Chiropractic Practice Compliance 201

Presented by
Dr. Daniel J. Reida
Educational Objectives

- Demystify the great unknown that is compliance
- Improve clinical and practice documentation
- Teach the outline of a compliance program
- Reduce the possibility of a complaint or violation
- Develop more accurate reporting of services
What is Compliance?

Webster defines compliance as “conformity in fulfilling official requirements”

The Office of Inspector General defines a voluntary compliance program as “…a positive step towards assisting providers in preventing the submission of erroneous claims or engaging in unlawful conduct involving the Federal healthcare programs.”

A Chiropractic Compliance Plan can be defined as, “a documented set of standards, procedures, and policies that addresses the administrative and clinical protocols of a Chiropractic.”
Why do you need to be compliant?

- Protect your patients
- Protect your license
- Protect your employees
- Protect yourself

Change is inevitable – you can either resist it, deny it, accept it or embrace it
How this all began:


- OIG compliance program for individual and small-group physician practices. Agency: Office of Inspector General (OIG, HHS)
On September 8, 1999, OIG published the solicitation notice seeking information and recommendations for developing formal guidance for individual and small-group physician practices. In response to the solicitation notice, the OIG received 83 comments from various outside sources.

This material was published June 12, 2000 in Federal Register to encourage further comments and recommendations. By October 5, 2000 the components for the compliance program were formulated and published.
The goal of voluntary compliance programs is to provide a tool to strengthen the effort of healthcare providers, to prevent and reduce improper conduct.

The OIG believes that the great majority of physicians are honest and share our goal of protecting the integrity of Medicare and other federal healthcare programs. To that end, all healthcare providers have a duty to ensure that the claims submitted to federal healthcare programs are true and accurate.
Through this document, the OIG provides its views on the fundamental components of physician practice compliance programs.

1. For the purpose of this guidance, the term "physician" is defined as:
2. A doctor of medicine or osteopathy.
3. A doctor of dental surgery or of dental medicine.
4. Podiatrist.
5. Optometrist.
6. A chiropractor – all of whom must be appropriately licensed by the state.
OFFICE OF INSPECTOR GENERAL’S COMPLIANCE PROGRAM
GUIDANCE FOR INDIVIDUAL AND SMALL-GROUP PHYSICIAN PRACTICES

INTRODUCTION:

- While this document presents basic procedural and structural guidance for designing a voluntary compliance program, it is not in and of itself a compliance program. Indeed, as recognized from the OIG and the healthcare industry, there is no "one-size-fits-all" compliance program, especially for physician practices.

- As with the OIG's previous guidance, these guidelines are not mandatory. Nor did they represent an all-inclusive document containing all components of a compliance program.
BENEFITS OF A COMPLIANCE PROGRAM:

OIG acknowledges that the patient care is, and should be, the first priority of a physician practice. However, a practice’s focus on patient care can be enhanced by the adoption of a voluntary compliance program. For example, the increased accuracy of documentation that may result from a compliance program will actually assist in enhancing patient care.
BENEFITS OF A COMPLIANCE PROGRAM: Quality Assurance

1. Speed and optimize proper payment of claims.
2. Minimize billing mistakes.
3. Reduce the chances that an audit will be conducted by the HCFA or the OIG.
4. Avoid conflicts with a self referral and anti-kickback statutes.
BENEFITS OF A COMPLIANCE PROGRAM:

- Compliance programs also provide benefits by not only helping to prevent erroneous or fraudulent claims, but also by showing that the physician practice is making additional good-faith efforts to submit claims appropriately.

- Physicians should view compliance programs the same as practicing preventative medicine for their practice.
BENEFITS OF A COMPLIANCE PROGRAM: Quality Assurance

A compliance program also sends an important message to the physician practice’s employees, that while the practice recognizes that mistakes will be made; employees will have an affirmative, ethical duty to come forward and report erroneous or fraudulent conduct, so that it may be corrected.
THE DIFFERENCE BETWEEN “ERRONEOUS” AND “FRAUDULENT” CLAIMS TO FEDERAL HEALTHCARE PROGRAMS:

The OIG is very mindful of the difference between innocent errors ("erroneous claims") and reckless or intentional conduct ("fraudulent claims"). For criminal penalties, the standard is even higher. Criminal intent to defraud must be proved beyond a reasonable doubt.
THE DIFFERENCE BETWEEN “ERRONEOUS” AND “FRAUDULENT” CLAIMS TO FEDERAL HEALTHCARE PROGRAMS:

- Even ethical physicians are negligent and this results in erroneous claims. The physician practice should return the funds erroneously claimed, but without penalties.

- It is reasonable for physicians (and other providers) to ask: what duty do they owe the federal healthcare programs? The answer is: that all healthcare providers have a duty to reasonably ensure that the claims submitted to Medicare and other federal healthcare programs are true and accurate.
FRAUD:

- Is intentional.
- Routinely up-coding intentionally.
- Intent is key.
- Chiropractic Boards do not assume what an insurance company presents as fraud, is necessarily fraud.
What are the essential elements of a healthcare compliance program?

**WARNING!**

- Don't throw together a plan.

- A poorly written or implemented compliance plan can also create problems for you.
COMPONENTS OF AN EFFECTIVE COMPLIANCE PROGRAM:

1. Conducting internal monitoring and auditing.
2. Implementing compliance and practice standards.
3. Designated compliance officer or contact.
4. Conducting appropriate training and education.
5. Responding appropriately to detected offenses and developing corrective action.
6. Developing open lines of communication.
7. Enforcing disciplinary standards through well-publicized guidelines.
8. Due diligence in hiring
STEPS FOR IMPLEMENTING A COMPLIANCE PROGRAM:

Implementing a voluntary compliance program can be a multi-tiered process. Initial development of a compliance program can be focused on practice risk areas that have been problematic for the practice such as coding and billing. Within this area, the practice should examine its claims denial history or claims that have resulted in repeated overpayments, and identify and correct the most frequent sources of those denials or over payments. A review of claims denials will help the practice scrutinize a significant risk area and improve it’s cash flow by submitting correct claims that will be paid the 1st-time they are submitted.
An ongoing evaluation process is important to the successful compliance program. This ongoing evaluation includes not only whether the physician practices standards and procedures are in fact current and accurate, but also whether the compliance program is working. For example, whether individuals are properly carrying out their responsibilities and claims are submitted properly. Therefore, an audit is an excellent way for a physicians practice to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems. There are 2 types of reviews that can be performed as part of this evaluation.
Conducting Internal Monitoring & Auditing

1. Review of Standards and Procedures
2. Claims Submission audit

Overseen by Compliance Officer
- Performed by day to day operations personnel
- Log updates and additions
- Monitoring is an ongoing basis
Objective of a Standards & Procedures Audit

- Verify written protocol for the compliance program
  - Affirm the eight components of a compliance plan exist and are adequately supported
  - Review specific instruction for the Compliance Officer and compliance contact
  - Review the current procedures and instruction on implementation including the Practice Standards, Procedures, Protocol etc.
Objective of a Claims Submission Audit

- Establishes a baseline*
- Are bills accurately coded (ICD-9, CPT, HCPCS) to reflect the service provided (from the documentation)
- Documentation completed correctly
- Services and/or items reasonable & necessary
- Does Incentive exist for unnecessary services or items
**Baseline establishment**

- After implementation of compliance program including Education & Training the initial 3-months following should be audited to establish a baseline so as to give the practice a **benchmark** against which to measure future compliance effectiveness.

- A baseline is the results of a retrospective claims submission audit that include:
  - Number of total errors discovered
  - Number of similar errors (duplicative errors)
  - Related offenses
  - Employee related offenses
Monitoring:

- Monitoring is an internal system that updates the plans administrative procedures and clinical resource manuals.
- Done by an individual involved with day-to-day operations.
- **Log, what updated material is added to the plan**, for example: revised CPT versions, new Board regulations, etc.
- When incidences occur, review where the plan's procedures may have failed, and if necessary, make all needed changes to the compliance plan. Log these changes and educate the staff about these changes.
- Monitoring is performed on an ongoing basis.
MONITORING & AUDITING THE OFFICE

Auditing:

- Auditing is a retrospective process that tests to see if the compliance plan is actually working as designed.

- Performed by an independent "outside" individual who has comprehensive experience in chiropractic legal standards, clinical understanding and the billing/coding process. This may be fellow a chiropractor.

- Random audits of patient files should be done annually!

- Regular auditing can be done on a specific date and time.

- Log the specifics of the audit including the date, the person who conducted the audit, their qualifications, what was reviewed, and what was found.

- If a violation is found, don't forget to review the plan, see what failed, make all needed changes and educate the staff.
Recommended that a review of 5 or more records for each payor is performed. Files with the last service date being 6-months or less:

- Medicare
- Group/Indemnity/HMO/PPO
- Personal Injury Protection
- Workers Compensation
- Self-Pay / Barter
Claims Submission Audit Continued

- The larger the sampling the more accurate the baseline
- An important component of a successful claims submission audit is the appropriate and timely response to identified problems.
- There is no boiler-plate solution to a compliance problem
Claims Submission Audit Continued

- Corrective Actions can be straightforward
- It is important to establish a system to respond to an allegation or reported compliance problem
- Preservation of documentation to track the practice’s reaction and resolution to a reported issue
Claims Submission Audit Continued

- Were Correct Modifiers Used?
- Are there ICD codes to cover the areas adjusted?
- Was referencing used to relate the CPT with the ICD code?
- Were the claim form fields filled in correctly?
#2 - Establish Practice Standards & Procedures

- After an internal audit that reveals the practice risk areas, the next step is to develop written Standards & Procedures to deal with risk areas.
- **Written Standards & Procedures** are essential and central to any compliance program.
- Development of a binder located in a readily accessible location to all employees would allow:
  - Updated communications to employees
  - Training tool for New Hires
  - Resource for an employee to verify possible violation
  - Provide guidance for employees day-to-day
If updates to the standards and procedures are necessary, those updates should be communicated to employees to keep them informed regarding the practices operations. New employees can be made aware of the standards and procedures when hired and can be trained on their contents as part of their orientation to the practice.
Specific Risk Areas

- Coding and billing
- Reasonable and necessary services
- Documentation
- Improper inducement, kickback, self-referral
Specific Risk Areas

- **Coding and Billing**
  - Billing for items or services not rendered or not provided pursuant to the documentation.
  - Submission of claims for items or services that are not reasonable and necessary (not warranted) pursuant to the patients documented medical condition
  - Double billing resulting in duplicate payment
Specific Risk Areas

- Billing for non-covered services as if covered
  - Using a CPT code that is payable rather than the more accurate CPT code that would not be covered
- Knowingly misusing provider numbers which results in improper billing
  - Covering Doctor billed under your PIN number
Specific Risk Areas

- **Unbundling of services**
  - Billing for components of a service instead of using an all-inclusive code.

- **Failure to properly code modifiers or improperly coding modifiers, e.g.**
  - Adding -59 to CPT: 97140, 97124 or 97112 when performed same day as CMT in same anatomical.
  - Addition of -25 modifier to E/M service that was not distinct and separate from primary service (CMT)
Specific Risk Areas

- **Clustering - Billing and average code**
  - Example = always billing a Level III Exam under the rationale that sometimes a Level IV is performed and sometimes a Level II is performed.

- **Up-coding Level of Service**
Specific Risk Areas

- Over-utilization could lead to fraudulent charges.
- Improper charges could lead to fraudulent charges.
- Misrepresentation or deceit can lead to fraudulent charges.
- A Physical Therapist Assistant (PTA) is only licensed to practice under a PT.
A practices compliance program may provide guidance that claims are to be submitted only for services that the physician practice finds to be reasonable and necessary in the particular case.
SPECIFIC RISK AREAS:

This list of risk areas is not exhaustive or all-encompassing. Rather, it should be viewed as a starting point for an internal review of potential vulnerabilities within the physician practice.
Standards & Procedures

- Written Standards and Procedures should reflect the current reimbursement principals set forth by the Committee for Medicare & Medicaid Services (CMS), The AMA CPT, HCPCS, ICD coding principals and definitions and where applicable the medical policies and billing guidelines of contracted carriers as well as Federal, State and local laws.
ESTABLISH WRITTEN STANDARDS AND PROCEDURES FOR THE PRACTICE

Office manual.

- Covers office administration and operations:
- General operating procedures.
- Employee job description.
- Employee benefits.
- Code of conduct and discipline of employees.
- Confidential channels of communication for reporting questions or potential problems.
- Policies on referral of patients.
- Procedures for investigating/responding to specific complaints or discrepancies.

For example: a policy on when a patient is upset about money. What do you do?
ESTABLISH WRITTEN STANDARDS AND PROCEDURES FOR THE PRACTICE

Office manual.
- Covers clinical record keeping issues/patient records:
- Documentation of informed consent.
- Creation of treatment records.
- Content of treatment records.
- Time frames for entry of data.
- Preservation of treatment record.
- Privacy of treatment record.
- Access of the patient records, (by patient, by other providers and by third-party payors) and authorizations required for access-HIPAA compliance necessary.
ESTABLISH WRITTEN STANDARDS AND PROCEDURES FOR THE PRACTICE

Office manual.
- Practice resource manuals (clinical).
- Should include:
  - State and federal laws.
  - State board rules and regulations.
  - Federal regulations (Medicare and Medicaid).
  - Medical dictionary.
  - Insurance coding books (For example: CPT, ICD-9-CM, HCPCS).
  - Published chiropractic clinical guidelines.
  - Third-party payer manual's.
- Keep readily available for periodic review and updating.
- Treatment must be based on some set of guidelines that are published guidelines.
Standards & Procedures

- Standards and Procedures on coding should be based on medical record documentation:
  - ICD coding reflected in the record
  - CPT coding reflected in the record
  - E/M Service Level reflected in the record
  - HCPCS coding reflected in the record
  - NCCI being followed
IMPROPER INDUCEMENTS, KICKBACKS AND SELF-REFERRALS:

Physician practices should also consider implementing measures to avoid offering inappropriate inducements to patients. Examples of such inducements include routinely waving co-insurance or deductible amounts without a good faith determination that the patient is in financial need or failing to make reasonable efforts to collect the cost-sharing amount.
RETENTION OF RECORDS:

In light of the documentation requirements faced by physician practices, it would be to the practices benefit if its standards and procedures contained a section on the retention of compliance, business and medical records.

We suggest that particular attention should be paid to documenting investigations of potential violations uncovered by the compliance program and the resulting remedial action.
RETENTION OF RECORDS:

In short, it is in the best interest of all physician practices, regardless of size, to have procedures to create and retain appropriate documentation. The following record retention guidelines are suggested:

1. The length of time that a practice's records are to be retained, can be specified in the physician practice's standards and procedures.
2. Medical records (if in the possession of the physician practice) need to be secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption, or damage.
3. Standards and procedures can stipulate the disposition of medical records in the event the practice is sold or closed.
Developing Standards & Procedures in compliance program for monitoring & warning indicators

- Monitoring for significant changes in the number or type of claims rejections or reductions
- Correspondence for Carriers challenging the Medical Necessity or validity of a claim
- Illogical patterns or unusual changes in pattern of CPT, HCPCS or ICD codes utilized
- High volume of unusual changes or payment adjustment transactions
Implementing & Maintaining Written Standards & Procedures for Practice

- Office Administration
- Office Operations
- Human Resources
  - Employee job descriptions
- Expected resources
  - Medical Dictionary
  - Federal Regulations
  - Insurance Coding books CURRENT
  - State Board rules & Regs
  - Federal & State Laws (HIPAA)
  - 3rd party payer manuals
  - Published chiropractic clinical care guidelines
Standards & Procedures (Documentation)

● Medical Records May be used to verify:
  ● The site of the service
  ● The appropriateness of the service
  ● The accuracy of the billing
  ● The identity of the servicing provider

● Medical Record should be complete and legible
Standards & Procedures (Documentation)

- Documentation of each patient encounter should include:
  - Reason for the encounter
  - Any relevant history
  - Physical exam findings
  - Prior diagnostic test results
  - Assessments
  - Clinical Impression or Diagnoses
  - Plan of care
  - Date and legible identity of observer
Standards & Procedures
(Documentation)

- CPT and ICD codes used for claim submission are supported by the documentation and the Medical Record
- Appropriate health risk factors are identified
- Patient progress and response to changes in treatment
- Any revisions in diagnoses noted
- Servicing provider easily identified by the record
Standards & Procedures (Documentation)

“These issues can be the root of investigations of inappropriate or erroneous conduct, and have been identified by HCFA [CMS] and the OIG as a leading cause of improper payments” ¹

¹ Federal Registry / VOL 65, No 194, Page 59440, October 5, 2000
Proper Completion of CMS-1500 Claim Form

- Claim Fields properly filled out
- Review of claim form boxes
  - Accurate and complete fields
  - Referencing used (box 24e)
  - Modifiers correct (box 24d)
  - Initial onset or injury date (box 14)
  - Servicing provider (box 31)
Improper Inducement, Kickback, Self Referral

- Anti-kickback statute
  - Remuneration for referral is illegal
  - In general the statute prohibits knowing and willful giving or receiving of anything of value to induce a referral
Standards & Procedures

- Should address measures to avoid improper inducement to patients
  - e.g. routine waiving of co-pays, co-insurances, and/or deductible amounts without a good faith determination that the patient is in financial need or failing to make reasonable efforts to collect the cost sharing amounts.
  - Jeopardize your provider contracts
FELONY ALERT!

IMPROPER SOLICITATIONS, INDUCEMENTS OR REFERRALS ARE A FELONY
Improper Inducement, Kickback, Self Referral Risk Factors

- Financial arrangements with outside entities to whom the practice may refer
- Joint ventures with entities supplying goods or services to the physician practice or its patients
- Consulting contracts or Medical Directorships
- Office & Equipment leases with entities to which the physician refers
Improper Inducement, Kickback, Self Referral Risk Factors

- Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those that might benefit from a physician practice referral
  - A clear Standards & Practice written Policy should be documented if any exchange of value to patients or other entities are given as a thank you.
- OIG website offers copies of all relevant fraud alerts and advisory opinions
Retention of Records

It is necessary to maintain records and raw data of audits, investigations, resolutions and Standards and Practices updates in the event of an involuntary audit.
#3 - Designation of Compliance Officer (CO)

- Chiropractor of Record in a Facility setting should be the C.O.
- Compliance Contact
  - Key Staff Member(s)
- Compliance Committee
  - Chiropractor Of Record (CO)
  - Compliance Contact (Key Staff Member)
  - Outside Member (Compliance Consultant)
THE COMPLIANCE OFFICER:

- Designate a specific individual.
- The compliance Officer is the leader; compliance is everyone's job.
- **The compliance Officer should have the following qualities:**
  - Honesty and integrity.
  - Ability to act independently.
  - Knowledge of applicable laws and regulations.
  - Experience with coding and billing.
- **The Compliance Officer's Tasks Include:**
  - Responsibility for identifying potential problems.
  - Oversee correcting the problem or discrepancy at hand.
  - Document corrective actions when necessary.
  - Take appropriate actions when reportable events occur.
  - Take appropriate steps to avoid reoccurrence (write new procedures).
CHIROPRACTOR OF RECORD VS. A PRACTICE's COMPLIANCE OFFICER

- Recommend that the Chiropractor of Record also serve as the facility's Compliance Officer.
- If the Chiropractor of Record and Compliance Officer are to be separate individuals: the chiropractor of record should be involved in the selection of the facility's Compliance Officer.
- The Chiropractor of Record should oversee and approve the work of the Compliance Officer.
- The Chiropractor of Record is ultimately responsible for the actions and omissions of the facility's Compliance Officer.
Compliance Officer

- Responsible for day to day operations and oversees the Compliance Plan
- Designates the Compliance Contact(s)
  - The CO would create Standards & Practice for the duties of Compliance Contact
  - Reports to the CO
Compliance Officer
Quality Assurance

- Establish methods such as periodic audits to improve the practice’s efficiency, quality of service and to reduce the practice vulnerability to fraud and abuse
- Periodically revising the Compliance Program in light of changes and the needs of the practice, laws and in the Standards & Practices, Procedures, Government and Private Payer changes.
Compliance Officer

- Developing, coordinating and participating in a training program that focuses on components of the Compliance Program and ensures trainings are appropriate
  - Review of all employees, staff and independent contractors
  - Investigate any reports or allegations concerning possible unethical or improper business practices and monitoring corrective actions for complaints
Once an audit has been completed, Risk Factors and problems detected and Compliance Officer designated
- Tailor the Training & Education to your practice needs
- Reaction to discovered risk factors & issues
3 Basic Steps

1. Determining who needs training
   - Billing
   - Coding
   - Compliance
   - Documentation

2. Determining the type of training that best suits the practices needs
   - Seminars
   - In-Service
   - Self Study
   - Online, i.e. www.chirocredit.com
   - CD or DVD
3 Basic Steps

3. Determining when and how often education is needed and how much each person should receive

Compliance Officer should gauge the most effective way to deliver the education & that upon completion the person being training comes away with a better understanding.
Conduct training sessions on the content of the compliance plan and the employee's responsibilities.

Maintain a log of these staff meetings the names of attending staff, date and what information was covered.

Bring staff to seminars that address issues of office procedures, insurance coding, HIPAA and compliance programs.

Treat everyone with respect.
EMPLOYEE TRAINING
& EDUCATION

Address sensitivity issues:

● Be clear and concise about inter-office and extra-office employee conduct.

● Be clear and concise about employee conduct towards patients.

● Good communication is the key: complaints arise out of inattentiveness.

● Discuss financial matters, obligations and expectations. For example, log missed appointments in the SOAP notes. Don't let patients run their care. The doctor should run their care.

● Discrimination policies should be posted on a wall poster.

● Sexual conduct and inappropriate behaviors.
Compliance Training

- At the direction of the C.O. or C.C. initial and recurrent training is advisable

- Important components in training are:
  - The operation and importance of the compliance program itself
  - Consequences of violating the Standards & Practices set forth in the program
  - Role of each employee in the operation of the compliance program
Compliance Training Goals

- All employees will receive training on how to perform their job in compliance with the Standards and Practices
- Each employee will understand that compliance is conditional on their continued employment
Compliance Training Cont.

- Compliance training focuses on the explanation of why the practice has developed a compliance program.
- Each employee should understand that following the Standards and Practices will not get them in trouble. Violating the S&P will cause disciplinary action.
Compliance Training Schedule

- All employees should receive initial Compliance Training
- New Hires should receive training as soon as possible
- Recurring training should happen annually or sooner of required through violations or revealing Risk Factors
Coding & Billing Training

- Coding and billing training should be included for all employees responsible that code services. This includes the providers that code their own services.
- Chiropractic Assistants and/or Claims Specialists that code from documentation should have continued training at least annually when new, deleted and updated CPT definitions are released.
Claims development and submission
Signing a form for a provider without permission
Proper documentation of services rendered
Proper billing standards and practices and submission of accurate bills
Understanding the impact of erroneous and false claims submission on a practice whether intentional or unintentional
Laws that govern claims submission and compliant billing
Format of Training Program

- In-service or outside resources
- Working with your third party billing agency
- Ensuring documentation is adequate for claims submission and CMS-1500 format
- Updated coding books
- Available for all employees
- Training can be all inclusive or separated into pieces relevant for job tasks
- Training and education enhances Q/A
Continuing Education on Compliance Issues

- OIG recommends:
  - Annual Education & Training for all employees
  - New Hires E&T ASAP
  - Timely E&T for updates in coding, laws, guidelines, clinical discoveries, discovered violations
QUALITIES OF A SUCCESSFUL CHIROPRACTOR AND KEY COMPONENTS TO AVOID MALPRACTICE

- Practice with a high degree of technical competence in the skills of clinical interviewing, clinician patient interaction, and in your scope of professional practice.
- Become a doctor who is empathetic, respectful and who listens well and responds appropriately to the patient. This will help generate trust and satisfaction among your patients.
- Listen to what the patient does and doesn't say.
- Avoid trivializing or demeaning the patient.
- Acknowledge the patient's level of concern.
- Strive for the patient to visualize or understand your reasoning and recommendations.
- Be clear about what you know and what you don't know.
QUALITIES OF A SUCCESSFUL CHIROPRACTOR AND KEY COMPONENTS TO AVOID MALPRACTICE

- Never make promises you can't keep.
- Be available to the patient.
- Pay careful attention to informed consent.
- Pay attention to your communication with other health professionals involved in the patient's care. Make sure that they know what you are doing and you know what they are doing. Obtain this information by letter, phone, e-mail, or fax.
- Remember that documentation is essential. Make your progress notes clear, comprehensible, concise, and complete.
- Document your attempts to follow-up on missed appointments or tests.
- If a mistake is made in the patient's record, correct the mistake carefully and indicate enough information so that others can understand what you're doing and when you are doing it. Mark in the patient's chart addendum, indicate the date and record the new information then sign or initial entry.
INFORMED CONSENT

- The Doctor of Chiropractic must understand that informed consent is a process of communication between the doctor and the patient. The doctor must realize if there is a risk of harm or injury from a particular treatment he or she is proposing to the patient, it is the doctor's responsibility to tell the patient about such risks. In addition, the patient should be fully informed of the risks involved and be willing to accept such risks.

- Keep in mind, the doctor has no legal obligation to disclose or discuss risks that are considered immaterial. This means the less serious the risk and the less chance of the risk then the less likelihood that the legal system would require such disclosure.
LEGAL REQUIREMENTS OF INFORMED CONSENT

1. Information:
The patient should be provided with information that a "reasonable person" would want to know about the nature of the procedure, benefits, risks and in non-technical terms of all significant potential consequences of a proposed service, so that the patient's consent is given with full knowledge of any inherent dangers involved. Also, the doctor should explain alternative options available.

2. Understanding:
The patient must understand the information provided.

3. Voluntary:
The patient's decision must be freely made, without evidence of coercion. Remember it is the patient, not the doctor, who makes the decision whether to proceed or not in view of the possible consequences and alternatives. This is called "giving informed consent".

4. Competency:
The patient should be capable of making an independent medical decision in the particular setting.
INFORMED CONSENT

- Have a document titled “Informed Consent”.
- Tell patient about any material risk they have that may be a problem with treatment: for example: herniated disc, stroke, osteoporosis, etc.
- **Give patient the risk of treatment or not treating**: for example: “Mr. Smith, in my opinion it there would be a huge risk by doing nothing with your current complaint.”
- Material risk should be specific to that patient.
First the C.O. should review the allegation to determine its validity and significance

- Monetary loss is not the only form of violation
- Ethical breeches
- Documentation issues
- Employee violations of S&P
Respond to problems through corrective actions.

- Report suspected problems to the boss or compliance officer.
- Identify the best course of corrective action.
- Implement the corrective action in a timely manner.
- Properly document the corrective actions taken in the appropriate patient file. For example, photocopy a check that I wrote to re-pay an overpayment or refund.
- Log these corrective actions within the compliance plan itself under a separate sheet (keep a log of all re-payment checks).
- Make any appropriate changes to the office policies and procedures, if needed to avoid possible reoccurrence.
- A corrective action plan is a prospective process.
- Have a written policy, such as no open alcohol allowed in the office
- No employees in the office after 9 p.m.
Responding to Detected Offensives & Developing Corrective Actions

Corrective Steps may include:

- Refunding overpayments
- Disciplinary action of employee
- Re-training of employee(s) for section of S&P offense occurred
- Referral to governing authorities of violation
Responding to Detected Offensives & Developing Corrective Actions

- Criminal Violations
  - Standards & Practice should include steps for prompt referral or disclosure to an appropriate governing authority or law enforcement

- Overpayment Issues
  - Standards & Practice should include steps for prompt detection
  - Prompt repayment with explanation to the carrier
  - Log kept in Compliance Manual