the initiation of care of a cervical spine patient.

Spinal Manipulation and Cervical Arterial Incidents
NCMIC, Chapter 8, page 48: "In contrast to earlier clinical practice recommendations, auscultation of the neck and use of functional vascular test variations (e.g., Estridge's, deKleyn's, George's, Hautant's, Houle's, Maigne's, Smith's, Wallenberg's tests, etc.) now are known to have no diagnostic value in identifying patients with cervical vascular susceptibility."

The Acute Management of Stroke
If a patient presents with what is believed to be a stroke, time is of essence! The acute management of stroke is supportive and emergent. The doctor should keep in mind that the principle is to get the patient to the hospital as fast as possible.

The treatment of acute ischemic stroke has advanced in the last 10 years. Intravenous fibrinolytic drugs, such as tissue plasminogen activator (TPA) Activase, dissolve the thrombi, reduce morbidity, and improve the proportion of patients who have a complete recovery. To be effective, thrombolytic therapy *must* be administered within three hours of onset. Faster administration (less than three hours) will result in a better outcome. It is most effective in the first 90 minutes.

The role of the chiropractor is to recognize the stroke and the stroke-in-progress, resulting in rapid delivery of the patient to the emergency room.

Several marketing and public service announcements have been released regarding this issue. It is also helpful for the physician and staff to be aware of these useful tips:

In the case of suspected stroke, a person should “Think Fast.”

Think F.A.S.T.
Facial…have the patient show their teeth (smile). Asymmetry is a warning sign.
Arms…raise both arms. Inability or weakness is a warning sign.
Speech…slurred speech is cause for alarm.
Time…time is of essence

Steps if a Stroke Occurs – Time is of Essence
Stroke Attack is a Brain Attack
Early Care is Critical Care

If a Stroke Occurs
Get the patient to the hospital as fast as possible.
Place the patient on a bed or table in a rescue and recovery position.
DO NOT MANIPULATE THE NECK!
Do not give the patient anything to eat or drink; they may be dysphagic.

If a Stroke Occurs
Look at the clock and note the time of onset.
Call EMS (911) immediately

- Tell them you have a suspected stroke patient in the office
- Tell them the age of the patient
- Tell them the time of onset
- Tell them of any known past medical history

While waiting for EMS:

- Do not allow the patient to ambulate
- Check their pupils
- Test the lower cranial nerves looking for
    - Facial numbness or paresis
    - Swallowing
    - Gag reflex
    - Slurred speech
    - Palatal elevation
- Note all vital signs

If the patient improves spontaneously, DO NOT allow them to go home. Even if it is a TIA, it requires evaluation.

Diagnostic Imaging Indications for VAD
MRI/MRA yields the best information without being invasive. MRI is best suited for viewing vessel abnormality, while MRA is useful for characterizing flow within the vessel.

The MRI is best to visualize the effects of the dissection such as ischemia and hemorrhage.

The MRI and MRA are often used in combination but must be done in the same encounter. The MRI and MRA are considered to be the method of choice for initial diagnosis and follow-up of craniocervical artery dissection.

HNS provides a sample "**CVA Risk Evaluation Form"** to assist practitioners. This form is available on the HNS website under **"HNS Documents"** so practices can download and customize the form.

XVII. Reducing Malpractice Risk

Medical malpractice is an unfortunate reality of practicing medicine in the current health care environment and, unfortunately, no one can promise immunity from lawsuits. However, maintaining clinical competence; developing excellent relationships with patients; and assuring effective communication with patients, colleagues, and other members of the care team while consistently producing accurate and legible charts that tell the "whole story" can go a long way toward reducing malpractice risk.

This section is presented in 5 parts:

- The 4 C's of Risk Management
- Patient Noncompliance
- Discharging a Patient from your Practice
- Professional Boundaries
- Informed Consent

1. The Four Cs of Risk Management

Developing a risk management style of practice involves four C's:

- Competence
- Charting
- Communication
- Compassion

Competence
Most doctors went into health care to help people. The best defense against a malpractice claim is to be a good clinician. Being a good clinician means a commitment to lifelong learning.

Physicians are keenly aware of the need to stay up to date on the latest evidence and clinical recommendations, yet no one can remember everything that is needed for the care of every patient. Flow sheets, protocols, and other tools can reduce the chance that important factors are overlooked. Physicians should make sure they understand and follow standards of care and state board practice guides. Plaintiff attorneys will measure your care to the standard of care and to board requirements or guidelines.

> *Standard of Care* is defined as "that course of action that a reasonably prudent [physician] in the defendant's specialty would have taken under the same or similar circumstances" (*Washington v. Washington Hospital Center, 579 A2d 177 (DC App 1990)).*

Charting

A physician's written documentation serves as evidence of the physician's involvement and thought process regarding the patient's care. The health care record *provides the basis for legal testimony* regarding the patient's illness or injury, treatment, and response to treatment.

Written documentation supports the physician's findings, recommendations, orders, and plans concerning patient care. The quality of medical record documentation is critical in minimizing the risk of malpractice and in defending the actions of the physician if a lawsuit occurs. If a physician is sued, the ultimate responsibility (i.e., who will be held liable) sits squarely on the shoulders of the health care provider.

Omissions, illegible, or incomplete records may leave physicians open to lawsuits. Plaintiffs' attorneys scrutinize records and quickly identify documentation issues when evaluating a possible malpractice claim. Problems with documentation make nearly 40% of malpractice cases difficult to defend. Never alter the record! Physicians must resist the urge to clarify the record after they have been served with a lawsuit. *Documentation before there is a legal problem is viewed as an explanation; after there is a legal problem it is viewed as an excuse.*

A prudent practitioner operates under the assumption that at some point their health care records will be scrutinized by a plaintiff's attorney. The default assumption is "if it was not documented, it was not done." The greatest charting mistake physicians make is that they fail to assure that the health care record tells "the whole story." Write what's important and include enough objective and subjective information so that the rationale for all treatment will be clearly evident to someone other than the author.

Written documentation is not limited to time spent with a patient during office visits. Often a patient will call in with a concern or question. Any such communication with patients over the phone or via email should be documented in the patient's chart. The fact that a return call was made, as well as the nature of the conversation, should be noted. Providing dates, and preferably times, for all written documentation is vitally important. If it cannot be determined when a note was written, it is all but useless.

At its best, the health care record forms a clear and complete plan that legibly communicates pertinent information, credits competent care, and forms a tight defense against allegations of malpractice by aligning patient and provider expectations.

- **Excellence in documentation reflects and promotes excellence in chiropractic care.**

- **It should be assumed that any and all clinical documentation will be scrutinized at some point.**

- **Physicians should revise their view of documentation from a necessary chore to an *opportunity to clearly establish the excellent care they provide.***

When physicians are viewed as dispensers of advice and patients follow that advice, the credit or burden for outcomes goes to the physician. In reality, it's impossible for physicians to guarantee particular outcomes. For better or worse, patients possess the greatest control over the behaviors and choices that affect their health.

Correlating patient expectations with likely clinical outcomes and enrolling patients in the decision-making process are early steps in preventing malpractice allegations. Effective documentation captures these steps in a format that may help derail erroneous charges or immediately exculpate the wrongly accused.

Physicians typically approach documentation with the goal of communicating effectively with themselves. This approach creates problems when malpractice allegations are made. Plaintiff attorneys, arbitrators, and juries engage in what is often anger- or sympathy-driven reviews of physicians' records that, in the absence of contrary evidence, assume negligently omitted or committed acts. There is no quick and effective solution to such allegations.

The health care record should never be erased or altered and once requested by a reviewer it cannot plausibly be amended. Thorough and thoughtful documentation provides protection against miscommunication and misunderstanding.

Successful clinical care is a collaborative activity with shared responsibilities. The patient and physician work together to learn about the patient's illness and concerns, review the diagnostic and treatment options, and enact a patient chosen plan. Health care documentation records this shared effort.

SOAP Notes

By routinely using SOAP techniques, practitioners can stimulate patient-physician communication, align expectations, and fortify malpractice defenses. This format prompts two-way communication, patient participation, and informed consent collection and records the patient's acceptance of responsibility for following through with the treatment plan. Properly documented SOAP notes can improve communication, enhance patient care, and decrease physicians' risk of being charged with malpractice.

Additional tips to help minimize the risks of malpractice suits:

1. Comply with HNS' *Clinical Quality and Documentation Standards*.

2. When possible, use direct patient quotes to demonstrate attention to patients, highlight main areas of concern, build credibility into the record, and accurately document a patient's attitude. Not unexpectedly, a patient's attitude may change significantly between the time of encounter and the time of an appearance before an attorney or jury. For example, if during an initial visit a patient says, "I've been to 20 doctors, and no one can help me," documenting such a remark communicates his or her attitude. Patients' abusive or threatening words will sufficiently demonstrate their

level of cooperation and credibility, while removing any biases in interpretations.

3. Document non-pregnancy verification. Knowledge of the gravid state of the patient is important in the medical decision-making of a case. If the patient denies pregnancy, written documentation of this fact is crucial. A Non-Pregnancy Verification Form is important when initiating care in the chiropractic office or when the patient has been out of care. A good rule of thumb is that any patient out of care for 90 days or more must revalidate that they are not pregnant before radiographic studies or physiotherapy modalities and procedures are performed.

4. Prior to care, obtain consent to treat minors from the parent or legal guardian and be sure this is documented in the health care record. This should include permission for treatment by the physician as well as any other employee in the office.

5. Documenting all concerns addressed demonstrates thoroughness in obtaining the patient's history and avoids later charges that the patient brought an important symptom to a physician's attention that he/she then ignored or neglected. Include supportive observations.

6. When appropriate, assure a qualified CA is present in the treatment room. Include the CA's initials to confirm who witnessed the care the physicians provided. Careful documentation in this area is especially important because allegations of sexual misconduct are criminal charges *not generally covered under malpractice insurance policies.*

7. Avoid judgmental or potentially anger-provoking descriptors. Avoid embarrassing or easily misunderstood descriptors as the patient may respond with anger. Remember, the health care record belongs to the patient.

8. Avoid false certainties in diagnoses and reduce the burden of unmet expectations by accurately *aligning patient hopes with likely outcomes and* document the above. To patients, their families, and jurors, unmet expectations are the emotional equivalent of broken promises. Disappointment provokes anger. Anger precipitates malpractice claims.

9. Understand that while patients may desire and appreciate immediate and firm diagnoses for their ailments, a diagnosis cannot always be given with certainty. Physical examinations and imaging studies are better at ruling diagnoses out than ruling them in. Because of this and the revealing effects of time on treatment response, view diagnoses as works in progress and document accordingly.

10. Clearly explain to patients that the assessment is an opinion, new findings may develop, different explanations may be found, and additional treatments may be necessary. Document this discussion.

11. Obtain informed consent prior to treatment and document. Both initially and throughout the care process discuss the alternatives, risks, and benefits of evaluations and treatments, including a review of likely outcomes if a treatment is withheld or refused. Document the discussion.

12. In cases where a patient refuses treatment, document his/her ability to understand the repercussions of the refusal. Though practitioners may sometimes disagree with the informed choices of competent adults, they must respect these decisions. Document in a manner that makes it clear that the patient chose to refuse treatment by using the wording, "Consistent with the patient's informed choice…" Physicians should also welcome and document a patient's continual right to reverse his/her decision and receive a recommended treatment.

13. Physicians should share their expertise and encouragement to help guide the patient's choice. Document the reinforcement of the principle that the physician advises, and the patient chooses.

14. Eliminate misunderstandings by confronting unreasonable expectations. This approach may also prevent an adverse response to an inappropriate treatment and uncover a patient-physician relationship in need of attention. Open disagreement need not damage the patient-physician relationship, but neglected discontent can prevent successful outcomes.

15. Document the encouragement of maintenance and wellness care. Information such as, "Urged patient to consider regular maintenance care" (and the reasons given for why maintenance care is important) should always be included in the health care record.

16. Document objective goals/expected outcomes and specify a time frame for reaching them. Include a concise statement of the agreed plan, with a statement such as, "Patient understands and agrees," which seals the patient's accepted responsibility into his/her medical record.

17. Anticipate possible serious adverse outcomes; teach patients to notify physicians if these outcomes occur and document that discussion. Inform patients of the practice's 24-hour, 365-day access policy, and advertise it in notes. The phrase "Patient knows to call any time if an emergency arises" reminds reviewers of the tremendous effort's physicians expend on the patient's behalf.

18. Inform patients of test results in a timely manner and document the date and time.

19. Document follow-up arrangements with, “Patient agrees to follow up” or, “Patient states he’ll keep appointment.” If a patient fails to keep a scheduled appointment, make certain this is noted in the health care record, as well as any attempts to reestablish patient care.

20. If unsure, refer. Document all referrals to other health care professionals and follow up to assure the patient kept his/her appointment.

21. Remember, physicians are a “point of contact” for observing abuse or neglect. *Any time* abuse or neglect is suspected, practitioners must report it to the Department of Child and Family Services (DCFS). In the case of a suspected child abuse case, the parent no longer has the right to obtain the child’s health information.

Communication

Be honest and open yet discreet with all oral and written communications. Effective communication between the provider and the patient is one of the best defenses against malpractice claims. Listen carefully to patients and understand their expectations. When patient expectations are aligned with anticipated outcomes, patients will be more satisfied with their care.

Practitioners should trust their instincts and communicate concerns. Have you ever reviewed a radiograph that didn’t meet your original suspicion? Have you ever felt worried or uncomfortable after seeing a patient? Trust your instincts! If something feels “wrong,” chances are something actually may be wrong. Always communicate concerns openly and honestly to the patient. If in doubt, refer for a consult and communicate the concerns to the specialist.

Be wary of speaking ill of colleagues. It’s a competitive environment out there and it’s very easy to take verbal swings at colleagues. Avoid the temptation, keeping in mind that what goes around comes around. Obviously, if a colleague is a true danger to the public, the correct thing to do is speak up. The proper venue to do this is not in an examination room with a patient, but with the appropriate authorities.

Be wary of speaking ill of patients. Resist the temptation to pepper the chart with words describing a patient as “hysterical,” “histrionic,” or “crazy.” If these words are wrong, physicians can pay dearly. Even if they’re correct, physicians can pay dearly. Keep it professional.

Be wary of accepting patients who badmouth their previous doctors. It’s all too easy to be enticed by a patient who flatters a physician, particularly when they contrast their current doctor to all the “incompetent” physicians he/she has seen previously. See this as a red flag. Remember that some or all of the “incompetent” physicians were also flattered in the past, just like the patient is doing now.

Compassion
Displaying compassion for patients and their families builds trust and strengthens relationships; both factors can minimize malpractice risk. Studies have shown that patients who like their health care provider are less likely to sue, even if there's a true act of malpractice. This speaks directly to physicians' bedside manner and connection with each patient and his/her family.

Do you have a patient who has not paid his/her bill? When patients don't pay, it may be a signal that they are having significant financial problems or that they were not happy with their care. It is surprising how often patients don't pay because they are dissatisfied with their care or are angry about the way the provider or CA acted or something that was said. Take advantage of these risk management opportunities by listening and displaying compassion. Patients appreciate the chance to discuss their concerns or issues. Once they are given an opportunity to explain their concerns, they are usually happier. Happier patients are less likely to sue.

2. Patient Non-Compliance – A Powerful Legal Defense

Few practicing physicians doubt that patient non-compliance is a significant and contributory factor to poor outcomes and potential malpractice claims. There is also little doubt that patient non-compliance can often lead to more aggressive and costly treatments.

What physicians may not know is the extent to which a patient's non-compliance can increase their risk for a malpractice claim and just how much good documentation can protect practitioners.

While it is reasonable to expect a patient to share in the responsibility for their own care, juries nationwide have placed a significant amount of responsibility for follow-up on the provider. When patients fail to follow treatment advice, it is prudent to document this in the health care record. There are compelling reasons for providers to document patient non-compliance.

If such non-compliance contributes to an injury which results in a malpractice suit, it can usually be introduced as evidence in the doctor's defense. Documentation of patient non-compliance may provide a powerful defense to any lawsuit. Depending on state law, a plaintiff's recovery may be reduced or prohibited based on the percentage of fault attributed to the plaintiff.

It is important to recognize the difference between non-compliance and the patient's right to refuse care. Patients have the right to make informed decisions regarding their care, including being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment.

Non-compliance may be the result of an educated, rational, and reasonable decision on the patient's part to exercise control over their health care. The medical record should include documentation that the diagnosis and proposed procedure/treatments were explained to the patient and that *the explanation included the patient's prognosis without the procedure, the risks and benefits, and alternative therapies.*

Suggestions to Enhance Patient Compliance

- Emphasize the seriousness of any recommended imaging studies
- Explain the rationale for any treatment advice
- Allow the patient to voice any concerns they have about recommended treatments
- Attempt to gain agreement on the treatment plan
- Emphasize the importance of adhering to the treatment plan

Document Non-Compliance

When the patient has failed to comply with physician recommendations, document the non-compliance, avoiding any documentation that may look judgmental or self-serving.

HNS has created a Patient Non-Compliance form for this purpose. The form is posted on the HNS website under "HNS Documents".

Among the most common problem areas are:

- Repeated failure to keep appointments
- Failure to have diagnostic studies or consultations with other health care professionals as recommended.

Maintain a Reliable Tracking System

Without a reliable tracking system, it may be difficult to identify patients who fail to keep scheduled appointments. If the patient refuses studies, recommended care, etc., document it.

Failure to maintain a reliable tracking system is one of the most frequently cited problems in malpractice cases where there is an allegation of delay in diagnosis and/or failure to supervise care.

Coordinate Treatment Plans with Other Providers Involved in Patient's Care

Maintain good communication with other providers involved in the patient's care and maintain a clear understanding of the expectations and role in the patient's plan of care. Physicians should ask consultants to notify them if the patient fails to keep an

appointment and request periodic updates on the care and treatment plan or a summary at the conclusion of care, whichever is appropriate.

When patients fail to follow recommended advice and a poor outcome results in a malpractice claim, objective documentation of non-compliance can be the most powerful defense.

3. Discharging a Patient from the Practice

Occasionally, practitioners may encounter patients who they no longer wish to treat. Reasons for ending the physician-patient relationship are many and may include chronic non-compliance, rudeness to office staff, or non-payment of bills.

While these patient behaviors can affect the interactive care-giving process, they may also identify patients with a propensity to file a claim against a physician. To help reduce the risk of a future claim, a physician may terminate or discharge a patient from the practice.

There are, however, certain exceptions that apply to terminating a patient.

- Physicians may not terminate their professional relationship for any discriminatory purpose or in violation of any laws or rules prohibiting discrimination such as the Americans with Disabilities Act.

- Physicians are also not permitted to terminate a patient when they know, or reasonably should know, that no other health care provider is currently able to provide the patient that specific type of care or services.

Reduce the risk of abandonment for the patient
Abandonment occurs when a physician suddenly terminates a patient relationship without giving the patient sufficient time to locate another practitioner. A patient, however, may withdraw from a physician's care at any time without notifying the physician.

- To reduce the risk of allegations of abandonment, it is recommended that physicians discuss with the patient in person the difficulties in the physician-patient relationship and any intention to discharge the patient from the practice.

- Be sure to document the discussion fully in the patient's medical record, also noting the presence of any witnesses such as a patient's family member or a member of the office staff.

Write a formal discharge letter to the patient
Physicians are required by law to notify the patient in writing of the termination. The letter must state that the practitioner will no longer provide care to the patient as of a certain date. *The date should be at least 30 days from the date of the letter.* Physicians must also state in the letter that they will be available to provide emergency care or services, including provision of necessary prescriptions, during the 30-day notice period.

The discharge letter should also include:

- A description of any urgent medical problems the patient may have
- An offer to forward copies of the patient's medical records to the subsequent treating physician
- The name and phone number of a local physician referral service or the local/state medical society to assist the patient in locating a physician who is accepting new patients

The care of a patient is a mutual agreement between a physician and the patient, but when that relationship is strained and a practitioner can no longer feel that he/she is able to provide quality care to the patient, at that point it is time to end that patient-provider interaction. Physicians should make sure they have attempted all they can do to help. When there is no more to do, discharging the patient may be the only course of action.

Steps to Discharge (from *Medical Economics*, July 10, 2012)

Taking the proper steps to discharge a patient is critical to avoid legal consequences

- **Put your dismissal policy in writing** and practice it consistently. Make sure your staff members understand what constitutes a reason for dismissal and that you apply your own rules with consistency so no legal ramifications result.
- **Check your insurance carrier contract** regarding discharge and inquire about any responsibilities you may have to it in the process. If you are the patient's primary care physician, send a copy of the discharge letter to his or her managed care organization or preferred provider organization and make note of your doing so on the patient's chart. Urge the patient to select a new physician without delay.
- **Check your responsibilities to your malpractice insurance carrier.** Document all correspondence of discharge. Carry out this policy without exceptions.
- **State your reason for dismissal in a letter to the patient**; be as objective as you can. Give the patient 30 days (recommended) continuance of care. Make a referral for other physicians, but never suggest a specific physician. Send a copy

of your medical records transfer form for the patient to fill out so that the new doctor has the information necessary to provide continuing care without delay.

- **Send the discharge letter to the patient** via both regular and certified mail. Be sure to keep all documentation. Occasionally, a letter of dismissal does not reach a patient. Legal counsel has indicated that a physician cannot be held responsible indefinitely for a patient because of an unsuccessful attempt at notifying the patient via certified mail.

- **If the certified letter is returned undeliverable, mark the return date on the envelope, and attach the letter and envelope to the patient's chart.** Once a termination letter is sent via certified mail to a patient who has moved and left no forwarding address or to a patient who has refused to accept the letter, you are no longer responsible for the patient's care.

- **Always offer to send medical records to the patient's new physician**, whether or not the patient has an outstanding balance with you. Be sure to obtain a written request for the release of a copy of the medical records. If you elect to charge the patient for the copy of the medical records, inform the patient.

Should a patient subsequently request medical attention from you, agree to treat the patient only if the situation is a genuine emergency. If it is not an emergency, then inform the patient diplomatically but firmly that their physician-patient relationship is irretrievably damaged, refer to the letter previously sent, and indicate a willingness to find the patient another doctor, and transfer his or her medical records. Document these actions in the patient's record and send a letter confirming the conversation to the patient at the new address, with a copy of the original letter of dismissal enclosed.

BE PREPARED
We must be realistic about patient discharges. They can occur many times within a practice, for many reasons. The goal is to be prepared and handle these situations and patients with professionalism to mitigate any liability issue that may arise later.

Tips for saying goodbye

- Provide the patient with written notice of dismissal, and state the reason for termination
- Send the notice by certified mail with at least 30 days' notice
- Agree to provide care for any emergency needs until a new physician is found
- Help find another physician
- Keep records documenting notices and other matters relating to the termination

4. Professional Boundaries

Sexual misconduct allegations are becoming more and more prevalent among the chiropractic profession. Unfortunately, while some allegations may be justifiable, often

they are based on misunderstanding or even malice rather than on a doctor's actual behavior.

Before physicians can defend themselves regarding this somewhat ambiguous concept, they need to understand what *boundaries* are. *Boundaries are mutually understood, unspoken physical and emotional limits of the relationship between the patient and the doctor.*

ACA Statement on Sexual Intimacies with a Patient

In response to numerous requests for clarification relative to the ethical implications of sexual intimacies between a Doctor of Chiropractic and a patient he or she is treating, the ACA Ethics Committee issued the following advisory opinion in 1991. Per the ACA Ethics Committee, sexual intimacies with a patient are unprofessional and unethical based on the existing ethical provisions in the ACA Code of Ethics:

> "The physician/patient relationship requires the doctor of chiropractic to exercise utmost care that he or she will do nothing to 'exploit the trust and dependency of the patient.' Doctors of chiropractic should make every effort to avoid dual relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by the patient."

As most seasoned doctors are clearly aware, there are situations in which a patient initiates improper behavior and time in which a doctor may inadvertently behave in a manner which could give rise to a lawsuit. The following steps can help physicians minimize their risks.

Identifying the high-risk patient

Though the patient normally establishes the boundaries, there are three exceptions (keep in mind a patient may fall into more than one category):

- **The flirtatious patient.** Some flirtatious patients may just want a reaction from the doctor while others wish to establish a relationship with the chiropractor. These patients may attempt to justify inappropriate behavior by saying something like, "Don't worry. It'll be our little secret." Other patients may be naturally flirtatious or flirtatious only with the doctor—the doctor may not be able to differentiate the behavior. By asking staff to observe the patient outside the treatment room, physicians can gather clues about the patient. For example, is the patient flirtatious in the waiting room as well as in the examination room? By collecting information from staff, doctors will be better able to determine the best management approach to use with the patient, such as including a chaperone.

- **The predatory patient.** A predatory patient is one who is looking for a lawsuit or has a hidden agenda. He or she may appear to be simply flirtatious, but is actually very scheming.

A predatory patient may:

- Want to be the last patient of the day or see a physician only after hours—always a red flag.
- Be very blatant and intimidating with staff (note: staff often will recognize this behavior before the doctor).
- Disregard staff instructions (e.g., may appear naked in the treatment room).
- **Patients with unrealistic expectations/perceptions of the doctor.** These are patients who unconsciously idolize or see the doctor as a replacement for another important person from the patient's past.

Preparing for the high-risk patient

By being prepared and establishing personal policy in advance, physicians can avoid being caught off guard, thus avoiding some awkward—and potentially risky—situations. Here are some ways to prepare for situations in which physicians must establish control:

- **Train your staff.** Be aware of risky patients and situations. Develop procedures for staff to alert physicians to potential problems without letting the patient know. One office developed a fictional code name of "Dr. Black" for situations where the doctor wanted a staff member present during the treatment phase. The doctor would tell a staff member, "Dr. Black needs copies of the records" to communicate the need to be present and assist in the treatment of a high-risk patient.

  Recognize, respond, and deal with aggressive patients and empower staff to handle difficult situations.

- **Physicians should listen to their staff, even if it goes against their ego**. Staff will tend to have a more objective viewpoint and can observe patients' behavior with staff and other patients.

- **Check with past doctors** to find out why a patient was discharged (a release from the patient will be needed to contact his or her prior doctor). Flirtatious and/or predatory patients are experts at appealing to a doctor's ego, and this step can provide doctors with a reality check.

- **Understand diversity within cultures and how this affects sexual boundaries.** Comply with HNS Cultural Competency Standards. Different cultures have different expectations regarding touching, personal space, chaperoning, and the parts of their bodies they consider private. Be aware of the needs of ethnic or cultural groups, especially those prevalent in the local community.

- **Appropriate and effective communications.** Not only does this mean avoiding inappropriate comments and/or jokes, but physicians should plan ahead for ways to put patients at ease without appearing inappropriate. For example, doctors should be less chit-chatty with mildly flirtatious patients, while being firmer with patients who exhibit blatant behavior. Doctors also should be able to communicate honestly with their patients if they feel uncomfortable about a patient's behavior.

- **Always get consent for photography (medical or otherwise).** With minors, always have a parent in the room.

- **Watch for signs of patient discomfort.** Does the patient pull away when touched? Doctors should ask if that particular touch made the patient feel uncomfortable or caused pain. As a way to measure a patient's comfort level, the doctor may wish to start with a touch to the forearm. The doctor then can demonstrate the degree of pressure applied during a chiropractic palpation and what it will feel like. A touch to the forearm is generally considered acceptable because it is nonsexual and allows the patient to see and respond to the touch without surprise. In contrast, a patient who has no prior experience with chiropractic care or one who has issues with being touched may react negatively if a chiropractor's first touch is the doctor's hands being placed from behind the patient on the shoulders.

- **Be aware of physical interactions.** The practice of chiropractic involves a great deal of hands-on interaction between doctors and patients. The fact that chiropractors place their hands-on patient's more than most health care professionals can create greater opportunities for risk. Helping patients feel comfortable and in control to the greatest extent possible and using the measures listed below may help minimize risks during visits.

- **Physicians should clearly explain what they are going to do and why during the initial exam** so there are no surprises that could be perceived as a boundary violation. A patient's first visit to is an especially critical time for effective communications.

- **Use examination gowns when necessary.** If a practice requires patient to don a gown, make sure to administer gowning procedures consistently. (For example, require all patients to wear a gown or patients with previously identified conditions to wear a gown.) Gowns that afford the greatest degree of privacy while allowing for a complete competent clinical examination should be used. Give explicit instructions regarding the articles of clothing to be removed.

  Example: *"Please remove both of your shoes, socks, pants, and shirt, but do not remove any of your undergarments. Wear the gown with the opening in the back. Be sure and close the gown using the Velcro or ties on the back."* After giving these instructions to the patient, the patient should be given instructions as to how

to alert staff that they have finished gowning. This allows the patient to initiate the examination process and maintain more control.

- **Drape for privacy.** When the clinical investigation includes placing the patient in a prone position, draping of a towel over the buttocks is suggested. This affords the patient the highest level of privacy without interfering with the clinical investigation.

- **Avoid removal of patient undergarments and do not place hands inside of undergarments.** Proper chiropractic care would require the removal of undergarments in *only the rarest of clinical situations.* Example: A patient needed to remove her brassiere for x-rays. If clinically required, explain the procedure to the patient and why the removal of undergarments is necessary. Seek the patient's permission and expose the smallest area possible. This will help patients feel more in control over their bodies.

- **Explain all tests and obtain patient's permission before performing them.** This usually requires explaining the clinical necessity of examinations. A patient's consent and permission are especially important for exams involving any private areas.

- **Explain the types of treatments performed.** This helps avoid misunderstandings. For example, someone with radicular lower extremity pain secondary to piriformis syndrome might not understand the need to ultrasound the sciatic nerve in the buttock region. Therefore, the patient may be reluctant to expose the area for an ultrasound. Without a proper explanation, the patient may feel out of control and may misconstrue this as an erotic act or improper treatment.

- **Perform all initial examinations, whenever possible, during normal business hours.** This is especially important with patients of the opposite sex. After-hours examinations, when the chiropractor is the only staff member present in the office, can result in misunderstandings. These misunderstandings can lead to allegations of improper conduct and ultimately, he said/she said scenarios.

- **Consider a chaperone when treating members of the opposite sex.** If the doctor encounters a patient who is making inappropriate or suggestive comments or when terminating the doctor/patient relationship, a chaperone is strongly advised. Ideally, a patient should be given the option to request a third party be present during any examination. Physicians may wish to add a question to the patient intake form. Example: "Do you wish to have a third person present during your examination and treatment?" This question may help identify patients who are sensitive to such issues before they even enter the examination room. The response could also alert the staff to provide a chaperone without the patient having to request one.

- **Have a parent/guardian of the same gender supervise when treating a minor**, even after the parent signs a “consent to treat a minor” authorization.

Keep in mind that staff should be involved in helping physicians manage risk through appropriate verbal communications and physical interactions. Training can be done when staff is hired and/or during regular staff meetings. Always post or print in a manual the policies and procedures for staff in areas only staff can see.

5. Informed Consent

HNS Policy:
Prior to initiating treatment for any condition, informed consent must be obtained from the patient and evidenced in writing.

HNS Network Physicians must utilize a written informed consent form, and the form must be dated and signed by the patient (or legal guardian) and maintained as part of the healthcare record. However, because of the fact-specific nature of the informed consent process, HNS does not endorse nor offer opinions as to the sufficiency of a physician’s overall informed consent form used in that process.

Overall, HNS Network Physicians should keep in mind that informed consent is a process, which may or may not be satisfied with a written form. Importantly, a signed written consent form is not a valid substitute for, nor does it replace, a discussion between doctor and patient. Ultimately, it is the doctor's responsibility to make sure the patient is properly informed, understands, and consents to the treatment to be provided.

Generally, informed consent arises from the principle that a patient has the right to exercise control over his or her body by making an informed decision concerning whether to consent to a particular course of treatment or procedure. A patient also has the right to withdraw consent at any time.

For a patient to truly consent, it is generally held that they should know and completely understand the following:

a) Nature of their condition;
b) Nature of the treatment to be rendered;
c) All material risks attendant to that treatment;
d) The possibility of an occurrence of said risks;
e) Alternative treatment available and the risks attendant to those treatments; and,
f) The consequences of allowing the condition to remain untreated.

Even though the principles above have been generally accepted throughout the United States, it is up to each individual state to define the necessary elements to establish informed consent within their jurisdiction.

As such, considering all factors involved in the informed consent process, HNS recommends that HNS Network Physicians contact attorneys who practice healthcare-related law in their state to obtain guidance concerning the informed consent process used in his/her practice, including, but not limited to, what specific information to include in the informed consent form.

That said, HNS does make available sample informed consent language on the HNS Website under "**HNS Documents**", which HNS Network Physicians and their counsel may consider should they choose to do so.

XVIII. HNS Payor Contracts

HNS contracts with various health care and managed care organizations. For a current listing of those contracts, please refer to the **"Billing and Claims Support"** section (HNS contracts) on the HNS website.

XIX. Fee Schedules

HNS fee schedules for each contracted health care plan are posted on the secure portion of the HNS website.

Fees included on the fee schedule represent the fees negotiated by HNS. In some instances, other services may be covered, so please be sure to verify benefits prior to rendering care.

It is important to become familiar with these contracted rates and to check the EOP's to ensure payments reflect the appropriate fee. If a physician should receive a payment that is inconsistent with the contracted rates, he/she should contact his/her HNS Service Representative immediately.

HNS fee schedules are proprietary and confidential and may not be reproduced in whole or in part unless authorized in writing by an authorized representative of HNS, or unless required by law.

XX. HNS Administrative Fee

HNS wants physicians to understand why an administrative fee is required.

The HNS administrative fee is not a charge for processing claims.

The HNS admin fee provides the network with revenue to fund the costs of the programs, initiatives, and services provided. (HNS does not receive any compensation from the insurance companies and managed care organizations that contract with HNS.)

The amount of the HNS admin fee paid by each health care professional is included with remittance information provided by HNS on the scheduled payment dates.

Calculation of the HNS Admin Fee
The HNS Admin Fee is calculated against the "allowed amount" (or "contracted amount") shown on the EOB.

The admin fee is calculated against the sum of the deductible amount, the copayment/coinsurance amount, plus, the amount paid by the health plan, for each service line shown on the EOB.

The allowable amount is the sum of monies due to the provider, *from either the member or the insurance company*, for each covered service provided, and includes copayments, deductibles, and/or coinsurance that must be collected from the member.

The allowed amount represents the amount the payor intends for the provider to collect for the services provided, that is represented by a particular CPT or HCPCS code.

HNS does not charge an admin fee when, per the EOB, the provider is not entitled to receive any payment, *either from the member or insurance company*, for the service shown on the EOB. By calculating the admin fee against the allowed amount, the provider is assured that HNS only receives its fee for those services for which the provider will receive payment.

To promote the delivery of cost-efficient care to members of contracted health care plans, the HNS admin fee may be reduced for those providers who consistently deliver cost-efficient care, as indicated by HNS' Comparative Practice Patterns Program and Code Audit Review Program.

XXI. Remittances from HNS

After claims are adjudicated by contracted payors, EOPs and payments are sent to HNS for disbursement to contracted health care professionals. HNS receives most payments from payors electronically and EOPs, most often, are received in bulk electronic payment files.

HNS tracks and allocates all monies and EOPs received from each health care plan, for each contracted health care professional, and is responsible for ensuring timely delivery of those payments and remittance information to each provider.

With a few exceptions, all payments to contracted health care professionals are made via electronic fund transfers (EFT).

HNS issues provider payments on prescheduled payment dates; three times per month, on the **10th, 20th (or next business day) of the month and the last business day of each month.**

All monies received by HNS since the previous payment date are sent to the provider on the next scheduled payment date. On the same date, HNS provides EOPs and other remittance information, including the amount of your HNS admin fees associated with the payments. Remittance information can be downloaded from HNSConnect®. HNS also provides remittance information in a HIPAA compliant format (ANSI 835 file) that can be downloaded to your billing software for automatic payment positing directly to your patient accounts.

In order to assure that your patients' accounts are current, and your accounts receivable figures are accurate, HNS providers are required to post all EOB/NOPs within 15 days of receipt.

If there are ANY inconsistencies in the amount paid by HNS, and the amount shown on your EOB/NOP as the amount actually due from the payor, (less the HNS administrative withhold) OR if the amount shown on a provider statement does not match the amount on a HNS check, *contracted health care professionals must notify HNS within 10 days.*

XXII. HNS Documents (Clinical and Administrative)

HNS has developed and/or provides numerous clinical and administrative forms to promote the delivery of safe, effective, cost-efficient care, as well as compliance to laws and regulations applicable to our industry. The forms can also help to ensure health care records comply with HNS' Clinical Records Quality Standards, support medical necessity, and assist in minimizing malpractice risk.

HNS encourages the use of electronic health care records (EHR) but understands that not all health care professionals have made this transition. Whether a practice has embraced EHR or still utilizes a paper-based record system, our forms can help.

HNS Documents are available on the HNS website, www.healthnetworksolutions.net, and are provided in Microsoft Word format so they may be customized for use in each practice.

Available in Spanish

As part of our cultural competency program, HNS provides relevant clinical and administrative forms in Spanish. Forms provided in Spanish include:

- Informed Consent
- Election Not to File (PI Cases)
- Election Not to File (Non-PI Cases)
- Bournemouth Back Questionnaire
- Bournemouth Neck Questionnaire
- Functional Rating Index
- Oswestry Low Back Pain Disability
- Roland Morris Questionnaire
- Modified Roland Sciatica Questionnaire
- ADL Form
- Non-Covered Services Waiver
- Maintenance/Supportive Care Waiver
- Maintenance/Supportive Care Letter to Patients
- Confidential Financial Hardship Worksheet
- Financial Hardship Policy

XXIII. Payor Corporate Medical Policies

Compliance to payor corporate medical policies is a requirement for continued participation.

Corporate medical policies are updated frequently. Copies of the most current policies are posted on the HNS website.

XXIV. References

1. Centers for Medicare and Medicaid website at http://www.cms.hhs.gov
2. CIGNA Healthcare website at www.cigna.com
3. Blue Cross and Blue Shield of North Carolina website at http://bcbsnc.com
4. Current Procedural Terminology, 2008. American Medical Association
5. International Classification of Diseases ICD-9-CM 2007. American Medical Association
6. Documentation Guidelines for Evaluation and Management Services. American Medical Association 2007
7. Healthcare Common Procedure Coding System. American Medical Association
8. Chiropractic Coding Solutions Manual. American Chiropractic Association
9. Chiropractic Economics, Vol. 53, Issue 17, October 2007
10. Medical Group Management Association website at http://mgma.com
11. OIG Compliance Program Guidance for Third Party Medical Billing Companies http://oig.hhs.gov
12. Anti-kickback law http://www.physiciannews.com/law
13. Dr. John Davila, Compliant Services and Solutions
14. *Federal Register,* Vol. 72, No. 15, January 24, 2007, pp. 3147-3148
15. North Carolina Board of Examiners: www.ncchiroboard.com
16. Dr. Mario Fucinari, DC, CCSP, MCS-P – Prevention of Medical Errors

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