



# Medical Office Policies and Procedures



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# Table of Contents

Introduction .....	12
About Cardiology Medical Group .....	13
Changes to the Policies and Procedures .....	14
Cardiology Medical Group Values .....	15
Physicians .....	16
Physicians' Hours of Work .....	17
Locum Arrangements .....	18
Staff .....	19
Business Manager Job Description .....	20
Office Assistant Job Description .....	21
Immunization .....	23
Bonding of Employees .....	24
When the Physician is Away .....	25
Continuing Education .....	26
License Recertification .....	27
Providing Advice without a License .....	28
Dating Patients .....	29
Manual Handling Techniques .....	30
Patient-Physician Relationship .....	32
Rights and Responsibilities .....	33
Complaints .....	35

Facility Standards .....	36
General Information .....	37
Staff Room .....	38
Smoking .....	39
Checklists .....	40
Office Visits .....	42
Appointment Scheduling Guidelines .....	43
Appointment Reminders .....	44
Emergency and Priority Cases .....	45
Appointment Status Change .....	46
Appointment Status Change and No-Show Policy .....	47
Appointments for Specialists or Consultant Physicians .....	48
Checking In Patients .....	49
New Patient Registration .....	50
Insurance Validation .....	51
Returning Patients .....	52
Patient Emergencies and Triage .....	53
Calling Patients from the Waiting Room .....	55
Office Encounter Forms .....	56
Payment Methods .....	58
Payment by Credit Card .....	58
Payment by Check .....	58
Payment by Cash .....	59
Health Services Information .....	60
Telephone Evaluation .....	61
No-Show Policy .....	62

Noncompliant Patients .....	63
Terminating the Physician-Patient Relationship .....	64
<b>Emergency Plan Procedures .....</b>	<b>67</b>
General Emergency, Disaster, and Safety Procedures .....	68
Emergency Plans .....	69
Evacuation .....	69
Transfer of Patient to Ambulance .....	70
Staff Roles and Responsibilities .....	70
Staff Training .....	71
Emergency Supplies and Equipment .....	72
Communication within the Office and with Emergency Services .....	73
Earthquake .....	74
Fire (Code Red) .....	75
Prevention Reminders .....	76
Fire Safety Policy .....	77
Fire Extinguishers/Sprinkler System Policy .....	78
Fire Prevention Policy .....	78
Power Outage .....	78
Bomb Threat (Code Purple) .....	79
Bomb Threat Checklist .....	79
Cardiac Arrest/Medical Emergency (Code Blue) .....	81
Flood or Water Leak Emergency (Code Yellow) .....	82
Gaseous Leak or Gas Explosion Nearby (Code Yellow) .....	83
Hold Up or Violent Person (Code Black) .....	83
<b>Consent Policies .....</b>	<b>85</b>
Consent Policies (with or without Representative) and Minor .....	86
Sample Consent for Treatment .....	100

Refusal of Treatment .....	102
Refusal to Permit Medical Treatment Form .....	103
Emergencies and Consent .....	104
Confidentiality Agreement .....	107
<b>Prescriptions .....</b>	<b>108</b>
Refilling Prescriptions .....	109
Preauthorizing Prescriptions .....	112
5-Day Supplies without Prior Authorization .....	112
Initiating the Prior Authorization Request .....	112
Requirements for Prior Authorization Review .....	113
Automated Prior Authorization Approvals .....	113
Clinical Review Process .....	114
Denials .....	115
Maintaining Medicines .....	116
Narcotic Drug Controls .....	118
Initiation of Opioid Treatment .....	118
Evaluation Following a 90-Day Period of Usage .....	119
Pharmaceuticals at the Office .....	122
Proper Maintenance and Storage of Drugs .....	122
Cytotoxic Drugs .....	123
Medication Record and Other Therapeutic Modalities .....	125
<b>Reporting Violence and Abuse .....</b>	<b>126</b>
Immunity .....	127
Guidelines for Assessment .....	128
Documentation of Abuse .....	129
Reporting .....	130

Penalties .....	131
Physicians Domestic Violence Training .....	132
Reporting Child Abuse or Neglect .....	133
Diagnosis .....	134
Reporting .....	135
Immunity .....	136
Penalties .....	136
Employee Statements .....	136
Reporting Elder and Dependent Adult Abuse .....	137
Abuse .....	137
Physical Abuse .....	138
Sexual Assault .....	138
Sexual Abuse .....	138
Physical Abuse Indicators .....	138
Fiduciary Abuse .....	139
Neglect .....	140
Abandonment .....	140
Isolation .....	140
Dependent Adult Abuse .....	141
Medical Record Documentation .....	142
Reporting .....	142
Endangered Adults Laws .....	144
Employee Acknowledgement Form .....	146
<b>Patient and Office Safety .....</b>	<b>148</b>
Patient Injuries at Cardiology Medical Group .....	149
Physician Office Adverse Incident Report .....	150
Office Security .....	155
Office Data Security .....	156

General Guidelines .....	156
Email Communication .....	157
Red Flag Rule Identity Theft Compliance Program .....	158
Identifying Red Flags .....	158
Detecting Red Flags .....	159
Responding to Red Flags .....	160
OSHA Resources .....	162
OSHA 300 Log .....	163
Workplace Violence Prevention .....	164
Medical Services and First Aid .....	165
Infection Control .....	166
Universal Precautions .....	167
Sterilization .....	172
Steam Sterilization .....	173
Cold Sterilization .....	174
Gas Sterilization .....	175
Hazard Communication to Staff .....	176
Container Labeling .....	176
Safety Data Sheets .....	176
Employee Information and Training .....	177
Hazardous Non-Routine Tasks .....	179
Multi-Employer Work Places .....	179
List of Hazardous Chemicals .....	180
List of Chemicals/SDS Identity .....	180
Rights of Employees .....	180
HCS Pictograms and Hazards .....	181
Preventing Transmission Respiratory Infection .....	183
Hazardous Waste .....	184

Sharps .....	184
Spills of Blood and Other Bodily Substances .....	184
Disposal of Patient Specimens .....	185
Containment .....	185
Personal Protection .....	186
Waste Collection .....	187
Needlestick and Sharps Injuries .....	188
Treating the Contamination Site .....	188
Reporting the Incident .....	188
<b>Medical Records .....</b>	<b>191</b>
Requirements and Standards .....	192
Advance Directives .....	197
Information Confidentiality and Access to Records .....	199
Releasing Confidential Records .....	204
Confidentiality Agreement for Physician Office Employees ..	207
Model Letter to a Patient Who Requests Withholding of Information from Disclosure .....	209
Authorization to Transfer Medical Records .....	211
Authorization for Release of Medical Information .....	213
Privacy Complaints .....	215
Mitigation of Privacy Breaches .....	217
Review of Test Results .....	226
Scanning Medical Records and Documents .....	228
Limited Data Set Records .....	229
Data Use Agreements .....	230
Creating the Limited Data Set .....	231
Responsibility for Data Use Agreements .....	232
When CMG is the Provider of the Data .....	232



When CMG is the Recipient of the Data .....	232
Tracking and Accounting .....	232
Accounting of Disclosures .....	234
Included in the Accounting .....	234
Not Included in the Accounting .....	237
Release of Information Under Permissive Disclosures .....	239
Disclosure to Families and Loved Ones .....	240
Disclosing Mental Health Information .....	241
With Consent .....	241
Without Consent .....	241
Mandatory Disclosures .....	244
HIV Consent and Reporting .....	245
Reportable Diseases .....	246
Responding to Law Enforcement .....	247
Response to Private Investigators .....	251
De-identification of Records .....	252
Expert Determination .....	252
Safe Harbor .....	253
Re-identification .....	254
Chart Review Protocol .....	255
Final Evaluation Types .....	255
Types of Consent .....	256
Sample Chart Review Protocol .....	257
<b>Financial Management .....</b>	<b>261</b>
Coding and Billing Standards .....	262
Claim Denials .....	264
Time of Service Payment Control .....	265

Internal Control Procedures .....	266
Petty Cash .....	267
Medicare Advance Beneficiary Notice of Non-Coverage .....	268
Mandatory Use of the ABN .....	268
Voluntary Use of the ABN .....	269
Charge Capture and Charge Entry .....	270
Claims Edits .....	271
Billing .....	272
Medicare Secondary Payer .....	272
Third-Party and Patient Bills (Uninsured Fee Schedule) .....	272
Billing Capitated Plans .....	275
Professional Courtesy .....	275
Patient Bankruptcy .....	276
Do Not Call the Patient .....	276
Chapter 7 Bankruptcy .....	276
Chapter 13 Bankruptcy .....	277
Medical Bills Owed by Deceased Patients .....	277
Using a Collection Agency .....	279
Internal Processes .....	279
Non-sufficient Funds .....	280
Write-Offs .....	281
Necessary or Approved Write-Offs .....	281
Unnecessary Write-offs .....	282
Guidelines for Managing Write-Offs .....	283
Overpayments and Refunds .....	283
Insurance Follow-Up .....	284
Posting Payments .....	285
Unapplied Payments .....	286
Purchasing and Inventory .....	287

Monitoring Supplies Inventory .....	287
Purchase Requests .....	287
Purchasing Controls .....	287
Receiving .....	288
Medicare Recovery Audit Contractor Program .....	288
Paying Invoices .....	288
Exam Room Supplies .....	289
Emergency Supply Kit .....	292
Office Budget Plan .....	293

# Introduction

This manual includes the policies and procedures for Cardiology Medical Group (CMG) and replaces all previous manuals and directives. This document will be maintained and updated by designated staff members.

If you have any feedback on the contents of this manual, please let designated staff members know, and he or she will take any necessary action.

# About Cardiology Medical Group

CMG opened on November 28, 2007 when the clinic was established.

CMG is located in San Diego, CA, and serves both metropolitan and rural areas. The area includes a culturally and age diverse population of about 3,000,000.

CMG includes six family physicians. The clinic hosts itinerant specialists and family practice residents and provides an urgent care clinic for the general public on evenings and weekends.

The office physicians estimate that almost 70% of the area's population is attached to their family practices, while their urgent care clinic serves the rest of the population for immediate care issues.

The area is also served by ABC Ambulance Services and several other services, including Home and Community Care based in Anytown, public health services, and an Environmental Health Officer.

# Changes to the Policies and Procedures

Our philosophy is one of continuous improvement, using the Plan – Do – Study – Act quality improvement process. We expect frequent changes to this manual as we continuously implement improvements in our policies and processes.

The physicians approve any changes to policy or procedures.

The designated staff members facilitate policy and procedure change requests, document changes, and update this manual.

Anyone may develop a policy or process for consideration by the physicians. Everyone should be looking out for and communicating improvements to the way we work.

# Cardiology Medical Group Values

Cardiology Medical Group is a group family medicine clinic based on the following ideals.

## **For everyone on the team:**

- Patient-centered focus for planning and care.
- Supportive, inclusive, multidisciplinary team approach to family medicine.
- Respect for all roles in the multidisciplinary team and tolerance of our differences.
- Open and clear communication among all team members.
- Recognition of and respect for all team members' private lives.
- Mindfulness in delivering efficient and cost-effective services.

## **For the physicians:**

- Shared on-call responsibilities.
- Cross-coverage of each other's practices when needed.
- Consensus decision-making based on a structured, consistent approach.
- Physicians as a resource to the larger community.
- Collaborative approach to teaching responsibilities of medical residents and students.
- Rotating community roles.
- Needs-based planning (services based on community needs and capacity, not previous activities or physician interests).

# Physicians

CMG has six physicians, including:

Joe Surfer, MD CCFP MHSc

- Joe graduated from the University of Calgary medical school in 2003 and completed family practice residency in Vancouver in 2005. He also obtained a Masters of Health Sciences in community medicine and epidemiology at UBC in 2010.
- Joe's practice interests include primary mental health care services and pediatric medicine.
- Joe is married with two small children. He enjoys an active lifestyle, including competing in marathons, kayaking, biking, and skiing.



## Physicians' Hours of Work

The physicians have a standard schedule that is the basis for CMG's hours. Physicians may choose to alter their hours at their own discretion, as long as the physician provides the other physicians and staff with as much notice as possible.

# Locum Arrangements

When the physicians are away from the clinic for holidays or other absences, they should arrange for a qualified physician (locum) to provide relief coverage.

Physicians establish locum arrangements under a private arrangement between themselves and the locum.

The process for setting up a locum arrangement is as follows:

1. CMG physician finds a locum physician to fill the vacancy.
2. The locum physician completes the Assignment of Payment Agreement.
3. The CMG physician pays the locum according to the Assignment of Payment Agreement.

# Staff

CMG employs five office assistants, as well as the following positions:

- **Business Manager:** Contacts and schedules staff and manages finances. For more information, see "[Business Manager Job Description](#)" on the next page.
- **Medical Office Assistant:** Coordinates patient care and performs administrative duties. For more information, see "[Office Assistant Job Description](#)" on page 21.

# Business Manager Job Description

## **Reports to:**

Physician responsible for human resources

## **Job purpose:**

Carries out several aspects of office administration, including:

- Manages finance, including payroll, bookkeeping, assisting the physicians in developing and maintaining a budget, financial reporting, banking, cash flow, etc.
- Serves as the main point of contact between the office staff and physicians for matters pertaining to pay, benefits, and hours worked, and makes human resource decisions in accordance with policies established by the physicians.
- Coordinates performance review process for office staff.
- Coordinates staff and physician recruitment, orientation, and training activities.
- Recommends, plans, and implements pay structure revisions.
- Ensures compliance with applicable human resource laws.
- Maintains employee human resource files.
- Develops, recommends approval, and maintains staff hours and vacation schedules.
- Provides advice to physicians on finance, human resources, and other administrative matters.
- Performs other related duties as required.

# Office Assistant Job Description

## **Reports to:**

Provider responsible for human resources

## **Job purpose:**

To support office physicians in clinic operations and delivering patient care. All work should be delivered to standards and procedures established in office and requested by physicians.

- Coordinates patient care through the clinic by checking in patients, prepping patients, escorting patients to exam rooms, and preparing exam or treatment rooms for the next patient.
- Answers inquiries by phone and in person in a helpful, respectful, and efficient manner.
- Operates fax machines.
- Maintains appointment schedule and manages recalls.
- Maintains electronic medical record, including the patient chart.
- Ensures exam rooms are stocked appropriately, and ensures that they are ready for the next patient.
- Ensures patient confidentiality.
- Cleans and sterilizes materials and instruments.
- Performs patient prep procedures, and documents findings on the patient record.
- Performs billing procedures for multiple payers, and applies and collects non-insured fees where applicable.
- Orders and receives office and medical supplies.
- Performs all other related clinical tasks, administrative tasks, or special tasks as required.

## **General skills and abilities:**

- Works well in a team environment.
- Exhibits good written and verbal communication skills.
- Demonstrates proficiency with a computer, including using the Internet, medical software, and Microsoft Office software.
- Performs tasks with speed and accuracy.
- Solves problems with ease.
- Shows good judgment.

# Immunization

Office offers all staff immunizations appropriate for their duties at no cost. This includes influenza and hepatitis B.

# Bonding of Employees

Precautionary measures are sometimes taken to ensure adequate protection of property, personnel, assets, etc. CMG may opt to bond certain employees with specific or sensitive responsibilities within the office.



## When the Physician is Away

When the physician is out of the office during normal office hours, coverage must be maintained. With approval, you may do one of the following:

- Work in the office.
- Take time off without pay.
- Take time off and use vacation.

# Continuing Education

Keeping up-to-date professionally is a benefit for you, the practice, and the patients. Your attendance at meetings, lectures, and training programs will be counted as hours worked, and wages will be paid when such sessions are conducted during your normal work schedule with the approval of the office manager.

Attendance will not be counted as hours worked when any of the following is true:

- You attend the training after normal work hours.
- The training is not directly related to your job.
- You do not obtain approval to attend during normal work hours.

# License Recertification

Technically certified office staff are responsible for maintaining valid licensing by attending the necessary number of continuing education courses required for recertification.

Staff members are required to attend such courses during non-scheduled hours and will receive no pay during such attendance.

CMG assumes no responsibility for staff members who become delinquent in the number of units needed for recertification and who lose their license as a result.

## Providing Advice without a License

Over time staff gain knowledge regarding certain standard medical advice given to patients. However, from a legal standpoint, when patients have a medical question, you must inform them that you will relay the question to the physician, and then get back to them with the answer. Non-licensed staff should never provide medical advice without consulting licensed staff.

# Dating Patients

Sometimes a patient wants to date a staff member, and sometimes a staff member wants to date a patient. Regardless of who initiates the interest, it could present problems for the office and could be considered unethical. This includes flirting in any fashion. CMG is here to provide a professional service to our patients.

In such a situation, it is the responsibility of the employee to discuss the situation with the physician and/or office manager to determine the most appropriate method for dealing with the situation.

# Manual Handling Techniques

Before you lift someone or something, ask yourself whether the job could be done in a different way. For example, can you:

- Get someone to help you.
- Use mechanical aids for lifting or trolleys.

Assess the weight of the load before you lift. Only carry loads you can handle with ease.

## **Prepare to lift:**

1. Stand close to the load with your feet spaced apart.
2. Bend at the knees, and keep your spine straight.
3. Grip the load firmly.

## **Lift:**

1. Tighten your stomach muscles.
2. Lift by straightening your legs.
3. Keep your back and neck in a straight line. Never bend from the waist.
4. Do not twist, move, or jerk suddenly.
5. Do not lift objects higher than your waist.

## **Move and carry:**

1. Make sure that your path is clear.
2. Keep the object close to your body.
3. Take short steps and move carefully.
4. Avoid sudden or jarring movements.

**Lower:**

1. Keep your back and neck in a straight line.
2. Tighten your stomach muscles.
3. Bend at the knees. Never bend from the waist.
4. Place the load firmly on the ground.

# Patient-Physician Relationship

The relationship between patients and physicians involves certain rights and responsibilities. It also entails complaints from patients and how to deal with them.



# Rights and Responsibilities

Patients must receive quality care that is professionally delivered in a manner that respects their rights.

## **Patients have a right to:**

- Receive information about services and physicians.
- Be treated with respect in recognition of their dignity and right to privacy. Never respond to patients with indifference. Always show warmth, caring, professionalism, efficiency, and competence.
- Participate with physicians in decision-making regarding their health care.
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about their care.
  - Positive comments made by the patients about the improvement of their health about the physician, other staff, or any aspect of the service that they are receiving should be relayed to the physician.
  - Negative comments should also be relayed to the physician, as the comment may be a signal about a misunderstanding or a problem that should be addressed. Route any comments directly to the physician via a note on the patient's folder. For more information, see ["Complaints" on page 35](#).
- Be represented by parents, guardians, family patients, or other conservators when the patients are unable to fully participate in their treatment decisions.
- Discuss potential treatment options without regard to plan coverage, side effects of treatment, and management of symptoms. Physicians must educate patients regarding their health needs

and share findings of history and physical examinations.

- Make the final determination of the course of action among clinically acceptable choices.

**Patients have the responsibility to:**

- Provide information that physicians need in order to care for them.
- Follow the plans and instructions for care that they have agreed to with their physicians.

**Physicians and staff have the responsibility to:**

- Provide services in a culturally competent/non-discriminatory manner to all patients, including those with limited English proficiency or reading skills and those with diverse cultural or ethnic backgrounds.
- Provide information that is readable, easily understood (at 8th grade level), consumer tested, and in the languages of the major population groups served. If 10% of the population speaks a language other than English, patient materials should be provided in that language.
- Make public declarations through such things as posters, patient handbooks, newsletters, and mission statements that provision of health services is not influenced by the patient's race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Provide patients with information needed to understand benefit coverage and obtain primary and specialty care.
- Provide patients, upon request, with information about prior authorization rules.
- Provide written information to the patient about how to voice a complaint.

# Complaints

CMG is committed to monitoring the effectiveness of the service we provide to our patients. All complaints need to be handled promptly and with a caring and polite attitude.

If a patient complains about the service provided by the office, record the following information and pass the information on to the Business Manager:

- Name of the patient
- Nature of the complaint, for example:
  - Telephone access to clinic
  - Appointment availability
  - Being made to wait too long
  - Clinic facilities
  - A complaint about a physician
- Whether the complaint was made in person, on the telephone, or in writing

Reassure the patient that the complaint will be taken seriously and passed on to the Business Manager.

All complaints will be reviewed by the Business Manager, and measures will be put in place to avoid a repeat occurrence of the situation.

# Facility Standards

The CMG facility must meet certain standards in order to best serve our patients.

# General Information

Following is some general information about facility standards:

- The medical office must be clearly identified on the exterior of the building. The office must be identified near the street entrance and at the front door entrance.
- Facilities must be accessible to the physically disabled. Parking, elevators, ramps, hallways, waiting rooms, examining rooms, and restrooms must be clean and clear of debris.
- Facilities must be readily accessible to the mentally disabled.
- A plan showing exits for evacuation during an emergency must be posted where it can be easily seen.
- Office hours must be clearly posted.
- At least two examination rooms must be available for each physician on duty.
- Fire extinguishers must be visible and conveniently located. The extinguishers must be tagged and inspected annually.
- Hallways, doorways, and exits must be free of any obstruction.
- Trash must be contained and properly stored.
- Prescription pads, needles, and syringes must not be stored in examination rooms or be accessible to patients.
- The on-site lab must be CLIA certified, or (if it meets requirements) have a certificate of waiver.

# Staff Room

The staff room is the responsibility of employees. Building cleaners clean floors and empty garbage and recycling daily. Cleanliness of the fridge, microwave, and cupboards is the responsibility of users of the staff room. It is expected that staff keep this space in acceptable order. If an employee wants to book the staff room for an event, it must be written on the staff room calendar.

Lockers are the responsibility of the employees to whom they are registered. If an employee leaves employment at CMG, he or she must clean out this space and leave the locker unlocked.

Showers are cleaned daily by cleaners. Employees who use showers must take their belongings with them when they are finished. No personal items should be left in the shower area.

# Smoking

To minimize any risk to health and safety, all forms of tobacco usage are prohibited inside the CMG premises. This includes enclosed walkways and stairwells.

# Checklists

## Start of day:

- ☐ Unlock doors.
- ☐ Disarm alarm.
- ☐ Allocate exam rooms to physicians.
- ☐ Turn music on.
- ☐ Start coffee maker.

## End of day:

- ☐ Check that all rooms are empty of patients.
- ☐ Check that exam rooms are stocked.
- ☐ Ensure all office staff and exam room desks are clean (no patient info, Rx pads, etc.).
- ☐ Pull charts for next day.
- ☐ Lock chart room.
- ☐ Lock storage area for narcotics.
- ☐ Turn off music.
- ☐ Confirm on-call physician with paging service.
- ☐ Set phones to "Night."
- ☐ Turn off lights.



- ☐ Set alarms.
- ☐ Lock all doors.

**Daily:**

- ☐ Check mail.
- ☐ Check vaccine supply.
- ☐ Empty “OUT” baskets in physicians’ offices (11 a.m., 4 p.m.).
- ☐ Call patients with appointment reminders.
- ☐ Create Medicare Secondary Payer (MSP) claims submission.

**Exam room prep:**

- ☐ Clear counters, sinks, beds, and floor.
- ☐ Check that the computer is logged off (so patients cannot access information while alone).
- ☐ Check that clean cloth gowns are available.
- ☐ Change paper on beds.
- ☐ Ensure tissue and hand towel supply is not empty.

**Weekly (Fridays):**

- ☐ Check emergency kits.
- ☐ Perform PAP recalls.

# Office Visits

This section describes guidelines and information for office visits at CMG.

# Appointment Scheduling Guidelines

The office maintains patient appointments based on patient clinical need, patient preference, clinical staff availability, and time requirements for the type of appointment.

The office provides clinical services by appointment 8 hours daily, 5 days a week. Office hours are posted on the front door and reviewed with patients during their office visit. All patients have access to a physician on-call 24-hours a day. In emergency situations, patients are referred to the nearest emergency room.

During the week (Monday through Friday), patients needing appointments after hours are referred to the on-call physician.

Office appointments should follow the guidelines shown below:

Type of Appointment/Definition	Guideline for Scheduling Appointment
<b>Annual Health Physical Examination:</b> Comprehensive annual examination and physical appropriate for age and gender of patient.	Available within 30 days. Annual physicals require a 30-minute appointment.
<b>Routine Care:</b> Patient visit for routine preventive care other than a comprehensive physical examination.	Available within 14 days. Routine appointments require a 15-minute appointment.
<b>Non-Urgent Examination:</b> Conditions requiring clinical examination for patient complaints, signs, and symptoms of illness, with no immediate threat to the patient.	Available within 2 days, depending on patient circumstance.
<b>Urgent Examination:</b> Conditions requiring medical intervention on the same day.	Available within the same day or within 4 hours.

Type of Appointment/Definition	Guideline for Scheduling Appointment
<b>Emergency Care/Situation:</b> Life-threatening or other conditions for which the patient needs to be seen immediately	Available immediately, or patient is referred to nearest emergency room.

## Appointment Reminders

Call patients to remind them of regularly scheduled appointments 2 business days prior to their appointment. When applicable, send an email or text reminder as well.

# Emergency and Priority Cases

The appointments system is designed to accommodate patients with urgent problems or those who need a longer consultation. It is the responsibility of reception staff to determine the priority of need and book appointments accordingly.

All reception staff must understand the clinic's procedures in relation to medical emergencies. For more information, see "[Transfer of Patient to Ambulance](#)" on page 70.

# Appointment Status Change

Document changes in a patient's appointment status as follows:

1. The receptionist notifies the nurse or physician regarding the change in a patient's appointment.
2. The designated employee documents the change in appointment status in the patient's chart as follows:
  - **No Show:** Patient does not arrive for scheduled appointment.
  - **Canceled:** Patient cancels appointment on the date of the scheduled appointment. If known, include a reason.
  - **Rescheduled:** Patient or physician changes the date of appointment. If known, include a reason.
  - **Canceled >24 hours:** Patient cancels appointment more than 24 hours before appointment but does not reschedule.
3. Staff notifies the physician of the patient's appointment change to allow the physician to determine if the visit is medically necessary. This determines the need for aggressive follow-up.
4. Staff must make two attempts to contact the patient on the telephone to reschedule and at least one attempt in writing.
  - Use the emergency contact number to contact the patient if necessary.
  - If the visit is for a medical-legal condition, send the letter certified, return receipt requested.

# Appointment Status Change and No-Show Policy

Office hours are posted on the front door and reviewed with patients during their office visit. All patients have access to a physician on-call 24 hours a day or, in emergency situations, referred to the nearest emergency room.

Effective patient scheduling is essential for patients to have access to clinical care, to ensure office productivity, and to support patient rights.

Careful management of patient access to the office is critical for quality and patient satisfaction. This includes the following steps:

1. Whenever possible, accommodate patient convenience and appointment preference.
2. While appointment scheduling should follow guidelines established by the practice, be flexible to support treating physicians' decisions regarding a patient's access to clinical services, appointments, and patient flow management.
3. Give surveys to other practices from time to time to see if there is a written policy or guidelines statement regarding appointment scheduling, and if the guidelines are followed in actual practice. Inquire regarding the practice's systems for handling missed and canceled appointments, and check for follow-up attempts in the medical records, if applicable.

# Appointments for Specialists or Consultant Physicians

For a patient to receive a Medicare benefit at the referred rate, a referral letter is required before seeing a specialist or a consultant physician. If a patient sees a specialist or a consultant physician without a referral, the refund paid to the patient by Medicare will be at a much lower “unreferred” rate.

**Note:** It is the responsibility of the receptionist to advise patients if they need a new referral.

Use the following for making appointments for specialists or consultant physicians:

- Each new patient should be referred either by their physician or by another specialist. Optometrists may refer to ophthalmologists, and dentists may also refer patients.
- A referral from a physician is valid for 12 months (unless otherwise specified).
- A referral from another specialist is valid for 3 months.
- If a patient makes an appointment for another consultation, check if the referral will still be current. If not, advise the patient to get a new referral from the physician.



# Checking In Patients

Upon arrival, patients are asked to check in at the front desk.

Two signs are posted at the front desk.

- Check In helps avoid “losing” patients in the waiting area during busy times.
- Saying “Please take a seat until it is your turn” helps provide patient confidentiality at the front desk.

Staff should avoid making or receiving phone calls at the front desk to ensure patient confidentiality.

Keep the waiting area tidy at all times.

# New Patient Registration

New patients must complete the following forms to provide information in order for the physician to provide proper care: Editable, printable forms can be accessed by clicking on each form below:

- [Patient Registration](#)
- [HIPAA Privacy Notice](#)
- [Patient History Form](#)

# Insurance Validation

When prospective patients call to make an appointment, take time to discuss payment and insurance coverage with them. Provide new patient paperwork prior to or at the first appointment. This paperwork should include a form designed specifically to collect insurance information, as well as a statement regarding payment responsibility. Explain the payment options we offer and require patients to verify who is responsible for their bill, aside from any insurance they have. You can direct patients to our website, where the forms can be accessed.

In order to confirm insurance eligibility, the insurance information form should ask for the following:

- Patient's name and date of birth.
- Name of the primary insured.
- Social security number of primary insured.
- Insurance carrier.
- Photo ID and ID number.
- Group number.
- Contact information for the insurance company, including phone number, website, and address for submitting claims.
- Any secondary insurance.

After obtaining the insurance information, contact the insurance company to verify the following information:

- Patient is covered by the insurance.
- Insurance coverage effective dates.

- In-network or out-of-network coverage.
- Services covered for the patient. Do they need pre-authorization and/or a referral by a primary care physician?
- Amount of copay for services, if any.
- Deductible amount. Has the deductible been met for the year?

When the patient arrives for the appointment, copy his or her photo ID and insurance card, and collect any applicable copay.

## **Returning Patients**

Keep returning patients' records up-to-date. Personal information such as address, contact information, and insurance coverage can change over time, so always have patients verify their personal information each time they visit the office. If a returning patient indicates a change in insurance, follow the procedure to verify the benefits prior to providing care.

# Patient Emergencies and Triage

We must ensure that a patient's needs are met in an emergency situation. Appropriate evaluation and management of patients in emergency situations are dealt with to optimize the patient's health and well-being. The medical office personnel will be trained in patient emergency procedures. It is recommended that all physicians and nurses maintain CPR certification. If emergency equipment is kept, it is also required that the equipment be kept current, complete, assessed, and documented on a regular basis.

When a potential medical emergency is recognized, do the following:

1. Notify the physician or nurse by calling for help. Two persons stay with the patient, if possible.
2. If possible, form a 3-4 member team with one person (usually the physician or RN) in charge, giving directions.
3. All other staff continue patient services as usual and maintain a calm attitude.
4. The physician or nurse in charge conducts a physical assessment of the patient and carries out essential medical procedures with the assistance of other designated staff.
5. A medical assistant moves available emergency equipment and supplies to the patient care area.
6. If patient care needs are beyond the scope of the physician's office, call 911. For more information, see ["Transfer of Patient to Ambulance" on page 70](#).
7. Route urgent patient conditions, such as elevated fever or pain, to the physician or nurse.

Review the patient's record and assess the patient's condition to determine:

- A need to see the physician and the timeframe recommended for the visit.
- A need for new medication or an adjustment to current medication.
- Immediate recommendations for the patient's next steps.
- The severity of the patient's condition.

- The need for behavior modification, such as limitations on physical activity.
- The time interval for follow-up and next communication.

# Calling Patients from the Waiting Room

To provide a positive experience calling the patient from the waiting room to the exam room, do the following:

1. To identify patients in the waiting area, the receptionist puts a sticky note on the front of the chart using some sort of identifying comment to identify the patient (e.g., “red sweater or blue coat”). This allows you to walk directly to patients and let them know you are ready to take them back to the exam room.
2. To assure you can be seen, walk out into the waiting area as close to patients as possible to call them back.
3. Smile and greet the patient warmly.
4. Address the patient formally by Mr., Mrs., or Ms. This is not a privacy violation.
5. Direct the patient to the assigned room (e.g., “third door on the right” or “room 6”).
6. Assist older patients or patients who have limitations or obvious injuries back to the room by taking their coats or other personal items.
7. Do not ask any medical questions in the hall where answers can be overheard by others.
8. Do not weigh people in the hall unless the scales are set up for privacy. Take into consideration how coats, purses, and other extra clothing get in the way of an accurate weight.
9. Take blood pressure in the exam room only.
10. After the patient is in the room, close the door and keep him or her apprised of their waiting time.
11. Keep conversations in the hall to a minimum, so patients do not overhear private or inappropriate information.

# Office Encounter Forms

An Office Encounter form is divided into four different parts, including information about the patient, services, modifiers, and a summary. Record complete information about the patient in this form, including the patient's ID number, address, city and state, social security number, date of birth, age, and contact number. Payment method is also listed in detail, including the primary ID number, primary group number, secondary ID number, secondary group number, and cash, credit card, or other billing information. Detailed visit information is also mentioned in this form, including the date of visit, visit number, rendering physician, referring physician, and reason for visit.

Following is an example of an Office Encounter form:



[Company Name] YOUR LOGO HERE

### Outpatient Encounter Form

Patient Information		Payment Method		Visit Information	
Patient ID number		Primary		Visit date	
Patient name		Primary ID number		Visit number	
Address		Primary group number		Rendering physician	
City/State		Secondary		Referring physician	
Social Security number		Secondary ID number		Reason for visit	
Phone number		Secondary group no.			
Date of birth		Cash/credit card			
Age		Other billing			

E/M Modifiers		Procedure Modifiers		Other Modifiers	
24 — Unrelated E/M service during postop.		22 — Unusual, excessive procedure			
26 — Significant, separately identifiable E/M		60 — Bilateral procedure			
57 — Decision for surgery		61 — Multiple surgical procedures in same day			
		62 — Reduced/incomplete procedure			
		65 — Postop. management only			
		69 — Distinct multiple procedures			

CATEGORY	CODE	MOD	FEE	CATEGORY	CODE	MOD	FEE
Office Visit — New Patient				Wound Care			
Minimal office visit	99201			Debride partial thick burn	11040		
20 minutes	99202			Debride full thickness burn	11041		
30 minutes	99203			Debride wound, not a burn	11000		
45 minutes	99204			Unna boot application	29580		
60 minutes	99205			Unna boot removal	29700		
Other				Other			
Office Visit — Established				Supplies			
Minimal office visit	99211			Ace bandage, 2"	A6448		
10 minutes	99212			Ace bandage, 3"-4"	A6449		
15 minutes	99213			Ace bandage, 6"	A6450		
25 minutes	99214			Cast, fiberglass	A4590		
40 minutes	99215			Coban wrap	A6454		
Other				Foley catheter	A4338		
General Procedures				Immobilizer			
Anoscopy	46600			Kerlix roll	A6220		
Audiometry	92551			Oxygen mask/cannula	A4620		
Breast aspiration	19000			Sleeve, elbow	E0191		
Ceumem removal	69210			Sling	A4565		
Circumcision	54150			Splint, ready-made	A4570		
DDST	96110			Splint, wrist	S8451		
Flex sigmoidoscopy	46330			Steele packing	A6407		
Flex sig. w/ biopsy	46331			Surgical tray	A4550		
Foreign body removal—foot	28190			Other			
Nail removal	11730			OB Care			
Nail removal/phenol	11750			Routine OB care	59400		
Trigger point injection	20552			OB call	59422		
Tympanometry	92567			Ante partum 4-6 visits	59425		
Visual acuity	99173			Ante partum 7 or more visits	59426		
Other				Other			

Vitals:		Other Visit Information:		Fees:	
B/P		Lab Work to Order:		Total Charges:	\$
Pulse		Referral to:		Copy Received:	\$
Temp.		Provider Signature:		Other Payment:	\$
Height		Next Appointment:		Total Due:	\$
Weight					

Company Name, Street Address, City, State ZIP Code, phone number

# Payment Methods

We accept payment by cash, credit card, or check in certain circumstances (see below). When a payment is made, a receipt should be issued from the computer and given to the customer.

## Payment by Credit Card

1. Process the credit card payment using the credit card machine.
2. When the patient has signed the receipt, separate the original and the patient's copy.
3. Enter the payment details into the computer.
4. Staple the patient's copy of the credit receipt to the patient's receipt from the computer.
5. Store the originals from credit card payments in the appropriate box below the reception desk.  
Bundle the receipts at the end of each day, and store them in the file storeroom, clearly labeled with the day's date.

## Payment by Check

1. If first-time patients want to pay by check, ask for some means of identification, such as a driver's license or Medicare card.
2. Record the type of identification and the number (license number or Medicare number) on the back of the check.

## **Payment by Cash**

The clinic keeps a small amount of cash on the premises to give change to customers who pay cash. Towards the end of each day, deposit cash amounts of more than \$100.00 in the bank.

# Health Services Information

CMG can provide patients with a range of written information on common and serious medical conditions and self-help groups. The clinic also works with a range of health and community services and allied health professionals to improve individual patient care.

Reception staff are responsible for maintaining stocks of brochures and leaflets in the information displays in patient waiting rooms, reception, and consulting rooms.

# Telephone Evaluation

The telephone is typically the first point of access by the patient to the practice. It is important that all staff, employees, and temporary personnel are aware of how telephone calls are handled during and after office hours. This includes the following steps:

1. The office telephone answering machine is turned on whenever staff members do not directly answer calls. Routine times for using the answering machine may include midday lunch hour, after office hours, and weekends.
2. The answering machine message informs callers to immediately dial 555-555-5555, the number for the office on-call group. The answering service has immediate access to the office on-call group/physician.
3. The message/answering service provides information regarding normal office hours for access to staff and patient appointments.
4. The message invites callers to leave a message after the tone. The answering service records all caller messages.
5. Physicians and clinical staff who see patients are available by pager when on duty but away from the office. Staff pages the physician and leaves a text message when appropriate.
6. Telephone calls with medical emergencies, such as chest pain, anaphylactic shock, heavy bleeding, or fainting, are routed to the physician immediately. If no physician is available, the next qualified staff member instructs the patient to go the emergency room.
7. Physicians may choose to discuss clinical care with a patient by telephone in situations where a face-to-face consultation is considered unnecessary and it is safe to do so. Physicians should make time available (at their convenience) to take or return patient calls. Physicians should advise reception staff accordingly. Reception staff should advise patients of the times physicians are available to take calls and take messages where appropriate.

# No-Show Policy

CMG tracks patients who fail to appear for their appointments and fail to call or are extremely late for continuity of care. This includes the following steps:

A “no-show” patient is one who:

- Cancels an appointment without rescheduling.
- Does not appear for an appointment.

All no-shows will have the progress note in their medical record stamped with a “No-Show” stamp by a front office appointment staff person by the end of the business day.

All no-shows will be contacted by phone, letter, or postcard to encourage prompt rescheduling of the appointment.

**Note:** Under no circumstances will a patient be penalized for a no-show when the physician reschedules the appointment.

Depending on the nature of the appointment (e.g., post-operative care or essential treatment follow-up), office staff can attempt to reschedule the appointment. Document attempts to reschedule in the patient’s medical record.

# Noncompliant Patients

In case of a noncompliant patient:

1. Determine the reason for noncompliance.
2. Do one of the following:
  - If noncompliance is due to financial reasons, provide free samples when possible and refer to programs that can help provide medication.
  - If noncompliance is due to not wanting to make an effort, counsel the patient to make sure he or she understands the importance of following the treatment as prescribed and the consequences for not doing so.
  - If noncompliance is due to forgetfulness, encourage the patient to take advantage of automated reminders and buddy programs to keep on track.
3. Discharge a patient only as a last resort only after repeated attempts to find out why the patient is disruptive or won't comply with your advice.

**Note:** It is important to end the physician-patient relationship carefully to avoid getting sued for abandonment or discrimination. Consult your liability insurer for the protocols and sample letters you can use to reduce risk for a lawsuit when you discharge a patient.

# Terminating the Physician-Patient Relationship

While a last resort, termination of a patient is sometimes required. Termination must be done carefully in order to avoid worsening a patient's physical condition and to avoid lawsuits.

The following is a partial list of situations in which termination is appropriate and acceptable:

- **Treatment nonadherence:** The patient does not or will not follow the treatment plan.
- **Follow-up nonadherence:** The patient repeatedly cancels follow-up visits or is a no-show.
- **Office policy nonadherence:** The patient uses weekend on-call physicians or multiple physicians to obtain refill prescriptions when office policy specifies a certain number of refills between visits.
- **Verbal abuse:** The patient or a family member is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel or other patients with threats of violent actions.
- **Nonpayment:** The patient owes a backlog of bills and has declined to work with the office to establish a payment plan.

The following circumstances require additional steps or a delay of the termination:

- If the patient is in an acute phase of treatment, termination must be delayed until the acute phase has passed. For example, if the patient is in the immediate postoperative stage or is in the process of medical workup for diagnosis, it is not recommended to end the relationship.
- If the physician is the only source of medical or dental care within a reasonable driving distance, he or she may need to continue care until other arrangements can be made.



- When the physician is the only source of a particular type of specialized medical or dental care, he or she is obliged to continue this care until the patient can be safely transferred to another physician who is able to provide treatment and follow-up.
- If the patient is a member of a prepaid health plan, the patient cannot be discharged until the physician has communicated with the third-party payer to request a transfer of the patient to another physician.
- A patient may not be terminated solely because he or she is diagnosed with AIDS/HIV or for any reason if the patient is in a protected class.
- If a patient is pregnant, termination can be safely accomplished during the first trimester with uncomplicated pregnancies and with adequate time for the patient to find another physician. Termination in the second trimester should occur only for uncomplicated pregnancies and with transfer of the patient to another obstetrical physician prior to actual cessation of services. Termination during the last trimester should occur only under extreme circumstances, such as illness of the physician.
- The presence of a patient's disability cannot be the reason for termination unless the patient requires care or treatment for the particular disability that is outside the expertise of the physician. Transferring care to a specialist who provides the particular care is a better approach.

Physician or dental groups with more than one physician may want to consider terminating a patient from the entire practice. This will avoid the possibility of the patient being treated by the terminating physician during an on-call situation.

### **To terminate the physician-patient relationship:**

1. Put the patient on written notice that he or she must find another physician. The notice should include:
  - **Reason for termination:** A specific reason for termination is not required. Under certain circumstances, it is acceptable to use the phrase "inability to achieve or maintain rapport" or to state "The therapeutic physician-patient relationship no longer exists."

- **Effective date:** The effective date of termination should provide the patient with a reasonable time period to establish a relationship with another physician. Usually, 30 days from the date of the letter is considered adequate, but be sure to follow state regulations. The relationship can be terminated immediately under the following circumstances:
  - The patient has terminated the relationship.
  - The patient or a family member has threatened the physician or staff with violence or has exhibited threatening behavior.
- **Interim care provisions:** Offer interim care. However, true emergency situations should be referred to an emergency department.
- **Continued care provisions:** Offer suggestions for continued care through local referral services such as medical or dental societies, nearby hospital medical staffs, or community resources. Do not recommend another physician by name.
- **Request for medical or dental record copies:** In your written notice, offer to provide a copy of the medical or dental record to the new physician by enclosing an authorization document, which must be returned to the office with the patient's signature. One exception to this element is the psychiatric record, which may be offered as a summary in lieu of the full copy of the medical record.
- **Patient responsibility:** Remind the patient that follow-up and continued medical or dental care are now the patient's responsibility and that both should be pursued.
- **Medication refills:** Explain that medications and refills will only be provided up to the effective date of termination.

2. Mail the written notice to the patient by regular and certified mail, return receipt requested.

3. Keep copies of the letter, the original certified mail receipt, and the original certified mail return receipt (even if the patient refuses to sign for the certified letter) in the patient's medical record.

For questions, contact your local medical association or liability insurance provider.

# Emergency Plan Procedures

Specific plans and procedures have been implemented in case of emergencies.

# General Emergency, Disaster, and Safety Procedures

All staff members are trained on the following procedures. In case of an office emergency or disaster, staff members will immediately:

- Assess the type and extent of emergency, if possible.
- Ensure that all staff, patients, and visitors are evacuated to a safe place using emergency exits.
- Ensure personal safety.
- Call 911/other number, and report disaster.

Office staff must:

- Know how to use communications equipment such as telephone, public address (PA) system, pagers, and fire and duress alarms.
- Know the location of emergency equipment.
- Know the location of physicians on duty.
- Keep emergency telephone numbers on hand.

# Emergency Plans

Following are the primary emergency plans.

## Evacuation

All employees should be familiar with the disaster plans to assist in a safe evacuation of the building. This includes the following steps:

1. Post an evacuation plan that is accessible to patients and employees.
2. In the event of evacuation, all employees, including physicians, assist in the safe evacuation of patients.
3. Evacuate ambulatory patients as follows:
  - Direct patients, staff, and any other individuals to evacuate away from the danger area.
  - Do not use elevators.
  - Back office staff supervises the evacuation of the exam rooms.
  - Front office staff supervises the evacuation of the reception area.
  - Calmly instruct individuals to collect their belongings and follow you to the nearest exit.
4. The Office Lead acts as the designated person to instruct all employees during the evacuation and of the steps necessary after the evacuation has been completed.
  - All employees should locate the Office Lead for their office/suite for further instructions.
  - The Office Lead takes a count of employees to ensure that everyone has evacuated safely. In buildings where more than one office is occupied by the company, each Office Lead will be responsible for his or her individual suite.
5. When deemed safe, the Office Lead instructs employees in pairs to re- enter the building to perform the following tasks:

- Unplug all machinery and lock all cabinets containing medication.
  - Turn off gas, water, and electricity to the building.
  - Survey the damage, and look for any individuals who may not have evacuated.
  - Retrieve the emergency drug box to provide emergency care for any individuals in need.
6. The Office Lead designates a person to call the Practice Management Director or Operations Manager.
  7. No front office or back office staff leave the parking area unless instructed to do so by the Office Lead, Practice Management Director, or Operations Manager.
  8. All physicians are required to remain in the parking lot until dismissed by the Practice Management Director or Operations Manager.

## **Transfer of Patient to Ambulance**

Following are the procedures for transferring a patient to an ambulance.

### **Staff Roles and Responsibilities**

You must first assign staff roles and responsibilities. CMG uses all staff members effectively and has a proactive team approach. The approach reinforces the important role that each staff member plays in emergency preparedness, and it stresses that appropriate preparation can potentially improve a patient's outcome.

Use the size of the practice and the staff members' skills and training to shape specific roles and responsibilities. Each individual must be well-versed in the office's emergency response plan, understand his or her duties, and know the appropriate steps to follow during a medical emergency.

Examples of roles include:

- Who will notify the physician of the medical emergency and direct him or her to where the patient is located (if the physician is not with the patient when the emergency occurs)?
- Who will take the lead in providing emergency care to the patient?
- Who will assist the team leader in bringing the emergency supplies and helping administer care?
- Who will call 911 (or another emergency service)?
- Who will meet the emergency responders when they arrive and direct them to the patient?
- Who will document the course of events?
- Who will direct the flow of patients while other staff members are responding to the emergency?

Specific responsibilities during a medical emergency are delegated based on job positions, rather than to specific individuals. This helps prevent gaps in responsibility if a staff member is out of the office. The individual who is covering the position needs to be notified of the duties that he or she will be expected to perform. If he or she does not have the appropriate training or skills, the responsibilities should be reassigned to an appropriate staff member.

Additionally, emergency response accountabilities are included in written job descriptions for relevant positions. Each position's assignments are reviewed at least annually to ensure that the office's emergency response plan is thorough and complete. Competencies for each staff position include skills that will likely be required for responding to emergency situations.

### **Staff Training**

All CMG staff should obtain certification in basic life support (BLS).

Depending on the nature of the practice and the patient population, the office may provide training in advanced cardiac life support (ACLS) and/or pediatric advanced life support (PALS). Any training or certification related to BLS, ACLS, or PALS is documented in staff members' personnel files.

Staff training also involves conducting routine emergency drills. These drills verify knowledge of emergency techniques, protocols, and usage of emergency response equipment and supplies. Drills should also be used to evaluate the team's ability to effectively provide emergency care at a moment's notice.

Continuing education (CE) also offers opportunities to learn more about emergency medicine and response. CE courses may be available through medical and dental schools, local hospitals, medical and dental societies, and other organizations, such as the American Heart Association (AHA) and the American Red Cross.

### **Emergency Supplies and Equipment**

Medical and dental professional organizations and emergency preparedness literature generally recommend that office practices maintain at least basic emergency supplies and equipment. Beyond that, the breadth and contents of each office's emergency kit largely depends on:

- The type of practice
- The patient population
- The procedures/therapies performed
- Anticipated emergencies or level of risk
- Geographic location
- Physician and staff training and skills
- State requirements



The most important consideration when purchasing or assembling an emergency kit is ensuring that office physicians and staff members have the knowledge and training to administer the emergency medications and use the emergency equipment. For medical and legal reasons, no office should stock equipment that cannot be used safely by office staff.

Emergency supplies and equipment are stored in a designated location that is cool, dry, and accessible at all times. Emergency kits are labeled and easy to transport. This allows staff to quickly transfer equipment and supplies to the person requiring assistance.

An assigned staff member routinely inventories all emergency medications, checks expiration dates, and restocks medications as appropriate. The staff member uses a checklist to facilitate thorough documentation of the results of these inspections.

Likewise, emergency equipment should be routinely inventoried and tested to verify that it is functioning properly. You should test critical equipment, such as lifesaving and emergency equipment, at least twice a year. The practice also should maintain equipment logs to document all inspections, testing, preventive maintenance, and repairs for emergency equipment (as well as other types of equipment).

### **Communication within the Office and with Emergency Services**

While the medical response is occurring, various communication activities take place, including calling for emergency help, directing staff, obtaining information from family members or caregivers and providing them with updates (if applicable), calling the hospital emergency department to alert it of the situation, and documenting the sequence of events as they take place.

The first step in managing a medical crisis in the office is a prompt call for emergency medical services. In addition to 911, other phone numbers, such as the local hospital's number, should be posted in a visible location to help facilitate the response process. If the caller has to dial a prefix to activate an outside line, that information also should be noted. The list of emergency numbers should be checked periodically for accuracy.

When calling for emergency help, the caller provides certain essential information, such as:

- The patient's age and gender.
- A preliminary diagnosis, such as a possible stroke.
- Symptoms and vital signs, such as whether the patient is conscious and his or her blood pressure reading.
- Details about any emergency treatment the patient is receiving, such as BLS, oxygen, and/or medication.
- The practice's phone number and address, including important identifying information about the office location, such as names of crossroads, proximity to landmarks, specific locations within a building, etc.

Assign a staff member to meet emergency responders as they arrive and direct them to the patient's location.

## **Earthquake**

All employees should be familiar with the disaster plans and safety procedures to assist in the event of an earthquake. This includes the following steps:

1. Remain calm at all times, and reassure others to remain calm.
2. Immediately instruct patients and any other individuals in the room to find protection under something structurally sound (desk, sturdy fixture) or braced in a doorway. If you are unable to locate a safe place, use items such as cushions, mattresses, or chairs for protection. Remain in that location/position until the earthquake/shaking stops.
3. Do not allow staff and patients to leave the building during the earthquake.
4. Stay away from windows.

5. If the earthquake appears to be minor (no damage noted and all systems still functioning), continue working.
6. If the earthquake appears to be major (damage noted and systems are not operational), evacuate the building through the main entrance into the parking lot in accordance with the evacuation policy.
7. In the event that a patient or employee is injured and is not trapped, do not attempt to move the individual alone. Call for assistance from another adult.
8. In the event that a patient or employee is injured and is trapped, do not attempt to move the individual if the earthquake is still shaking. Wait for the earthquake to end. Call for assistance from another adult. Any attempts made to free the individual should not increase risk to others.
9. If a trapped individual is unable to be freed, immediately evacuate the building and notify emergency services (911). Stay outside the building until the emergency personnel have arrived to assist in locating and extracting the trapped individual.
10. Do not re-enter a damaged building unless instructed to do so by emergency personnel.

**Note:** Earthquakes are usually followed by a series of smaller, yet potentially dangerous aftershocks. Continue to follow the procedures above to prevent possible injury.

## **Fire (Code Red)**

All employees should be familiar with the disaster plans to assist in a safe evacuation in the event of a fire. This includes the following steps:

1. If a fire occurs in your area, quickly evacuate all individuals who are in immediate danger. All office exits are marked and illuminated. Building exits are also marked and illuminated.
2. Keep all corridors clear of any equipment, supplies, or debris.
3. Ensure fire exits are never obstructed or blocked.
4. Close the door to prevent the fire from spreading.

5. If the fire is minor, do the following:

- Use the fire extinguisher to put it out. Minor fires are defined as fires that are localized to a small corner or table, and do not present an immediate danger of spreading. The fire extinguisher can be used to put out fires associated with paper, drapes, computer equipment, wiring, wood, oil, paint, gasoline, and solvents. Do not attempt to extinguish a fire that is moving and/or growing.
- Once the fire is successfully extinguished, the Office Lead contacts the Fire Department to notify it of the incident.

6. If the fire is moving or spreading rapidly, do the following:

- The person finding the fire is responsible for assigning an individual to notify the staff of the fire and to call the Fire Department and/or activate the nearest fire alarm.
- If it is possible to do so safely, remove oxygen containers.
- All individuals evacuate the building through the main entrance into the parking lot in accordance with the evacuation policy. Employees assist any non-ambulatory or elderly patients upon evacuation. Do not use the elevators for evacuation. Non-ambulatory or elderly patients should be assisted in the stairwell by employees.
- Upon evacuation, the front desk staff position themselves outside all entrances into the building to prevent anyone from entering.
- The Office Lead takes a formal count of all personnel to determine if all employees have evacuated.
- Do not re-enter the building under any circumstances, unless cleared to do so by the Fire Department.

### **Prevention Reminders**

- Electrical cords and plugs should be routinely checked for fraying.
- Turn off all electrical equipment, such as the coffee pot, before leaving for the day.

## Fire Safety Policy

The fire safety policy of this office is to act in a manner to preserve lives and prevent panic and the spread of fire. All employees must be aware of and receive training regarding:

- Proper fire safety procedures.
- Fire exits.
- Fire extinguishers (and sprinkler system).
- Fire zones and applicable space requirements.
- Staff member requirements and responsibilities.
- Steps to take in the event of fire.
- Containment of fire and smoke.

Staff members are not expected to take any actions that may endanger their life. To ensure the safety of patients and staff, the office maintains the following requirements:

1. All employees participate in an annual fire extinguisher training class.
2. A record of individual training is to be maintained in the personnel files.
3. Fire drills are conducted by building management at least twice a year. Both morning and after-noon shifts participate in fire drills to:
  - Maintain sufficient exposure to procedures for responding to fire, including office and building exits.
  - Practice to avoid panic under emergency circumstances.
  - Complete fire safety education training.
4. The office conducts or arranges for appropriate in-service training of office personnel on fire safety and prevention topics.

## **Fire Extinguishers/Sprinkler System Policy**

The office/building maintains fire extinguishers and a sprinkler system to use in case of fire. All extinguishers are inspected on a routine basis to ensure good working condition. The office conducts or arranges for an annual training session regarding the location and use of fire extinguishers.

## **Fire Prevention Policy**

The office maintains and trains all employees in basic office fire prevention procedures, including the following:

- All office exits are marked and illuminated. Building exits are also marked and illuminated.
- All corridors must be kept clear from equipment and supplies.
- Fire exits must not be obstructed or blocked at any time.
- Electric cords and plugs must be routinely checked for fraying.
- All machines in the staff lounge, such as coffee machines, are turned off at the end of the day.

## **Power Outage**

All employees should be familiar with the disaster plans and safety procedures to assist in the event of a power outage. This includes the following steps:

1. In the event that the building loses power for more than five minutes, the Office Lead and/or Switchboard Operator checks the circuit breaker.
2. If the power is restored by tripping the breaker, the Office Lead records the time and date of the power outage, as well as any additional action that was needed in restoring power. Patient care should continue as scheduled unless otherwise informed by the Office Lead.
3. If the power is not restored by tripping the breaker, the Office Lead and/or Switchboard Operator notifies all employees to continue patient care as regularly as possible. Instruct patients to safely leave the building via the stairway, if able.

4. The Switchboard Operator calls PG&E (Pacific Gas and Electric) to determine the possible cause and length of the power outage. In the event that PG&E is unaware of the power outage, lock the office doors, and post a sign requesting patients knock for assistance.

## **Bomb Threat (Code Purple)**

All employees should be familiar with the disaster plans and safety procedures to assist in the event of a bomb threat. This includes the following steps:

1. When a threatening phone call has been received, document the call in detail, including the time received and gender of the caller. Be attentive to any distinguishing background noises or characteristics of the caller's voice. Take note of the phone line the call came in on. For more information, see ["Bomb Threat Checklist" below](#).
2. Do not hang up. Leave the phone off the hook.
3. The Office Lead notifies the Police Department immediately.
4. The Office Lead informs the staff of the threat and asks each person to search his or her area for suspicious looking objects. An employee designated by the Office Lead searches other areas such as restrooms, utility closets, and stairwells.
5. If a suspicious object is discovered, you should seal off the area and notify the Office Lead.
6. All steps should be taken to continue with regularly scheduled patient care, unless instructed differently by the Office Lead or Law Enforcement.
7. If determined unsafe by the Office Lead or the Police Department, evacuate the building through the main entrance into the parking lot in accordance with the evacuation plan.
8. Complete the Bomb Threat Checklist as soon as possible.

### **Bomb Threat Checklist**

**Note:** Do not hang up after the call.

Questions to Ask	Caller's Voice
When is the bomb going to explode?	Male/Female
Where is the bomb?	Estimate age:
What does the bomb look like?	Accent:
Why was the bomb placed?	Speech impediment?
What will make the bomb explode?	Voice loud/soft?
What is your name?	Diction clear/muffled?
What is your address?	Manner calm/emotional?
Call taken  Date:  Time:  Duration:  Number called:  Received by:  Was caller familiar with details of the premises? Yes/No	Did you recognize the voice? Yes/No  If yes, who do you think it was?
	Threat language:  Well-spoken  Abusive  Incoherent



Questions to Ask	Caller's Voice
	Irrational Message read by caller Message taped Other:
	Background noises: Street noises: Domestic noises: Aircraft noises: Machinery: Unusual noises:

## Cardiac Arrest/Medical Emergency (Code Blue)

All staff at CMG must have first-aid training to assist them in dealing with medical emergencies. This training includes CPR and the operation of emergency resuscitation equipment.

If a patient or visitor presents to you in an injured or distressed state or collapses in front of you, do the following:

1. Remain calm, and give your undivided attention to the patient.
2. Place the patient in a comfortable position. If possible, move him or her to the medical emergency room.
3. Observe the patient's condition carefully, and rapidly assess the severity of the situation.

4. If the situation appears life threatening, announce “Code Blue” over the PA system.
5. If a physician is unavailable, call 911 for an ambulance. For more information, see ["Transfer of Patient to Ambulance" on page 70](#).
6. Give appropriate first aid until medical assistance arrives.
7. Keep uninvolved personnel away.

## **Flood or Water Leak Emergency (Code Yellow)**

All employees should be familiar with the disaster plans and safety procedures to assist in the event of a flood or water leak. This includes the following steps:

1. Isolate the source of the leak.
2. Render assistance to personnel if safe to do so.
3. Do not enter flooded areas.
4. Notify Office Lead on site.
5. If necessary, you or Office Lead calls 911.
6. If necessary, evacuate the facility.
7. Assemble at the evacuation assembly area (refer to the emergency evacuation diagram.).
8. Upon evacuation, the front desk staff position themselves outside of all entrances into the building to prevent anyone from entering.
9. The Office Lead takes a formal count of all personnel to determine if all employees have evacuated.
10. Do not re-enter the building under any circumstances, unless cleared to do so by the Fire Department.

## **Gaseous Leak or Gas Explosion Nearby (Code Yellow)**

All employees should be familiar with the disaster plans and safety procedures to assist in the event of a gaseous leak or gas explosion. This includes the following steps:

1. Activate nearest fire alarm, and call 911.
2. If possible to do safely, isolate the gas source.
3. If possible to do safely, turn off electricity.
4. Notify Office Lead on site.
5. Office Lead or fire department checks that all rooms have been evacuated.
6. Evacuate through the safest door. Under no circumstances should staff return to office area for files or personal belongings.
7. Assemble at the evacuation assembly area (refer to the emergency evacuation diagram.).
8. The Office Lead takes a formal count of all personnel to determine if all employees have evacuated.
9. Do not re-enter the building under any circumstances, unless cleared to do so by the Fire Department.

## **Hold Up or Violent Person (Code Black)**

This emergency type includes a person under the influence of alcohol or drugs, someone causing property damage (inside or out), an aggressive person, or any threat of an extreme nature.

If a person approaches you or other staff members in a persistent manner, listen to his or her concerns, speak with, and try to assist him or her.

When you are confronted with aggressive or agitated behavior:

1. Try to remain calm.
2. Seek help from other staff.
3. Do not attempt to resolve the situation.

If faced with a hold up, a violent person, or any threat of an extreme nature, do the following:

1. Announce a Code Black over the PA (if possible).
2. Activate the duress alarm.
3. Do a group call to staff on the emergency pager, or contact the most senior person on site.
4. If possible, call 911.
5. Do nothing to provoke or confront the intruder.
6. Observe the offender's appearance (height, weight, age, clothing, speech, disabilities, etc.).
7. Warn other staff and patients unobtrusively.
8. If possible, move the situation away from staff and patients.
9. Be reasonably slow in handing over keys, money, or information, but consider your safety.

# Consent Policies

This section discusses consent policies at CMG.

# Consent Policies (with or without Representative) and Minor

If a patient lacks the capacity (the ability to understand the nature and consequences of the proposed treatment), the patient's representative has the right to give informed consent or refusal on the patient's behalf. This includes the following steps:

1. A court determines the patient's incapacity per Probate Code 810-814.

Incapacity determination may be made by the patient's physician unless the physician's determination is disputed by the patient or the patient's representative. If incapacity is determined by the physician, that determination and its proponents must be documented in the patient's medical record.

A patient's representative may be a person designated under the Durable Power of Attorney, a conservator specifically authorized by a court to make health care decisions pursuant to Probate Code 1800 and 3200 et seq., a next of kin, any other appropriate surrogate designated consistent with statutory and case law, or if the patient is a minor, someone lawfully authorized to represent the minor.

2. Complete Informed Consent Forms, which must include the following:
  - Authorization for a specified physician and the physician's assistants to perform a specified medical procedure (described in both medical and lay terms).
  - General description of procedure's risks that may occur in connection with the procedures, a list of risks specific to the procedure, and a disclaimer statement regarding inability to list all possible undesirable effects and procedures which may or may not improve patient's condition.
  - Alternative methods of treatment, their risks and benefits, and why the physician recommends the specified procedure.

- Anticipated benefits of the specified procedure with a disclaimer regarding guarantees or assurances.
  - Encouragement to the patient and representative to ask questions concerning the procedure. Answer each question fully.
  - The patient's name, or legal representative, a place for his or her signature, and the relationship of the representative.
  - Statement that the patient has had an opportunity to obtain a second opinion.
3. Advise the patient that unforeseen circumstances may arise which may make it necessary or advisable, during the course of the procedure, to perform different or additional procedures. The patient must consent, in writing, to the performance of these procedures.
  4. Document whether the patient has received and reviewed additional material concerning the procedure, such as pamphlets, audiotapes, videotapes, slide presentations, and lectures.
  5. Encourage the patient or representative to ask questions.
  6. Comply with specific procedures. Compliance with California statutes is required in the case of assisted reproduction, blood testing in pregnancy, HIV testing, genetic testing, blood transfusions, breast cancer, treatment of patients with Dimethyl Sulfoxide (DMSO), hysterectomy, prostate cancer, silicone implants/collagen injections, research, sterilization, immunizations, electro-convulsive therapy, psychosurgery, psychotherapeutic drugs and physical restraints, human experimentation, and investigational use of drugs and devices.
    - **Assisted reproduction:** The patient must provide written consent before a physician removes sperm or ova from a patient that will not be reimplanted in the same patient or implanted in the patient's spouse. The consent must meet the following criteria:
      - Be in writing and contain the statement "I, [name of donor] do hereby donate [type and number, if applicable,] of sperm or ova to [name of clinic or recipient] for [specify purpose]."

- Contain a statement by the donor that provides for the disposition of any unused donated material.
  - Be signed by the patient and the physician who removes the sperm or ova.
  - Contain a notification that this is an important document that should be retained with other vital records.
  - If the procedure takes place in the hospital, the physician must provide a copy of the consent to the hospital. A violation of the assisted reproduction consent procedure constitutes unprofessional conduct and may subject the physician to civil and criminal liability.
- **Blood testing in pregnancy:** A physician providing prenatal care or attending a woman at the time of delivery must obtain or cause to be obtained a blood specimen on the first visit or within 10 days thereafter, and submit it to an approved laboratory to be tested for syphilis. That physician must also obtain a blood specimen for determination of rhesus (Rh) blood type and hepatitis B.
  - **HIV testing:** Physicians must offer HIV information and counseling to every pregnant patient.
  - **Genetic testing:** Physicians must offer genetic testing to every pregnant woman. Physicians must genetically test each child born in California, unless a parent or guardian of the newborn child objects on religious grounds (per Health & Safety Code 125000, 17 C.C.R. 6500 et seq. And 6521 et seq.).
  - **Blood transfusions:** Whenever there is a reasonable possibility that a blood transfusion may be necessary as a result of a medical or surgical procedure, the physician must inform the patient of the benefits and risks of receiving various types of blood transfusion options. The physician must provide the information by means of the standardized written summary (“If You Need Blood”) produced by the State Department of Health Services (DHS). Physicians must obtain and use the most current summary, reviewed by the



DHS annually. Copies of the summary may be requested of the DHS by writing to Address, City, ST 55555. The physician must note in the patient's medical records that the standardized written summary was given to the patient. When no emergency or contraindication exists, the physician must allow adequate time before the procedure for pre-donation to occur, unless the patient consents to an earlier time. DHS recommends that, in general, the optimal donation period begin 4-6 weeks prior to surgery and the last blood donation be collected no later than 72 hours before surgery.

- **Breast cancer:** Health & Safety Code 109275 requires that physicians provide a standardized summary discussing alternative breast cancer treatments and their risk benefits. In addition, physicians must note in the patient's chart that the physician has given the patient the summary prior to the performance of a biopsy. Distribution of a brochure prepared by DHS constitutes compliance with the law. This brochure may be ordered from:

Breast Cancer Treatment Options

1430 Howe Avenue, Suite 50

Sacramento, CA 95825

Phone (916) 263-2466 or Fax (915) 263-2479

- **Health & Safety Code 109277:** This requires every physician who screens or does biopsies for breast cancer to post a sign with prescribed wording relating to the above brochure. The sign concerning the brochure must be posted near where the breast cancer screening or biopsy is performed or at the patient registration area. The sign must be at least 8-1/2" x 11" and conspicuously displayed so as to be readable. The words "Be Informed" must be at least 1/2" in height and centered on a single line with no other text. The message must appear in English, Spanish, and Chinese.
- **Treatment of patients with a DMSO preparation:** Special informed consent requirements apply. Before treating a patient with DMSO, the physician must inform the patient,

in writing, if DMSO has been approved by the FDA as a treatment or cure for the disorder for which it is being prescribed. If DMSO is being prescribed for any purpose other than those that have been approved under the statutes governing new drug and device applications, the physician must first obtain a signed and dated, written informed consent form from the patient.

- **Hysterectomies:** Physicians must obtain verbal and written informed consent before performing a hysterectomy on any patient, unless the hysterectomy is performed in a life-threatening emergency, in which case, the physician must hand write and sign a statement certifying the nature of the emergency. The consent must contain the following:
  - That the woman is free to withhold or withdraw consent at any time before the hysterectomy without affecting the right to future care or treatment and without loss or withdrawal of any state or federally funded program benefits to which the individual might be otherwise entitled.
  - A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy.
  - Advice that the hysterectomy procedure is considered to be irreversible, and that infertility will result, unless the patient has been sterile previously or is post-menopausal.
  - A description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
  - A description of the benefits or advantages that may be expected as a result of the hysterectomy.
  - The woman's signed written statement prior to the performance of the hysterectomy indicating that she has read and understood the written information

provided above, and that this information has been discussed with her by her physician or the physician's designee. Unless the patient has been sterile previously or is post-menopausal, this statement must specifically indicate that the woman has been advised that the hysterectomy will render her permanently sterile and incapable of having children.

- **Prostate cancer:** Health & Safety Code 109282 requires every physician who screens for or treats prostate cancer to post a sign with prescribed wording. The sign must be posted near to where prostate cancer screening or treatment is performed or at the patient registration area. The sign must be at least 8-1/2" x 11" and conspicuously displayed so as to be readable. Moreover, the words "Be Informed" must be at least 1/2" in height and centered on a single line with no other text. Finally, the message must appear in English, Spanish and Chinese. DHS recommends the use of forms and summaries produced by the National Cancer Institute. These may be obtained by calling them at (800) 4CANCER.
- **Silicone implants/collagen infections:** The Cosmetic Implant Act of 1992 (Business and Professions Code 2259 and 2259.5) requires physicians to supply silicone implant patients a standardized written summary describing the risks and possible side-effects of silicone implants used in cosmetic, plastic, reconstructive, or similar surgery before the physician performs the surgery. In addition, collagen injection patients must receive similar materials regarding collagen injection. The physician must also note in the patient's chart that the patient was given the standardized written summary or other written information required under these laws. DHS recommends that until DHS summaries are available, physicians should distribute the material prepared by manufacturers since such materials are FDA approved.
- **Research:** A physician is required to inform a patient of the physician's research or other economic interests, and must obtain an informed consent.

- **Sterilization:** For private pay, an adult or a minor with legal capacity to consent to medical treatment can consent to sterilization. For Medi-Cal, a patient must be at least 21 in order to consent to sterilization. A person must also be able to understand the content and nature of the informed consent process prescribed in application regulations and be able to give voluntary consent to the sterilization. A competent person may not give informed consent to be sterilized if the person is in labor or within 24 hours after birth, after an abortion, seeking to obtain or obtaining an abortion, or under the influence of alcohol (ETOH) or other substances that affect the individual's state of awareness. An incompetent person can be sterilized pursuant to a court order under certain circumstances. Sterilization informed consents must be obtained as follows:
  - The person who obtains the consent provides the individual with a special consent form and a patient pamphlet on sterilization, both published by the DHS in Spanish and English. The sterilization pamphlets are "Understanding Sterilization" and "Understanding Vasectomy." The consent forms are "Medi-Cal/Federally Funded Patients Consent Form" PM 330, and "Consent Form Non-Federally funded" PM 283. These forms and pamphlets may be requested from DHS at 1037 N. Market Blvd., Suite 9, Sacramento, CA 95834.
  - The person who obtains the consent must offer to answer any questions the individual to be sterilized may have concerning the procedure.
  - The person who obtains the consent must orally provide all of the following information:
    - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.

- A full description of available alternative methods of family planning and birth control.
  - Advice that the sterilization procedure is considered to be irreversible.
  - A thorough explanation of the specific sterilization procedure to be performed.
  - A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
  - A full description of the benefits and advantages that may be expected as a result of sterilization.
  - Approximate length of hospital stay and time for recovery.
  - Financial cost to patient.
  - Information that the procedure is established or new.
  - Advice that the sterilization will not be performed for at least 30 days, except under certain circumstances.
- The person who obtains the consent must take steps to ensure that the patient understands the above information. This includes ensuring that information was effectively communicated to a blind, deaf, or otherwise disabled patient. If necessary, you must provide an interpreter to the patient so that information is communicated in the patient's language. You must permit the patient to have a witness of the patient's choice when the patient gives consent.
  - The consent form must be signed by the patient, interpreter, if one is used, the person who obtained the consent, and the physician who will perform the procedure.
    - In signing the consent form, the person obtaining the consent must certify that he or she advised the patient before the patient signed the consent form that no

federal benefits may be withdrawn because of a decision not to be sterilized, that he or she orally explained the requirements for informed consent as set forth on the consent form, and that he or she determined to the best of his or her knowledge and belief that the patient understood the content and nature of the informed consent process and knowingly and voluntarily consented to be sterilized.

- The interpreter must certify that he or she transmitted information orally to the patient, read and explained the form to the patient, and determined to the best of his or her knowledge and belief that the patient understood the form prior to signing the form.
- The physician performing the sterilization must certify, by signing the form, that the patient was informed, shortly before the performance of the sterilization, that federal benefits would not be withheld or withdrawn because of a decision to not be sterilized.
- After the appropriate time has passed after the date of the patient's signature on the form stating he or she understands the procedure, the physician performs the sterilization. A copy of the signed consent form must be provided to the patient and retained by the physician and the hospital in the patient's medical record.
- Unless an emergency abdominal surgery or premature delivery occurs or the patient voluntarily requests in writing (Medi-Cal patients cannot request this) that the procedure be performed in less than 30 days, 30 days (but not more than 180 days) must pass after the sterilization consent form has been signed by the patient and other appropriate parties before the sterilization procedure can be performed. However, in no case can sterilization be performed in less than 72 hours following the signing of a consent form. The physician must certify shortly before the procedure is performed that one of the above conditions has been met. Additionally, the physician must describe the emergency (for emergency abdominal surgery) or state the expected date of delivery (for a premature delivery) on the consent form. The above requirements apply only to elective sterilization.

- **Immunizations:** The federal National Childhood Vaccine Injury Act (42 U.S.C. 300aa-1 et seq.) requires that each physician who administers one of several types of vaccines to any person must provide to that person (or if a minor, to the parent or legal guardian) certain specified vaccine information materials regarding the benefits and risks of the vaccine prior to its administration every time a vaccine is administered. The CDC VIS forms may be obtained in 14 languages from the vaccine information materials order line of the DHS at (800) 555-5555. Vaccines for which this information must be supplied are diphtheria, tetanus, pertussis, polio, measles, mumps, and rubella. The information that must be given by physicians to the legal representative of any child or to any other individual receiving one or more of the specified vaccines includes:

- A concise description of the benefits of the vaccine.
- A concise description of the risks associated with the vaccine.
- A statement of the availability of the National Vaccine Injury Compensation Program.
- A copy of the CDC Vaccine Information Statement (VIS) for the administered vaccine.

7. Accept implied consent, instead of informed consent, only in the following situations:

- **Emergency situations:** Situations requiring immediate services for alleviation of severe pain or immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death. If the patient is mentally incapacitated and there is no legally authorized representative who can consent on behalf of the patient, a patient will be presumed to have consented to necessary medical treatment. Treatment should not exceed what is necessary to address the emergency. The reasons why the implied consent was invoked will be documented in the medical record.
- **Patient requests not to be informed:** The patient or patient's representative asks that he or she not be informed of the risks.

- **Therapeutic privilege/physician discretion:** In rare situations where a physician can prove that under the circumstances it was reasonable to believe that “the disclosure would so seriously upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment,” the physician may withhold the information.
8. A patient can refuse any recommended test, procedure, or medical recommendation after being informed (informed refusal). The physician must inform the patient who refuses to undergo the recommended procedure of the potential consequences. This informed refusal would be documented in the patient’s medical record.
  9. A written parental consent is required in order to treat a minor (under age 18) with the following exceptions:
    - **Minors with divorced parents:** Either parent can consent to treatment if parents have joint custody.
    - **Adopted minors:** Adoptive parents can consent to treatment.
    - **Children of minor parents:** The minor parent can consent to treatment.
    - **Minor pupil:** When the child is ill or has been injured during school hours and parents cannot be reached, the child can be treated without parental consent.
    - **Minor in custody:** The minor can be treated when ordered by the court.
    - **Minor patients with legal capacity to consent to medical treatment, which includes:**
      - Self-sufficient minor: A minor 15 years of age or older living separate and apart from his or her parents or legal guardian who manages his or her own financial affairs, regardless of the source of income, is capable of giving valid consent. This minor will affirm the above conditions in writing.



- Emancipated minor per court order: If the court order is obtained, the DMV issues an ID card, which states that the minor is emancipated. A copy of this card must be placed in the patient's medical record.
- Minors on active duty in the US Armed Forces.
- Minors receiving pregnancy care (treatment or prevention).
- Minors 12 years and older suffering from a reportable disease relating to the diagnosis or treatment of that disease.
- Married minor with marital proof (marriage certificate).
- **Pregnant minors (Civil Code Section 34.5):** In addition to the categories of minors who may consent for themselves, there are certain types of care for which minors of various ages may give their consent to treatment:
  - Any minor of any age may consent to hospital, medical, or surgical care related to treatment or prevention of pregnancy, except for sterilization procedures.
  - It is up to the minor to decide whether to involve her parents in these decisions.
  - If a parent requests a copy of the minor's medical record, the physician can make the birth control or pregnancy information available only with the minor's authorization.
  - The physician can provide the parent with a copy of all information in the record except that pertaining to decisions on pregnancy or birth control.
  - A best practice would be to keep minor patients' birth control and pregnancy information on a separate sheet within the medical record.
- **Minor with reportable disease, sexually transmitted disease (Civil Code Section 34.7):** A minor age 12 or older may consent to hospital, medical, or surgical care required to diagnose and treat any infectious, contagious, or communicable disease that is reportable to the local health officer.

- **Minor who is victim of rape (Civil Code Section 34.8):** A minor age 12 or older may consent to hospital, medical, or surgical care related to the diagnosis and treatment of rape or alleged rape.
10. Before delivering any health care by telemedicine, a physician who has the ultimate authority over the care or primary diagnosis of a patient must obtain the patient's verbal and written informed consent. Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. The informed consent procedure must ensure that at least all of the following information is given to the patient verbally and in writing:
- The patient has the option to withhold or withdraw consent at any time without affecting his or her right to future health care or treatment, and without risking a loss or withdrawal of any program benefits to which the patient would otherwise be entitled.
  - All potential risks, consequences, and benefits of telemedicine are described.
  - All existing confidentiality protections apply.
  - The patient is guaranteed access to all medical information transmitted during a telemedicine consultation, and copies of this information are available for a reasonable fee.
  - Dissemination of any patient-identifiable images or information from the telemedicine interaction to researchers or others will not occur without the patient's consent.

The patient must sign a written statement before the delivery of health care by telemedicine, indicating that the patient understands the written information provided above and that this information has been discussed with the physician, or someone designated by him or her. This law does not apply when the patient is not directly involved in the telemedicine interaction (e.g., when one physician consults with another physician). However, all existing confidentiality protections for patients' medical information apply. The law does not apply in an emergency situation in which the patient is unable to give informed

consent and the patient's representative is not available. The law also does not apply to a patient who is under the jurisdiction of the Department of Corrections.

11. Give a copy of the consent form to the patient, and retain a copy in the patient's medical record. Copies of court orders and other documents relating to the consent will also become part of the patient's medical record.

# Sample Consent for Treatment

## General Consent for Care and Treatment Consent

**TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you can make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition that has brought me to seek care at this practice. I understand that if additional testing or invasive/interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

---

Signature of Patient or Personal Representative

---

Printed Name of Patient or Personal Representative

---

Printed Name of Witness

---

Signature of Witness

---

Date

---

Relationship to Patient

---

Employee Job Title

---

Date

# Refusal of Treatment

Ensure that the patient has been given all the relevant information, has a complete understanding of the procedures being ordered by the physician, and is making an informed decision to refuse treatment. This includes the following steps:

1. Valid consent can only be obtained if the patient is free of duress or coercion.
2. Whenever a patient refuses drugs, treatment, or other procedures ordered by the physician, contact the physician immediately.
3. The physician explains to the patient the reasons for requiring the particular drug, treatment, or other procedure and the possible ill effects.
4. The physician gives the patient all the information that is relevant, so the patient can understand the consequences of declining to follow the recommended course of action.
5. The physician notes in the patient's medical record the initial refusal and the outcome (consent given or continued refusal). The note specifically documents that the physician gave the patient the relevant information, including that pertaining to the potential consequences of declining to follow the recommended course of action.
6. Refusal to Permit Medical Treatment forms must be completed. See ["Refusal to Permit Medical Treatment Form" on the next page](#).
  - Ask the patient to read and sign the form. The patient's signature must be witnessed by a responsible employee.
  - If the patient refuses to sign the form, write the notation "Patient Refuses to Sign" on the signature line, and the witness will sign the form on the designated line.

# Refusal to Permit Medical Treatment Form

I hereby acknowledge that my attending physician, \_\_\_\_\_,  
has fully informed me of the risks, possible complications, expected benefits, and the  
alternatives to receiving the following medical treatment:

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Notwithstanding the recommendations of my attending physician, I hereby refuse the fore-  
going treatment for me or my child. I hereby release my physician, his or her personnel,  
and any other persons participating in my care from any responsibility whatsoever for unfa-  
vorable or untoward results, which I understand may occur as a result of my refusal to per-  
mit this medical treatment.

---

Patient/Parent/Conservator/Guardian

---

Date

---

If signed by other than the patient, indicate relationship to the  
patient

---

Witness Signature

---

Date

The original goes into the patient's medical record, and one copy goes to the patient for  
his or her records.

# Emergencies and Consent

A medical emergency is defined as a situation where treatment appears to be immediately required and necessary to prevent the patient's death, severe disability, deterioration or aggravation of the patient's condition, or to alleviate severe pain. When an emergency situation occurs, consent is necessary unless the patient is incapacitated and is either permanently or temporarily unable to come to an informed decision.

This could be due to:

- Injury or sudden illness
- Alcohol or drug intoxication
- Shock or trauma
- An underlying mental or physical disease or handicap

The practical consideration of medical treatment for emergencies is based on a legal concept called "implied consent." The theory is that if the patient were able to consent to treatment, the consent would be given. Treatment is limited to that which is necessary to prevent:

- The patient's death
- Severe disability
- Deterioration or aggravation of the condition
- Alleviate severe pain

The emergency treatment exception does not apply if the patient has refused treatment because of his or her religious beliefs.

Use the following steps:



1. If the patient is of age or is an emancipated minor but is under the influence of drugs or sedatives, so that the patient might not be aware of what he or she is doing, the signature of the patient should be obtained, if possible, and one of the following in the order given should sign:
  - Court-appointed guardian, if any
  - Spouse
  - Parents
  - A brother or sister if there are no parents
2. Whenever treatment is being rendered on an emergency basis to a minor (male or female under the age of 18 whose parents or guardians have not accompanied him or her and may be away), the attending physician should:
  - Attempt to contact parents or guardians by phone.
  - Use a phone line with an extension or a speaker phone.
  - See that verbal consent is witnessed by another medical person listening on the extension or speaker.
  - Document how consent is received on the consent form.
3. In an emergency situation in which consent for procedures cannot be obtained, the medical record should give a clear indication of the nature of the emergency and the need to proceed with the procedures for the health and well being of the patient. The statement of medical need must be signed by the physician performing the procedure.
4. While there is no requirement that a physician obtain a consultation when he or she performs emergency treatment, it is recommended that the physician obtain a consultation with another physician.

The consulting physician should document his or her findings in the patient's medical record.

The documentation should include the physician's determination that an emergency existed and why the patient required treatment.

# Confidentiality Agreement

Affidavit of Confidentiality Statement Between office and \_\_\_\_\_  
(Name Employees, Consultants, and/or Contractors).

I, the undersigned, have read and understand the office Policy and Statement regarding the confidentiality of data and private medical information. I will abide by and conduct myself in accordance with confidentiality regulations, policies, and guidelines in the course of my activities and work with office.

I understand that any violation of confidentiality regulations and policies is grounds for termination and immediate dismissal from the practice or contract with the practice.

Signed \_\_\_\_\_

Employee, Consultant, or Contractor

\_\_\_\_\_

Date

# Prescriptions

This section describes guidelines and information for prescriptions at CMG.

# Refilling Prescriptions

It is the patient's responsibility to notify CMG in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days. If you use a mail order pharmacy, please contact the office fourteen (14) days before your medication is due to run out.

Medication refills will only be addressed during regular office hours (Monday-Friday 8 a.m.-5 p.m.).

Physicians can only authorize refills on medication prescribed by physicians from our office. Physicians cannot refill medications prescribed by other physicians. If a patient needs a refill prescribed by a physician from another office, he or she must either return to that office or make an appointment with a physician in this office.

If a patient calls to request a refill but is overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), a physician may agree to call in enough medication to a local pharmacy to last until the office is able to schedule an office visit (up to a 4-week supply).

Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your physician. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the physician can guarantee that your insurance company will approve the medication. Patients can check with their pharmacy or insurance company for updates. For more information, see ["Prior Authorizing Prescriptions" on page 112](#).

The office can provide prescriptions in one of the following methods:

- The office can send most prescriptions electronically to local pharmacies.
- The office can send prescriptions electronically to a mail-order pharmacy. Patients must have an account set up with the mail-order pharmacy for the office to do this.
- The office can provide written prescriptions.
- The office must print prescriptions for certain narcotics or attention deficit disorder medication, and patients must pick up the prescription at our office.
- The office must call in prescriptions for certain narcotics, anxiety medications, or sleep medications into the pharmacy. If you use a mail-order pharmacy for these medications, the office must fax the prescriptions to the pharmacy.

Provide the following instructions to patients:

- Before patients come to their regular appointment, they should look over their medications, diabetes supplies, inhalers, etc. to determine if they need to request any new prescriptions at their appointment.
- Patients must do their best to keep their scheduled appointments to ensure they receive timely refills. Repeated no-shows or cancellations will result in a denial of refills. Some prescriptions require a follow up appointment every three to six months.
- Patients should discuss questions regarding medications during their appointment. If for any reason patients feel their medication needs to be adjusted or changed, patients should contact the office immediately.
- New symptoms or events require a new appointment.
- The office does not accept refill requests for any controlled substance by telephone, email, mail, or fax. The office provides controlled substances only during an office visit and only in an adequate amount to cover the patient until the next scheduled office appointment.
- If patients are changing to a new local pharmacy, they should call the new pharmacy and request that their prescriptions be transferred from their old pharmacy.

- If patients are changing to a new mail-order pharmacy, they should contact the mail-order pharmacy to see if their prescriptions can be transferred from their old mail-order pharmacy or local pharmacy.
- If a patient is going on an extended vacation and needs to use a pharmacy out of town, the patient should ask the out-of-town pharmacy to contact his or her local pharmacy to have his or her prescriptions transferred. The patient should reverse the process when he or she returns home.

# Preauthorizing Prescriptions

Prescriptions that meet any of the following conditions must be preauthorized:

- A prescription for a non-preferred drug.
- A prescription for a preferred drug for a certain therapeutic class of drugs.
- A prescription for a drug when the prescribed quantity exceeds the quantity limit.
- A prescription for a multisource brand name drug that has an A-rated generic equivalent available for substitution.

If the Point-Of-Sale On-Line Claims Adjudication System indicates that a prior authorization is required and the prescription or the refill has not been preauthorized, the pharmacist notifies the patient and the prescriber that the prescription now requires prior authorization.

## 5-Day Supplies without Prior Authorization

The Department of Human Services allows the pharmacist to dispense a 5-day supply of the prescribed medication without prior authorization if, in the professional judgment of the pharmacist, the recipient has an immediate need for the medication. The pharmacist is never allowed to dispense a 5-day supply if the pharmacist determines that taking the prescribed medication, either alone or along with other medications, would jeopardize the health and safety of the recipient.

## Initiating the Prior Authorization Request

The prescribing physician must request the prior authorization.



1. The prescribing physician locates a copy of the appropriate Prior Authorization form for the medication or class of drugs that require prior authorization on the Pharmacy Services website.
2. The prescribing physician submits the completed, signed, and dated Prior Authorization form and the required supporting documentation of medical necessity to the fax number printed on the form.

## **Requirements for Prior Authorization Review**

The information required at the time prior authorization is requested includes the following:

- The name and card number of the recipient.
- The prescriber's license number.
- The specifics of the prescription, including drug name, strength, quantity, directions, number of days' supply, and duration.
- Clinical information to support the medical necessity for the medication.
- Diagnosis codes or diagnosis.

The clinical information provided during the review must be verifiable within the patient's medical record. Upon retrospective review, the Department of Human Services may seek restitution for the payment of the prescription and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the prescription.

## **Automated Prior Authorization Approvals**

When the Point-Of-Sale On-Line Claims Adjudication System can verify that the recipient has a record that documents medical necessity for a prescription that requires prior authorization, the request is automatically approved.

## Clinical Review Process

1. Prior authorization personnel review the request for prior authorization and apply the clinical guidelines to assess the medical necessity of the prescription.
2. The reviewer may request documentation from the medical record to assess medical necessity.
3. Depending on the reviewer's determination:
  - If the reviewer determines that the request for prior authorization of a prescription meets the medical necessity guidelines, the reviewer authorizes the prescription.
  - If the reviewer is unable to determine medical necessity:
    - The reviewer refers the prior authorization request to a physician reviewer for a medical necessity determination.
    - If necessary, the physician reviewer requests documentation from the medical record to determine medical necessity.
    - If, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient, the physician reviewer approves the request for prior authorization.

Authorization personnel respond to requests for prior authorization within 24 hours of receiving all information reasonably necessary to make a decision of medical necessity.

Authorization personnel consider requests to authorize multiple refills for a recipient when, in the professional judgment of the reviewer, treatment for the condition is expected to be ongoing. Multiple refills will not exceed a six (6) months or five (5) refill supply (whichever is less) from the time of the original filling of the prescription.

4. Authorization personnel notify the prescribing physician by return telephone call or fax to indicate whether the request for prior authorization is approved or denied. Authorization personnel also send a written notice of approval or denial of a request for prior authorization to the prescribing physician and the recipient.
5. When authorization personnel approve a request for prior authorization, they issue a 10-digit prior authorization number. This number should be written on the prescription and in the medical record in the event that the prescriber needs to later refer to the number for the patient or pharmacy.

## Denials

If the request to approve a prescription that requires prior authorization is denied or approved other than as requested, the recipient has the right to appeal the decision. The recipient has 30 days from the date of the prior authorization notice to submit the appeal in writing to the address listed on the notice.

If the recipient has been receiving the drug that is being reduced, changed, or denied and an appeal is hand-delivered or postmarked within 10 days of the date of the notice, authorization personnel authorize the prescription for the drug until a decision is made on the appeal.

# Maintaining Medicines

Medications should always be evaluated when considering a possible cause for a change in behaviors or a decline in functional or cognitive status. Medication should be assessed on a three-point scale (appropriate, marginally appropriate, inappropriate) in 10 domains: indication, effectiveness, dosage, directions, drug with drug interactions, drug with disease interactions, expense, practicality, duplication, and duration.

A chart audit should include:

- Newly prescribed medication.
- Recently discontinued medication.
- An increase or decrease in dosage.
- Any medication that is being refused.
- Medications that could have toxic levels (such as digoxin and lithium).
- Medications that should be monitored by therapeutic lab values.
- Thyroid medication.
- Diabetic agents.
- Iron and other vitamins.
- Blood thinners.
- Diuretics.
- Current medications against a hospital discharge or previous/current home list.
- Pain management medications (narcotic and non-narcotic). Too little pain control limits function, mobility, and motivation. Too much pain medication causes increased drowsiness, confusion, GI disturbances and constipation, and increased risk for falls and behaviors.

- Atypical anti-psychotic drug usage (Risperdal, Seroquel, Zyprexa). The first line of treatment must be looking at behavioral factors such as changes in daily routine or feeling rushed or crowded. Side effects include sedation, increased confusion, and Parkinson's-like symptoms.
- Anti-anxiety agents.

# Narcotic Drug Controls

Chronic pain is a major public health problem. However, opioid misuse and overdoses have also become very serious public health problems. Physicians must be aware of the legitimate medical uses of controlled substances for the treatment of pain, while safeguarding against opioid misuse and diversion.

## Initiation of Opioid Treatment

1. Physicians must be familiar with and follow the requirements of state and federal law and regulations on the use of the prescription monitoring program prior to initiating opioid treatment.
2. Physicians screen patients for pregnancy, personal or family histories of substance use disorder, mental health status, and relevant behavioral issues.
3. Physicians prescribing opioids inform patients about the cognitive and performance effects of these prescriptions and warn them about the dangers to themselves and others in operating machinery, driving, and related activities while under treatment.
4. Physicians consider referring patients with complex pain conditions, serious comorbidities, mental illness, or a history or evidence of substance use disorder to consultation from a colleague or specialist referral.
5. When clinically indicated, physicians initiate opioids as a short-term trial to assess the effects and safety of opioid treatment on pain intensity, function, and quality of life. In most instances, the trial should begin with a short-acting opioid medication.
6. Physicians prescribe the starting dosage to be the minimum dosage necessary to achieve the desired level of pain control and to avoid excessive side effects.
7. Physicians prescribe for short duration with possible partial-fill prescriptions or short-term, low-dosage, sequential prescription approaches.

8. Physicians should be aware of published dosing guidelines for pediatric patients and consider body weight and age as a factor in treating pediatric patients.
9. Physicians review concurrent prescriptions, including paying close attention to benzodiazepines and other medications that may increase the risks of harm associated with opioid use.
10. Physicians maintain records and engage in patient assessments consistent with state and federal laws.
11. Physicians counsel patients to store the medications securely, never share with others, and properly dispose of unused and expired prescriptions.
12. Patients should have regularly scheduled appointments to evaluate the progress of treatment. Patients and physicians should periodically reassess the need for continued opioid treatment, tapering whenever possible as part of the comprehensive pain care plan.

## **Evaluation Following a 90-Day Period of Usage**

1. The physician performs a detailed re-evaluation of the patient's history and a physical as soon as possible after the 90-day threshold is reached.
2. The patient completes an objective pain assessment tool.
3. The physician performs a risk of substance abuse assessment. The physician should consider the use of appropriate baseline urine drug testing if the risk assessment or other evidence indicates there may be issues with the use of other drugs or with compliance with prescribed treatment.
4. The physician tailors a diagnosis and treatment plan with functional goals at the initial 90-day threshold visit and every 60 to 90 days.

5. At each threshold visit:

- The physician again informs patients of the risks, benefits, and terms of continuation of opioid treatment. The physician uses the threshold visits to review alternative pain management options.
- The physician again counsels women on risks associated with opioid treatment and pregnancy.
- The physician again informs patients about the cognitive and performance effects of these prescriptions and warns them about the dangers to themselves and others in operating machinery, driving, and related activities while under treatment.
- The physician reviews the patient's current prescription monitoring program record. One goal of this review is to avoid duplicative or conflicting treatments from other physicians.

6. The physician and patient establish a treatment agreement plan.

- The physician ensures the plan includes measurable goals for reduction of pain, reduction in opioid therapy concomitant with reduction or resolution of the pain, and improvement of function. The plan should address what circumstances would allow a patient to receive prescriptions from other physicians.
- The patient assigns the treatment agreement with an updated signature at least yearly.
- The physician incorporates the plan into the patient's medical record.

7. The physician should discuss risks and warning signs of opioid dependence and addiction with chronic pain patients.

8. The physician discusses naloxone and its use to reverse overdoses. The physicians offer to prescribe naloxone to their patients after such discussions.

9. The physician who is not a pain management specialist should not initiate treatment plans that call for an excess of 100 milligrams of morphine equivalent opioids per day without a documented consultation with a pain management specialist.



If a patient is currently receiving >100 mg morphine equivalent per day, the physician institutes a plan to begin tapering the dose or advises the patient to consult with a pain management specialist.

10. When clinically possible, physicians should select abuse-resistant and abuse-deterrent medications.
11. If high risk or low benefit warrants a discontinuation of opioid therapy, physicians prescribe non-opioid alternatives for continued pain management.

# Pharmaceuticals at the Office

Following are guidelines for managing pharmaceuticals at CMG.

## Proper Maintenance and Storage of Drugs

This section provides guidelines to ensure that each facility has an established process to monitor the expiration dates of drugs, proper storage of drugs, ensure proper labeling of drugs, secure the safety of the drugs, and to ensure proper disposal and documentation of drugs.

Use the following steps:

1. Regularly verify that all medications are current, dates have not expired, and sample medications are listed and current.
  - Check the expiration date of all medications monthly.
  - Maintain a chart of medications with the inspector's initials and date.
2. Verify that all medications are properly labeled. The labeling should include the following:
  - Name of drug
  - Concentration
  - Route of administration (topical, oral, parenteral, etc.)
  - Storage information, such as the temperature and light requirements
3. Keep drugs in a locked cabinet or drawer that is accessible only to authorized office personnel. This includes sample medications.
4. Store internal and external drugs separately to avoid drug administration errors.
5. Maintain medications that require refrigeration at 35° - 46° F or 2 - 8° C. Maintain the freezer at 7° F or -14° C. In addition, perform the following:

- Purchase a thermometer specific for checking temperatures in the refrigerated unit for medications.
  - Complete a daily temperature log for each work day with the employee's initials on the form.
  - Ensure varicella is stored at 5° F or -1.5° C.
6. Prepare medications in a clean area, such as an area free of body fluids or dirty equipment, such as food trays, urinals, and dirty linen.
  7. Store needles and syringes securely in a locked container in an area where patients do not have access.
  8. Store all controlled drugs in a securely locked cabinet. Maintain a current inventory on each controlled substance. The physician is ultimately responsible. The DEA must be current.
  9. Ensure drugs are only dispensed by the physician and mid-level practitioner. A mid-level practitioner is a medical assistant, a licensed or registered nurse, nurse midwife, nurse practitioner, or physician's assistant. Physicians dispense drugs to their own patients. Physicians do not sell sample medications.
  10. Enter an appropriate record in the patient's chart referring to those drugs prescribed and dispensed. Also, record sample medications in the patient's medical record.
  11. Make the Poison Center telephone number accessible in a prominent location. The Poison Center can be used for poisoning emergencies, drug consultations, drug interactions, foreign and national drug identification, and other services. You can contact the Poison Center to obtain literature and telephone stickers.

## Cytotoxic Drugs

Cytotoxic drugs are therapeutic agents intended for, but not limited to, the treatment of cancer. They are highly toxic to cells, mainly through their action on cell reproduction.

Employees must be educated on safe handling and exposure of cytotoxic agents within their first three months of employment.

Access to cytotoxic agent storage areas, cytotoxic waste removal, and any handling of cytotoxic agents must be limited to authorized personnel only. Store these agents separately from other drugs kept on site, and label these agents appropriately. If you feel there is a potential risk in handling of any substance in the office, contact your supervisor immediately, who will assist in a risk assessment.

Do not handle any unauthorized or unknown substances without confirming with a supervisor.

# Medication Record and Other Therapeutic Modalities

Patient Name				Patient's Telephone		
Allergic Reactions:						
Pharmacist						
Therapist						
Medication	Signature	Amount Dispensed	Nurse to Refill (Yes/No)	Date		Refill Date, Strength, # of Refills, Initials
				Start	Stop	

# Reporting Violence and Abuse

When a physician (in his or her professional capacity) observes that a person has been injured or killed by a violent act, or where there is reason to suspect assault or abusive conduct by a domestic partner, that physician must report these observations by telephone and follow up with a written report to the local law enforcement agency. Assault or abusive conduct is defined to include any number of prohibited criminal acts or attempted acts, such as assault with a deadly weapon, murder, manslaughter, mayhem, rape, spousal rape, battery, and sexual battery—Penal Code 11160(d)(1)-(d)(24). Domestic violence can occur between unmarried or married, cohabitating or not, and heterosexual or homosexual.

Use the following steps:

1. Health professionals must report suspected assault or abusive conduct.
2. Send a written report to the local law enforcement agency within two (2) working days of the observation.

# Immunity

The law provides immunity for physicians from civil and criminal liability for reports of known or suspected instances of abuse. Physicians (or their agents) are also immune from liability for taking or causing to be taken photographs of the suspected victim of domestic violence and for forwarding the photographs with the mandated report. A physician who, pursuant to a request from an adult protective services agency or a local law enforcement agency, provides the requesting agency with access to the victim of a known or suspected instance of abuse, will not incur civil or criminal liability as a result of providing that access. In the event that a person required to report is required to defend a legal action based on the making of the report and prevails, the state will reimburse the individual's reasonable attorney's fees (not to exceed an hourly rate greater than the rate charged by the attorney general at the time the award is made, up to a maximum of \$50,000).

# Guidelines for Assessment

The possibility of assault should be considered if a patient's explanation of any injury does not seem plausible or when there has been a delay in seeking medical attention. There are certain types of injuries and/or behaviors that are commonly associated with abuse.

The injuries listed below may be indicative of abuse. However, an overall assessment of the individual may need to be done to produce conclusive findings. The following are indications of abuse:

1. Minor lacerations, contusions, abrasions, fractures, or sprains.
2. Injuries to the head, neck, chest, breasts, or abdomen.
3. Injuries during pregnancy, such as spontaneous abortions.
4. Multiple injury sites.
5. Chronic or repeated injuries.
6. Medical problems that indicate chronic or psychogenic pain.
7. Physical symptoms related to stress, anxiety disorders, or depression.
8. Chronic diseases, such as asthma, seizures, or arthritis.
9. Multiple gynecological problems.
10. Frequent use of prescribed minor tranquilizers or pain medications.
11. Psychiatric symptoms such as panic attacks, substances abuse, inability to cope, feelings of isolation, or suicidal tendencies.
12. Behavioral problems such as an appearance of fright, shame, or embarrassment.



# Documentation of Abuse

Well-documented medical records must be maintained by the physician and should include the following information:

- Name of the injured person.
- Location of the injured person.
- Extent and character of the person's injuries.
- Identity of the person the injured person alleges inflicted the wounds, other injuries, assault, or abusive conduct upon the injured person.
- Description of the abusive event or description of the major complaints in the injured person's own words, whenever possible.
- Medical and relevant social history of the injured person.
- Map of the location of the injuries on the victim's body documented at the time of the health care service.
- A copy of the law enforcement reporting form.

# Reporting

The physician should keep in mind that the abused or battered woman or man is often at greatest risk immediately after the police are first called and after the police leave the scene. Prior to reporting instances of spousal abuse, the physician should encourage the patient to locate a protected environment for herself or himself and children, if applicable, rather than run the risk of being in the same hostile environment he or she was in when the police were first called. Physicians should obtain information on battered women's or men's shelters in the local area, as well as information on counseling programs for both the victim and batterer to utilize in these instances.

The telephone report must be made immediately or as soon as practically possible, and must be followed up with a written report to the local law enforcement agency within two (2) working days of receiving the information regarding the injured person. The written report must be on a standardized form and include the name of the injured person, location of injury, extent of injury, description of how the person was injured, and identity of the person inflicting the injury, if known. To be reportable, the injury must be current and the patient still suffering from it. If two or more persons are required to report the same incident, they may agree among themselves as to one reporter. No person who is obligated to report may be inhibited or impeded in his or her reporting duties by any supervisor or administrator.

There are no penal code statutes prohibiting verbal or mental abuse or the psychological injuries arising out these acts, so physicians are not legally obligated to report such cases.

## Penalties

Failure to report domestic violence abuse is a misdemeanor punishable by up to six (6) months in jail and/or up to a \$1,000 fine.

# Physicians Domestic Violence Training

Physician applicants for licensure who have matriculated at medical school on or after September 1, 1994 must show that they have training or coursework in spousal abuse detection and treatment (Business and Professions Code 2089).

# Reporting Child Abuse or Neglect

Ensure child abuse cases are recognized, diagnosed, and reported as soon as practical by telephone and followed up with a written report.

The following signs and symptoms of abuse and neglect should be identified by the physician:

- **Physical abuse:** Physical injury inflicted on a child by another person by other than accidental means.
  - Bruises or welts that have a regular pattern resembling the shape of an article which might have been used to inflict the injury.
  - Burns that appear to be from a cigar or cigarette, especially on the soles of the feet, palms, back or buttocks, patterned burns, and immersion burns.
  - Abrasions such as rope burns or lacerations, especially on the wrist, ankles, torso, palate, mouth, gums, lips, eyes, ears, or external genitalia.
  - Fractures, many times at different stages of healing, to the skull, ribs, or long bones.
  - Injuries to the abdomen, kidney, bladder, or pancreas, intestinal perforation, ruptured liver, spleen, or blood vessels, or intramural hematoma of the duodenum or proximal jejunum.
  - Symptoms of suffocation or chemical abuse.
  - Indicators pointing to Munchausen Syndrome by proxy.
- **Sexual abuse:** Includes both sexual assault and sexual exploitation.
  - Bruises or abrasions to the inner thighs or external genitalia.
  - Attenuation or distortion of the hymen.
  - An alternation of anorectal tone.

- Evidence of sexually transmissible disease.
- Pregnancy (although pregnancy alone is not sufficient to constitute the basis of a reasonable suspicion of sexual abuse).
- **Willful cruelty or unjustifiable punishment of a child**
- **Unlawful corporal punishment or injury**
- **Neglect:** Negligent treatment or maltreatment of a child by a person responsible for the child's welfare where harm to the child's health or welfare is indicated or threatened.
  - History of lack of appropriate well-child care.
  - Failure of a child to thrive.
  - Malnutrition, untreated medical conditions, poor hygiene, or rampant dental caries.
  - Behavioral indicators such as anxiety, depression, sleep disturbances, enuresis, excessive masturbation, aggressive behavior, or excessive household responsibilities for age, including child care, poor school performance, discipline problems, and impaired personal problems.
- **Abuse in Out-of-Home Care:** All cases of abuse as defined above in a childcare, school, or other agency or institutional setting.

## Diagnosis

A thorough health assessment must be conducted by the physician, which includes a history, physical examination, and developmental assessment on a child who may be a victim of abuse. The Office of Criminal Justice Planning (OCJP) determines the protocols for performing physician examinations on a victim of sexual assault, including child molestation. For additional information on these protocols, call (916) 324-9120. X rays, CT scans, bone scans, or other laboratory studies are useful in determining and defining the current

trauma and previous traumas and excluding other medical conditions. In cases of suspected child abuse, a physician, surgeon, or dentist (or their agents) may take x-rays without parental consent.

The following diagnostic process should be performed:

1. Assess the child's immediate medical needs.
2. Compile the past medical and social history of the child and family members.
3. Assess the plausibility of the history being provided in light of pre-existing medical conditions.
4. Determine how great a risk it would be if the child returns home.

## Reporting

- A report must be made immediately or as soon as possible by telephone to a police or sheriff's department, a county probation department, or a county welfare department. The report must include the name of the person making the report, the name of the child, the present location of the child, the nature and extent of the injury, and any other information, including information that led the person to suspect child abuse and other information requested by the child protective services agency.
- The written report must be on a standardized form, which should be available from a child protective services agency and must be sent within 36 hours of notice of the abuse. Special forms must be used by physicians who conduct an examination for sexual assault in an acute care hospital. Three forms that are recommended for reporting child abuse cases are as follows:
  - "Suspected Child Abuse Report" form SS 8572, which may be obtained from the local child protective services agency.
  - "Medical report – Suspected Child Abuse" form DOJ 900, which may be obtained from the local child protective services agency.

- “Medical Report – Suspected Child Sexual Abuse” form OCJP 925, available by calling the office of Criminal Justice Planning at (916) 323-7428, or by writing to OCJP, 1130 K Street, Suite 300, Sacramento, CA 95814.

## **Immunity**

The law provides immunity for physicians from civil and criminal liability, for reports of known or suspected instances of abuse. Physicians (or their agents) are also immune from liability for taking or causing to be taken photographs of the suspected victim of child abuse without parental consent, and for forwarding the photographs with the mandated report. In addition, in the event that a person required to report is required to defend a legal action based on the making of the report and prevails, the state will reimburse the individual’s reasonable attorney’s fees (not to exceed an hourly rate greater than the rate charged by the attorney general at the time the award is made, up to a maximum of \$50,000).

## **Penalties**

Failure to report child abuse is a misdemeanor punishable by up to six (6) months in jail and/or up to a \$1,000 fine. A physician may also be liable in civil court for damages, which occur if the child is further victimized because of a failure to report the abuse.

## **Employee Statements**

Physicians and other employers who hire licensed physicians or other mandated reports must obtain a signed statement from those employees hired on or after January 1, 1985, attesting to the employees’ understanding of their child abuse reporting obligations per Penal Code 11166.5. Employers must retain these signed statements at the employer’s expense.



# Reporting Elder and Dependent Adult Abuse

Ensure physical injury or a condition appearing to be the result of physical abuse, abuse of financial affairs, neglect, or abandonment of an elder or dependent adult in accordance with state laws is reported to the local law enforcement agency and Department of Health (Welfare and Institutions Code Section 15600-15659). Elder means any person 65 years of age or older.

Physical abuse means a situation where any person who has the care or custody of, or who stands in a position of trust with, an elder or dependent adult willfully inflicts upon that elder a cruel or inhumane corporal punishment or injury.

## **Abuse**

Abuse includes physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods and services that is necessary to avoid physical harm or mental suffering. All health care professionals and care givers, health educators, designated employees of adult protective services agencies, and designated employees of local law enforcement agencies are required by law to report incidents of suspected abuse (physical abuse, sexual abuse, fiduciary abuse, neglect, abandonment, and isolation) of any elder or dependent adult. An immediate phone report is required to a 24-hour crisis line at the Department of Aging at 800-231-4024. A written report (Department of Social Services form SOC341) must be sent within 48 hours to either the long-term care ombudsman coordinator or to a local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility. A written report (Department of Social Services form SOC341) must be sent within 48 hours to either the county adult protective services agency or to a local law enforcement agency when the abuse is alleged to have occurred anywhere else.

## **Physical Abuse**

Physical abuse includes assault, battery, assault with a deadly weapon or force likely to produce great bodily injury, unreasonable physical constraint or prolonged or continual deprivation of food or water, use of a physical or chemical restraint or psychotropic medication for punishment for a period beyond that for which the medication was ordered pursuant to the instruction of a licensed physician and surgeon for any purpose not authorized by the physician and surgeon, and sexual assault.

## **Sexual Assault**

Sexual assault includes assault and battery, rape, rape in concert, incest, sodomy, oral copulation, or penetration of the genital or anal opening by a foreign object.

## **Sexual Abuse**

- Bruises or abrasions on the inner thighs or external genitalia.
- Alteration in anorectic tone.
- Evidence of a sexually transmitted disease.
- Multiple gynecological problems.

## **Physical Abuse Indicators**

- Multiple injury sites or bruises or welts that have a regular pattern resembling the shape of an article which might have been used to inflict the injury.
- Burns that appear to be from a cigar or cigarette.

- Injuries to the head, neck, cheek, breasts, or abdomen, contusions, abrasions such as rope burns or lacerations, especially on the wrist, ankle, torso, or extremities.
- Fractures, many times at different stages of healing, to the skull, ribs, or long bones, injuries to abdomen, kidney, bladder, or pancreas, intestinal perforation, ruptured liver, spleen, or blood vessels, spontaneous abortions resulting from injury to the abdomen, or intramural hematoma of the duodenum or proximal jejunum.
- Chronic diseases, such as asthma, seizures, or arthritis.
- Medical problems indicating chronic or psychogenic pain.
- Symptoms of suffocation or chemical abuse.
- Improbable explanation of injuries or major inconsistencies between elder or dependent adult and caregiver's injury etiology description.
- Changes in the elder or dependent adult's behavior when the caregiver enters or leaves the room.
- Appearance of fright, shame, embarrassment, depression, agitation, stress, inability to cope, panic attacks, feelings of isolation, withdrawal, or homicidal or suicidal tendencies.
- Frequent use of prescribed tranquilizers or pain medications.
- Risk factors such as caregiver substance abuse or historical family violence.

## **Fiduciary Abuse**

Fiduciary abuse is committed by a person who stands in a position of trust with respect to an elder or dependent adult and willfully steals the money or property of that elder, or secrets or appropriates the money or property of that elder to any use or purpose not in the due and lawful execution of his or her trust (inclusive of misappropriation of Social Security funds).

## **Neglect**

Neglect is failing to care for an elder or dependent adult to the degree of care that a reasonable person in a like position would exercise. Indicators include:

- Historical or current lack or delay of appropriate care.
- Failure to protect from health and safety hazards.
- Malnutrition, untreated medical conditions, or weight loss.
- Failure to provide physical aids, such as eyeglasses, hearing aids, dentures, and/or ambulatory assistive devices.
- Signs that the caregiver has been unwilling or unable to provide assistance with daily living skills, such as poor hygiene, lack of appropriate clothing, lack of proper diet, or urine stains on clothing.

## **Abandonment**

Abandonment is the desertion or willful forsaking of an elder or dependent adult by any person having the care or custody of that elder or dependent adult under circumstances in which a reasonable person would continue to provide care or custody.

## **Isolation**

Isolation includes acts that prevent a dependent adult from accessing or communicating with family, friends, or concerned persons. This includes the following:

- Acts intentionally committed for the purpose of preventing, and that do serve to prevent, a dependent adult from receiving his or her mail or telephone calls.
- False imprisonment.

- Physically restraining of elder or dependent adults for the purpose of preventing them from meeting with visitors.
- Telling a caller or prospective visitor that an elder or dependent adult is not present, does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

## Dependent Adult Abuse

A dependent adult is defined as a person between the ages of 18 and 64, who has physical or mental limitations, which restrict him or her from carrying out normal activities and of protecting his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. A dependent adult can also include any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility as defined in Section 1250, 1250.2, and 1250.3 of the Health and Safety Code.

You can use the following steps to detect and report dependent adult abuse:

1. A physician conducts a thorough assessment, which includes a history and physical examination of the elder or dependent adult suspected of being a victim of abuse.
2. For known or suspected sexual assaults, follow examination protocol per Penal Code 13823.5, 13823.7, 13823.9, and 13823.11.
3. Perform X-rays, CT scans, bone scans, or other laboratory studies to determine and define the current trauma and previous traumas and to exclude other medical conditions as follows:
  - Assess the elder or dependent adult's immediate medical needs.
  - Compile the past medical and social history of the elder or dependent adult and family members (if applicable).

- Assess the plausibility of the history being provided in light of pre-existing medical conditions.
- Determine how great a risk it would be if the elder or dependent adult were to return to his or her living situation or residence.

### **Medical Record Documentation**

Medical record documentation, maintained by the physician, should include but not be limited to the following:

- Name of abuse victim.
- Date/time abuse became known.
- Physical assessment/evaluation, location, extent, and character of injuries.
- Map of the location of the injuries on the abuse victim's body documented at the time of the health care service.
- Name/identity of the alleged abuser.
- Description of the abusive event or abuse victim complaints in his or her own words.
- Medical and relevant social history of the abuse victim.
- Physician follow-up, such as reporting.

### **Reporting**

Reporting is required of physicians, nurses, pharmacists, and all other medical physicians licensed under Division 2 of the Business and Professions Code. It is also required of certain non-medical practitioners, such as coroners, social workers, psychologists, family counselors, nursing home ombudsmen, care custodians, law officers, and probation and welfare personnel. The law does not extend to members of a physician's office support staff who are not licensed physicians.

One individual may make the required report for an entire group, and facilities may develop reporting protocols, so long as they are consistent with the statutory requirements. Reporting is required for physical abuse as defined above. Those required to report may, but are not required to, report known or reasonably suspected instances of other types of abuse, including cases of mental abuse, fiduciary abuse, neglect, abandonment, isolation, or other treatment with resulting physical harm or pain, mental suffering, or the deprivation by care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

When the reporter has knowledge or reasonable suspicion that abuse has occurred, the telephone report must be made immediately or as soon as possible to one of the following:

- The long-term care ombudsman coordinator when the abuse is alleged to have occurred in a long-term care facility.
- State Department of Mental Health, State Department of Developmental Services, or to a local law enforcement agency when the abuse is alleged to have occurred in a state mental hospital or state developmental center.
- County Adult Protective Services Agency or County Welfare Department when the abuse is alleged to have occurred anywhere else.

The report should include the name of the person making the report, the name, address, and age of the elder or dependent adult, the nature and extent of the dependent adult's or elderly person's condition, present location of the elder or dependent adult, the names and addresses of family members or any other person responsible for the elder or dependent adult (if known), the alleged incident of elder or dependent adult abuse, and any other information, including what led the person to suspect elder or dependent adult abuse. The 24-hour toll-free number for the Department of Aging Crisis Hotline is 800-231-4024.

A written report must be completed within 48 hours of the telephone report, on a California Department of Social Services form SOC341 entitled “Report of Suspected Elder or Dependent Adult Physical Abuse,” and mailed to the address indicated by the agency that took the phone reports and the county department of adult protective services. This form is obtainable from the County Adult Protective Services Agency or the local long-term care ombudsman program.

The law provides that care custodians, health physicians, or employees of adult protective services agencies or local law enforcement agencies will not incur either civil or criminal liability for any report they are required or permitted to make under this law. However, any person who knowingly fails to report, when required, an instance of elder abuse is statutorily guilty of a misdemeanor punishable by a fine not to exceed \$1,000, or imprisonment in the county jail not exceeding six (6) months or both. A physician may also be liable in civil court for damages that occur if the elder or dependent adult is further victimized because of failure to report the abuse.

## **Endangered Adults Laws**

Physicians should ascertain whether the Protective Placement and Custody Laws have been adopted in their county by calling their local county medical society, law enforcement agency, adult protective services department, or local county governing body. These laws provide that if a physician treating an adult determines that the person is an endangered adult, defined as in a situation posing an immediate risk of serious injury or death, when no other means are available to mitigate the risk to the individual, whether or not medical treatment is required, the physician may (but is not required to) delay the release of the endangered adult until one of the following:

- A local law enforcement agency takes custody of the endangered adult.
- It is determined by the responding agency that the adult is not endangered.



- The responding agency takes other appropriate action to ensure the safety of the endangered adult.

In these instances, the physician must immediately notify local law enforcement of the delayed release decision and request immediate assistance in the matter.

**Note:** There are no explicit immunities for the physician in the event the presumed endangered adult or his or her family or guardian sues the physician for damages arising from the delayed release.

# Employee Acknowledgement Form

Physicians or other employers who hire licensed physicians or other mandated reporters on or after January 1, 1995 are required to obtain a signed statement to the effect that the employee has knowledge of the mandated reporter statute and will comply with its provisions. Employers must retain the signed statements at the employer's expense. In addition, employers must inform licensed physicians and other mandated reporters in their employ who were hired prior to January 1, 1995 of their reporting responsibility. Effective with physician licenses issued on or after January 1, 1995, the Medical Board must obtain an acknowledgment that the physician understands and agrees to comply with the dependent and elder abuse reporting statutes.

Reporting is done to the following or to local law enforcement/police:

- Adults (60+ years, living independently)

Adult Protective Services

1725 Technology Dr.

San Jose, CA 95110

- Adults (18-59 years, living independently)

Adult Protective Services

591 N. King Rd.

San Jose, CA 95133

Hotline: (800) 414-2002

Fax: (408) 923-2134

- Adults (in RCH)

Long-Term Care Ombudsman – Catholic Charities

2625 Zanker Rd., #200

San Jose, CA 95134-2107

(408) 944-0567 9 a.m. to 5 p.m.

(800) 231-4024 after 5 p.m.

# Patient and Office Safety

This section describes guidelines and information for patient and office safety at CMG.

# Patient Injuries at Cardiology Medical Group

In the event that a patient is injured at CMG, steps must be taken to ensure the safety of the patient and properly report the incident.

1. When the injury occurs, take steps to properly protect and provide the ability to care for the patient.
2. Immediately notify a physician of the incident.
3. The physician evaluates and provides immediate care to stabilize the patient.
4. If the patient needs to be transported to a hospital, follow the procedure given in "[Transfer of Patient to Ambulance](#)" on page 70.
5. Complete a Physician Office Adverse Incident Report with the following information:
  - Office information
  - Patient information
  - Incident information
  - Analysis and corrective action
  - Physician's signature

For a sample of this form, see "[Physician Office Adverse Incident Report](#)" on the next page.

# Physician Office Adverse Incident Report

STATE OF STATE

Name, Governor

SUBMIT FORM TO:

Department of Health, Consumer Services Unit

Medical Way

City, ST 11111

## I. OFFICE INFORMATION

Name of Office

Street Address

City, Zip Code, County

Telephone

Name of Physician or Licensee Reporting

License & Office Registration Number

Patient's Address for Physician or Licensee

## II. PATIENT INFORMATION

Patient Name

Age

Gender

☐

Medicaid

☐

Medicare

Patient Address

Date of Office Visit

Patient Identification Number

Purpose of Office Visit

Diagnosis

ICD-9 Code for Description of Incident

Level of Surgery (II) or (III)

### III. INCIDENT INFORMATION

Incident Date and Time

Location of Incident

☐

Operating Room

☐

Recovery Room

☐

Other \_\_\_\_\_

If the incident involved a death, was the medical examiner notified?

☐

Yes

☐

No

Was an autopsy performed?

☐

Yes

☐

No

#### A) Describe circumstances of the incident (narrative)

(Use additional sheets as necessary for complete response)

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### B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident (ICD-9 Codes 01-99.9)	Accident, event, circumstances, or specific agent that caused the injury or event. (ICD-9 E-Codes)	Resulting injury (ICD-9 Codes 800-999.9)
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### C) List any equipment used if directly involved in the incident

(Use additional sheets as necessary for complete response)

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### D) Outcome of incident

<input type="checkbox"/> Death	<input type="checkbox"/> Surgical procedure performed on the wrong site **
<input type="checkbox"/> Brain damage	<input type="checkbox"/> Wrong surgical procedure performed **
<input type="checkbox"/> Spinal damage	<input type="checkbox"/> Surgical repair of injuries or damage from a planned surgical procedure
<input type="checkbox"/> Surgical procedure performed on the wrong patient	** if it resulted in <input type="checkbox"/> Death



☐ A procedure to remove  
unplanned foreign objects  
remaining from surgical pro-  
cedure

☐ Any condition that  
required the transfer of the  
patient to a hospital

Outcome of transfer  
(e.g., death, brain dam-  
age)

observation only

☐ Brain damage

☐ Spinal damage

☐ Permanent disfigurement not to include the  
incision scar

☐ Fracture or dislocation of bones or joints

☐ Limitation of neurological, physical, or sensory  
function

☐ Any condition that required the transfer of the  
patient to a hospital

---

Name of facility to which  
patient was transferred:

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**E) List all persons, including license numbers if licensed, locating information, and the  
capacity in which they were involved in this incident. This would include anes-  
thesiologist, support staff and other health care providers.**

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**F) List witnesses, including license numbers if licensed, and locating information if not  
listed above.**

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#### **IV. ANALYSIS AND CORRECTIVE ACTION**

##### **A) Analysis (apparent cause) of this incident.**

(Use additional sheets as necessary for complete response)

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##### **B) Describe corrective or proactive action(s) taken.**

(Use additional sheets as necessary for complete response)

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**V.** \_\_\_\_\_

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**SIGNATURE OF PHYSICIAN/LICENSEE SUBMITTING  
REPORT**

**LICENSE NUMBER**

---

**DATE REPORT COMPLETED**

---

**TIME REPORT  
COMPLETED**

# Office Security

The office uses a roster system to ensure that proper staffing levels are maintained throughout the hours of operation. The minimum staffing level requires at least one physician and one administration staff member to be on duty at all times.

Office security should be maintained at all times to prevent unauthorized access to office resources.

# Office Data Security

This section discusses office data security at CMG.

## General Guidelines

It is office policy that all information contained in the medical record is private and will remain strictly confidential. A patient's medical record information cannot be released without the express consent of the patient. The office maintains a standard Consent to Release Medical Records Form, which must be reviewed, understood, and signed by patients before the release of any part of the patient's medical records.

The following guidelines govern office data security:

1. The medical record belongs to the physician/practice and will not be made public.
2. Only the physician, clinical, and administrative staff, who have a specific need, will have access to and handle medical records.
3. All records are maintained in the office in a secure medical record storage facility. The facility is to be locked after hours. During normal business hours, only designated office staff members monitor the facility.
4. Information contained in the medical record is not to be discussed by or among employees or with visitors unless there is a specific reason to do so. Such conversations are considered confidential.
5. The office states its policy for releasing HIV/AIDS and STD information contained in medical records. Policy should reflect state law.
6. All employees, consultants, and contractors who may have access to confidential information are advised of their responsibility to maintain the confidentiality of all data and information,

including but not limited to the private medical information of patients, as well as any information deemed proprietary.

7. All employees, consultants, and contractors are informed prior to employment or contract execution of the confidentiality of private medical information and the rules and regulations regarding their use. All employees receive instruction on the appropriate handling and safeguarding of confidential information and are apprised of their responsibility for maintaining strict confidentiality of practice and patient data.
8. Only designated managers, staff, consultants, and contractors are authorized to review the medical records of patients seen by the practice. All such personnel are to be trained in the proper handling of medical records, and continue to receive such training as necessary.
9. Electronic information systems that maintain electronic protected health information must be secured so that only authorized users can access the information. This includes the following requirements:
  - Assign a unique user name or number to track the identity of the person accessing the information.
  - Establish procedures for accessing electronic protected health information during an emergency.
  - (Optional) Ensure electronic sessions are terminated after a predetermined time of inactivity.
  - (Optional) Encrypt all electronic health information.

## **Email Communication**

Due to the insecure nature of email communication, we do not use email as a means of communication with the public or patients for the following situations:

- Questions or issues of a medical nature.
- To establish physician-patient relationships.
- To book or cancel appointments.
- For inquiries regarding fees, services, or similar matters.

Email communications regarding such matters will not be responded to and will be discarded unread. If patients want to contact us regarding medical questions, issues, appointments, accounts, or other questions, they should do so by telephone, fax, or regular mail.

## **Red Flag Rule Identity Theft Compliance Program**

It is the policy of CMG to follow all federal and state laws and reporting requirements regarding identity theft. This policy outlines how CMG identifies, detects, and responds to “red flags.” A “red flag” as defined by this policy includes a pattern, practice, or specific account or record activity that indicates positive identity theft.

### **Identifying Red Flags**

In the course of caring for patients, CMG may encounter inconsistent or suspicious documents, information, or activity that may signal identity theft. CMG identifies the following as potential red flags:

- A complaint or question from a patient based on the patient’s receipt of:
  - A bill for another individual.
  - A bill for a product or service that the patient denies receiving.
  - A bill from a physician that the patient never patronized.
  - A notice of insurance benefits or explanation of benefits for health care services never received.

- Records showing medical treatment that is inconsistent with a physical examination or with medical history as reported by the patient.
- A complaint or question from a patient about the receipt of a collection notice from a bill collector.
- A patient or health insurer report coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.
- A complaint or question from a patient about information added to a credit report by a physician or health insurer.
- A dispute of a bill by a patient who claims to be a victim of any type of identity theft.
- A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
- A notice or inquiry from an insurance fraud investigator for a private health insurer or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.

### **Detecting Red Flags**

Office practice staff will be alert for discrepancies in documents and patient information that suggest risk of identity theft or fraud. CMG will verify the patient identity, address, and insurance coverage at the time of patient registration/check-in.

1. When a patient calls to request an appointment, the patient (or patient's guardian) is asked to bring the following at the time of the appointment:
  - Driver's license or another photo ID.
  - Current health insurance card.
  - Utility bills or other correspondence showing current residence if the photo ID does not show the patient's current address.

2. When the patient arrives for the appointment, the patient is asked to produce the information listed above. This requirement may be waived for patients who have visited the practice within the last six months.
3. If the patient has not completed the registration form within the last six months, registration staff verifies current information on file and, if appropriate, updates the information.
4. Staff should be alert for the possibility of identity theft in the following situations:
  - The photograph on a driver's license or other photo ID submitted by the patient does not resemble the patient.
  - The patient submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
  - Information on one form of identification that the patient submitted is inconsistent with information on another form of identification or with information already in the practice records.
  - An address or telephone number is discovered to be incorrect, non-existent, or fictitious.
  - The patient fails to provide identifying information or documents.
  - The patient's signature does not match a signature in the practice records.
  - The social security number or other identifying information the patient provided is the same identifying information in the practice's records provided by another individual, or the social security number is invalid.

## **Responding to Red Flags**

If an employee of CMG detects fraudulent activity or if a patient claims to be a victim of identity theft, CMG will respond to and investigate the situation. If the fraudulent activity involves protected health information (PHI) covered under HIPAA security standards, CMG will also apply its existing HIPAA security policies and procedures to the response.

If potentially fraudulent activity (a red flag) is detected by an employee of CMG:



1. The employee gathers all documentation and reports the incident to his or her immediate supervisor or designated compliance officer/privacy official.
2. The supervisor or designated compliance officer/privacy official determines whether the activity is fraudulent or authentic.
3. If the activity is determined to be fraudulent, CMG should take immediate action, including:
  - Cancel the transaction.
  - Notify appropriate law enforcement.
  - Notify the affected patient.
  - Notify affected physicians.
  - Assess impact to practice.

If a patient claims to be a victim of identity theft:

1. Encourage the patient to file a police report for identity theft.
2. Encourage the patient to complete the Identity Theft Affidavit developed by the Federal Trade Commission (FTC), along with any supporting documentation.
3. CMG compares the patient's documentation with personal information in the office's records.
4. After investigating, if it appears the patient has been a victim of identity theft, CMG determines and performs further remedial action and notifications as required.
5. The physician reviews the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies due to identity theft exist, add a notation to the record to indicate the identity theft.
6. Staff members determine whether any other records and/or ancillary service providers are linked to inaccurate information, remove additional files containing information relevant to the identity theft, and take appropriate action.
7. The office informs the patient that he or she is responsible for contacting ancillary service providers.

# OSHA Resources

The mission of the Occupational Safety and Health Administration (OSHA) is to ensure safe and healthy working conditions for working men and women by developing, setting, and enforcing standards and by providing outreach, education, training, and compliance assistance. Under the law, employers have the responsibility to provide a safe workplace.

Physicians, nurses, nurse practitioners, physician assistants, and other health care professionals often encounter work-related health and safety questions as they care for their patients. For more information, see the OSHA website:

<https://www.osha.gov/dts/oom/clinicians/index.html>

# OSHA 300 Log

OSHA's record keeping regulation (29 CFR 1904) requires employers with more than 10 employees (except those in certain low hazard retail, finance, insurance, or real estate industries) to document specific information about work-related illnesses or injuries on the OSHA 300 logs. Physicians may be asked questions by employers to help them decide what should or should not be recorded on the log. All work-related injuries and illnesses that involve medical treatment beyond first aid must be recorded. In addition, all work-related fatalities must be recorded. Employers are required to report a work-related fatality to OSHA within 8 hours. Starting in January 2015, employers are also required to report all work-related in-patient hospitalizations, amputations, and loss of an eye to OSHA within 24 hours. For more information, see OSHA's Injury and Illness Record keeping and Reporting Requirements page:

<https://www.osha.gov/recordkeeping/index.html>

# Workplace Violence Prevention

Workers in health care settings face significant risks of workplace violence because they work directly with people who have a history of violence or who may be delirious or under the influence of drugs. Health care accounts for nearly as many serious violent injuries as all other industries combined. Many more assaults or threats go unreported. OSHA has compiled resources to help you build and implement a comprehensive workplace violence program in your health care facility. For more information, see:

[https://www.osha.gov/dsg/hospitals/workplace\\_violence.html](https://www.osha.gov/dsg/hospitals/workplace_violence.html)

# Medical Services and First Aid

CMG staff must be adequately trained to render first aid. Adequate first aid supplies must be readily available.

Suitable facilities for quick drenching or flushing of the eyes and body must be provided for immediate emergency use for situations where a patient's or staff member's eyes or body are exposed to corrosive materials.

# Infection Control

This section describes guidelines and information for infection control at CMG.

# Universal Precautions

Infection control includes considering any materials that could be potentially contaminated with blood or other human body fluids as infectious, to consider all materials, instruments, environmental surfaces, etc. that could possibly be contaminated with blood or body fluids as infectious, and to prevent cross-contamination of infection between the following categories of persons: patients and employees, patients and patients, patients and visitors, employees and employees, and employees and visitors. This is accomplished using proper infection control techniques, appropriate use of clean/sterile supplies and equipment, and providing a safe environment using infection control procedures and precautions.

Use the following steps:

1. CMG ensures that all procedures meet all current and appropriate regulations and recommendations and provides training and review of all procedures mandated by OSHA and other applicable agencies for dealing with blood-borne pathogens (OSHA 29 CFR 1910.1030).
2. The office is responsible for cleaning, laundering, disinfecting, and repairing all personal protection equipment.
3. The office provides routine housekeeping services, including the removal and disinfection of contaminated laundry and linens.
4. All personnel are trained upon hire and annually thereafter during normal working hours about the risk of exposure to blood-borne pathogens and procedures for preventing exposure and post-exposure requirements.
5. All personnel at risk for occupational exposure to blood-borne pathogens are offered HepB vaccine and necessary boosters. The office maintains documentation of vaccine status or declination of vaccine.

6. The office supplies personal protection equipment to all employees at no cost to employees.

Equipment includes:

- Eye goggles, shields, and face mask/shield protection.
- Head protection, if needed. Caps for employees to restrain and protect hair.
- Foot protection, if needed.
- Hand protection, including latex gloves.

7. All personnel must wash hands after direct or indirect contact with contaminated sources.

8. All personnel must wear protective gloves during procedures where contact with potentially contaminated substances is likely to occur. Wear disposable, waterproof gloves when touching blood and body fluids or when handling contaminated items.

**Note:** Gloves should be used in addition to hand-washing, not as a substitute.

9. All personnel must wear protective masks during procedures when it is likely that their mouth or nose may be splashed with potentially contaminated substances.
10. All personnel must wear protective eyewear during procedures when it is likely that their eyes may be splashed with potentially contaminated substances.
11. All personnel must wear protective cover gowns during procedures when it is likely that their clothes will be contaminated with blood or body fluids.
12. All personnel must wash their hands when gloves are removed or after any direct or indirect contact with any blood or body substances.
13. Whenever possible, use mouthpieces or other ventilation devices instead of mouth-to-mouth resuscitation.
14. Handle potentially contaminated instruments carefully and while wearing gloves designed to withstand cleaning procedures.
15. Clean instruments, equipment, and environmental surfaces in solutions or sterilizers that are appropriate to their level of contamination and that meet appropriate guidelines.



- You must sterilize a critical instrument (one that has penetrated soft tissue or bone or come in contact with mucous membranes) in a heat or heat pressure sterilizer.
  - You must carefully disinfect a touch and splash surface (one that has been exposed to the splatter of blood or body fluids or contaminated by treatment personnel) with an intermediate or higher-level EPA registered, hospital-grade disinfectant. This includes, but is not limited to, equipment and environmental surfaces.
16. Implement appropriate housekeeping techniques to prevent cross-contamination.
  17. Manage infectious patients with communicable diseases appropriately to prevent a spread of the disease.
  18. Dispose of potentially contaminated waste per the "[Hazardous Waste](#)" on page 184 section.
  19. Implement a Blood-borne Pathogens Exposure Control Plan that includes the following:
    - Containers for reusable sharps, contaminated equipment, needles, and sharps
    - Exposure determination
    - Hazardous and regulated waste disposal
    - Hepatitis B vaccine and post-exposure evaluation and follow-up
    - Housekeeping
    - Implementation and compliance methods
    - Information and training
    - Labels and signs
    - Laundry procedures
    - Personal protective equipment
    - Record keeping
    - Specimens
    - Work area restrictions

20. A designated refrigerator must be available for medications that need to be stored in a controlled temperature environment. This refrigerator must not contain food material nor drink that is meant for patients or staff. For more information, see ["Proper Maintenance and Storage of Drugs" on page 122](#).
21. Use the designated area for preparing medications and storing cleaning supplies. This area is designated as a "Clean Area" where access to any material that may or does contain any body fluids is forbidden.
22. Designate an area where dirty laundry, dirty supplies, used food trays, and such items are kept for further processing.
23. Keep hazardous or medical waste separate from regular trash. Hazardous waste includes products that could contain body fluids that might transmit infectious diseases, used medical and surgical supplies that can be discarded rather than autoclaved, etc. A complete list can be obtained from state and county regulatory agencies.
  - Use biohazardous waste containers that can be opened with a step-on mechanism (no use of hands) and are lined with a red bag liner, which indicates contents are a bio-hazardous waste.
  - Ensure waste containers with red biohazardous bags are readily available, although they do not need to be kept in every examination room.
24. Use a specific container for disposal of used syringes and needles in compliance with state and safety regulations. Immediately dispose of (do not recap) used needles, and placed them in a puncture resistant, leakproof container. For more information, see ["Sharps" on page 184](#).
25. Dispose of outdated medications in a timely manner at least once a month. For more information, see ["Proper Maintenance and Storage of Drugs" on page 122](#).
26. Complete a contractual agreement with a pharmaceutical disposal company in your area. The Department of Pharmacy and Health and Safety codes have standards for disposal.

27. Clean patient care areas after each patient use as follows:
- Place a new protector over the examination table. A clean strip of paper should be available for each patient. Discard used paper strips between each patient visits. This protector/barrier is placed between equipment, such as an examination table, chair, and infant weight scale, and the patient.
  - Clean areas contaminated with blood or infectious waste after contact. A 10% bleach solution is recommended.
28. All personnel must wash their hands after going to the toilet, after blowing his or her nose, and after smoking.
29. All personnel must wash and dry their hands before and after patient contact. Wash hands with soap and warm water for 15 to 30 seconds. Waterless, alcohol-based hand-sanitizers are also effective, unless hands are visibly soiled.
30. All personnel must not use linen or cotton towels, but use disposable paper towels instead.
31. All personnel must cover all cuts, sores, and abrasions.
32. Clean products requiring cold sterilization with appropriate solutions that will kill HIV, HBV, and TB. Use solutions according to the product label. For more information, see ["Cold Sterilization" on page 174](#).
- Store cleaning fluid containers in an area controlled from patient access to avoid accidental misuse.
  - Label cleaning fluid containers with the name of the solution, the concentration (especially if dilution was indicated), the date of activation, and the expiration date.

# Sterilization

Ensure instruments, supplies, and equipment are properly sterilized. Post instructions for opening autoclaves and sterilizers in the area where they are located.

Use the following steps:

1. Conduct monthly bacteriological tests on the sterilizer per policy. Maintain results for one year.
2. Check and record sterilizer thermometers daily. Maintain results for one year.
3. Conduct preventative maintenance on the sterilizer according to policy. Maintain log for one year.
4. Transport all contaminated instruments from room to room in a lidded and closed container, such a stainless surgical tray.
5. Place any used and contaminated tools in the tray containing water/germiphene solution for a minimum of 30 minutes to dissolve residues before scrubbing.
6. When preparing to clean surgical instruments, put on gloves, a gown, goggles, and a mask to minimize exposure to contaminants.
7. Keep an effective separation of soiled or contaminated supplies and equipment from the clean and sterilized supplies and equipment. Handle sterile supplies and equipment in a manner that minimizes stress and pressure, and store in clean cabinets, cupboards, or other appropriate spaces protected from dust, insects, vermin, temperature, and humidity extremes. Use an orderly system of rotation of supplies, so that supplies stored first will be used first. For offices with high volume speculum use, these items may be stored unwrapped. You can use the following three types of sterilization, as applicable:
  - Steam sterilization
  - Cold sterilization
  - Gas sterilization

## Steam Sterilization

1. Thoroughly clean items with soap and water, rinse, and dry. Open and/or unlock all jointed items. Disassemble all items designed for disassembly.
2. Place items in appropriate covering/wrapping, and seal with pressure/temperature-sensitive indicator tape. This prevents contamination throughout or after the sterilization process.
3. Position items in a steam sterilizer to enhance air removal, allow free circulation and penetration of steam, and prevent excessive condensation.
4. Follow time temperature settings recommended by the device manufacturer.
5. Do not touch items until adequately cooled.
6. When items are removed, do the following:
  - Check the indicator tape to determine optimum exposure to steam.
  - Ensure no moisture is present.
  - Ensure packing is intact and no seals are broken.
7. Store sterilized items as follows:
  - Store items in an enclosed cupboard for items requiring aseptic delivery or in a sealed container for surgically clean items.
  - Store items away from direct sunlight and moisture.
  - Store items away from dust, insects, and other vermin.
  - Store items loosely packed on clean, smooth, washable shelves.
  - Rotate the packages by placing the newly processed items behind the items already in storage.
8. Use flash sterilization for emergency sterilization only of clean, unwrapped instruments and porous items.

9. Regularly check sterilization dates or expiry dates, and remove and reprocess out-of-date items.
10. Check and record sterilizer indicating thermometers daily. Keep records of thermometer charts for up to one year. If the autoclaves have computerized preset thermometers, this requirement is waived.
11. Conduct monthly bacteriological tests per test manufacture frequency instruction, and keep records of results for up to one year. AMA, JCAHO, CDC DORN recommends 3M Attest be used for weekly tests for the bacterial spore *Bacillus Stearothermophilus*.
12. Perform preventive maintenance of sterilizer on a scheduled basis by qualified personnel using the manufacturer's service manual for the sterilizer as a reference, and keep a maintenance record for up to one year.

## Cold Sterilization

Cold sterilization applies to heat-sensitive items, such as non-metal, non-disposable vaginal speculums, anoscopes, scopes with light bulbs, such as Cystoscopes, and stainless-steel instruments.

1. Use only activated high-level disinfectant at temperature 20° C or higher, and soak all items for a minimum of 10 hours.
2. Keep disinfectant solutions covered and in a well-ventilated area.
3. Thoroughly clean items with soap and water, rinse, and dry. Open and/or unlock all jointed items. Disassemble all items designed for disassembly.
4. Immerse items completely in an activated, high-level, disinfectant solution, such as Cidex Plus, that is at a temperature of 20° C or higher, and soak for a minimum of 10 hours.
5. Use sterile forceps to remove the items from the solution.
6. Rinse items with sterile water, and place on a clean drape or towel.

7. Use only sterilization disinfectant solutions. Keep solutions covered, and use in a well-ventilated area. Do not use solution after the expiration date determined according to manufacturer's written recommendations marked on the container.

## **Gas Sterilization**

Use gas sterilization for heat-sensitive items, such as plastic items. Only use gas sterilization in a well-aerated area. Ethylene Oxide is an example of the type of gas used.

1. Follow all environmental protection procedures.
2. Monitor the length of time for materials gas sterilized.
3. Ensure medical gas cylinders are handled and stored safely.

# Hazard Communication to Staff

CMG is committed to the prevention of exposures that result in injury and/or illness and to comply with all applicable state health and safety rules. To make sure that all affected employees know about information concerning the dangers of all hazardous chemicals used by CMG, the following hazard communication program has been established.

## Container Labeling

The labeling staff member is responsible for container labeling procedures, reviewing labels, and updating labels. All containers are labeled in English. Existing labels on containers of hazardous chemicals will not be defaced or removed.

All labels must include the following:

- A description of the procedures for labeling of secondary containers used, including making sure that they have the appropriate identification and hazard warning, etc.
- A description of procedures for reviewing and updating label warnings and how often the review is conducted.
- The name of the person and position who is responsible for reviewing and updating label warnings.

No container will be released for use until the above procedures are followed.

## Safety Data Sheets

The safety data sheet (SDS) staff member is responsible for establishing and monitoring CMG's SDS program. This person makes sure procedures are developed to obtain the



necessary SDSs and reviews incoming SDSs for new or significant health and safety information. This person ensures that any new information is passed on to affected employees.

An SDS should accompany each purchased item. If not, you can contact the Office of Regulatory Compliance. The SDS staff member must create and maintain procedures for the following:

- Keeping copies current and updated.
- Passing on any new information to affected employees.
- Managing employee access in work areas.

Copies of SDSs for all hazardous chemicals in use are located in the office. SDSs are available to all employees during each work shift. If an SDS is not available or a new chemical in use does not have an SDS, immediately contact the SDS staff member.

**Note:** If an alternative to a printed SDS is used (such as computer data), provide a description of the format.

## Employee Information and Training

The training staff member is responsible for the employee training program. This includes:

- The methods used for general and site-specific training.
- How employees will be informed when non-routine tasks arise.

If your employees work at other employers' job sites, the training staff member specifies where and how these employees will have access to SDSs and labels and how they will be informed of precautionary measures to take during normal or emergency operations, if any.

The training staff member ensures that before starting work, each new employee of CMG attends a health and safety orientation that includes information and training on the following:

- An overview of the requirements contained in the Hazard Communication Standard.
- Hazardous chemicals present at CMG.
- Physical and health risks of the hazardous chemicals.
- The symptoms of overexposure.
- How to determine the presence or release of hazardous chemicals in his or her work area.
- How to reduce or prevent exposure to hazardous chemicals through use of control procedures, work practices, and personal protective equipment.
- Steps CMG has taken to reduce or prevent exposure to hazardous chemicals.
- Procedures to follow if employees are overexposed to hazardous chemicals.
- How to read labels and review SDSs to obtain hazard information, including:
  - What are pictograms?
  - What are the signal words?
  - What are the hazard statements?
  - What are the precautionary statements?
- Location of the SDS file and written hazard communication program.

Before introducing a new chemical hazard into any section of this office, each employee in that section will be given information and training as outlined above for the new chemical. After attending the training, employees will sign a form verifying that they understand the above topics and how the topics are related to our hazard communication plan.

## Hazardous Non-Routine Tasks

Periodically, staff are required to perform hazardous, non-routine tasks, such as confined space entry, tank cleaning, and painting reactor vessels. Non-routine tasks that are performed at CMG include:

- [Add any non-routine tasks performed by employees]
- [Add any non-routine tasks performed by employees]

Prior to starting work on such projects, each affected employee will be given information by the SDS staff member about the hazardous chemicals he or she may encounter during these activities:

For each non-routine task identified above:

1. List the specific chemical hazards.
2. Document protective and safety measures the employee can use.
3. Provide the steps the employer has taken to reduce the hazards, including ventilation, respirators, presence of another employee, and emergency procedures.

## Multi-Employer Work Places

The SDS staff member provides employers of any other employees at the work site with the following information:

- Copies of SDSs (or make them available at a central location) for any hazardous chemicals that the other employers' employee may be exposed to while working.
- Inform other employers of any precautionary measures that need to be taken to protect employees during normal operating conditions or in foreseeable emergencies.
- Provide other employers with an explanation of the labeling system that is used at the work site.

The SDS staff member also identifies and obtain SDSs for the chemicals the contractor is bringing into the work place.

## List of Hazardous Chemicals

The following table lists all known hazardous chemicals used by our employees. Further information on each chemical may be obtained by reviewing SDSs located in the office.

The criteria, such as label warnings, SDS information, etc., used to evaluate the chemicals are:

[Include a description of a plan for how you will update the list.]

### List of Chemicals/SDS Identity

[Here is where you put the chemical list developed during the inventory. Arrange this list so that you can cross-reference it with your SDS file and the labels on your containers.]




Chemical Name	Manufacturer	Location Used







## Rights of Employees

1. Employees will not be required to work with a hazardous chemical from a container that does not have a label, except for a portable container intended for immediate use by the employee who performs the transfer.
2. Staff who are routinely exposed to hazardous chemicals will be informed of such exposures and will have access to SDSs for the hazardous chemicals. In addition, staff will receive training on the hazards of the chemicals and on measures they can take to protect themselves from those hazards.

3. CMG will provide, at no expense to staff, appropriate personal protective equipment to protect staff from exposures to hazardous chemicals.
4. CMG will not discharge, cause to discharge, or otherwise discipline or in any manner discriminate against a staff member because he or she has filed a complaint, assisted an inspector of the state or federal government, instituted or caused to be instituted any proceeding under or related to the Occupational Safety and Health Act or the Right to Know Act, testified or is about to testify in any such proceeding, or because of the exercise of any rights afforded pursuant to the provisions of the Act on behalf of staff or on behalf of others, nor will pay, position, seniority, or other benefits be lost for exercise of any right provided by the Act.
5. A staff member or his/her authorized representative may request, in writing, copies of all environmental monitoring records.

## HCS Pictograms and Hazards

Carcinogen	Flammable	Irritant (skin and eye)
 <ul style="list-style-type: none"> <li>• Mutagenicity</li> <li>• Reproductive Toxicity</li> <li>• Respiratory Sensitizer</li> <li>• Target Organ Toxicity</li> <li>• Aspiration Toxicity</li> </ul>	 <ul style="list-style-type: none"> <li>• Pyrophorics</li> <li>• Self-Heating</li> <li>• Emits Flammable Gas</li> <li>• Self-Reactives</li> <li>• Organic Peroxides</li> </ul>	 <ul style="list-style-type: none"> <li>• Skin Sensitizer</li> <li>• Acute Toxicity</li> <li>• Narcotic Effects</li> <li>• Respiratory Tract Irritant</li> <li>• Hazardous to Ozone</li> </ul>

		Layer (Non-Mandatory)
<b>Gas Cylinder</b>  <ul style="list-style-type: none"> <li>• Gases Under Pressure</li> </ul>	<b>Corrosion</b>  <ul style="list-style-type: none"> <li>• Skin Corrosion/Burns</li> <li>• Eye Damage</li> <li>• Corrosive to Metals</li> </ul>	<b>Exploding Bomb</b>  <ul style="list-style-type: none"> <li>• Explosives</li> <li>• Self-Reactives</li> <li>• Organic Peroxides</li> </ul>
<b>Oxidizers</b> 	<b>Aquatic Toxicity</b>  <ul style="list-style-type: none"> <li>• Environment (Non Mandatory)</li> </ul>	<b>Acute Toxicity (Fatal or Toxic)</b> 

# Preventing Transmission Respiratory Infection

1. Screen patients when scheduling appointments. Whenever possible, patients suspected of carrying a transmittable respiratory infection should be scheduled at the end of the day.
2. Quickly triage patients suspected of carrying a transmittable respiratory infection out of common waiting room areas.
3. Make waterless, alcohol-based hand antiseptics and disposable surgical masks available to all patients. Ask patients suspected of carrying transmittable respiratory infections to wear a mask and use the hand-sanitizer immediately upon entering the clinic and again before seeing a physician or nurse.
4. Close the door of exam rooms to limit access to the patient by visitors and staff members.
5. Indicate patients known to be carriers of antibiotic resistant organisms in their medical record, and take special care to prevent the spread of these organisms, including disinfecting all surfaces that have been in direct contact with the patient immediately after a visit.
6. Use routine infection control practices (hand-washing, sanitizing surfaces, and using personal protective equipment) with all patients, regardless of presumed infection or diagnosis.

# Hazardous Waste

Following are guidelines for dealing with hazardous waste.

## Sharps

Sharps, such as needles and scalpel blades, must be disposed of safely. This minimizes the risk of injury and the transmission of disease.

CMG uses sharps containers that are puncture resistant, clearly labeled, and include the appropriate biohazard symbol.

The person who uses the sharp is responsible for safely disposing of that sharp immediately after use. Do not force a sharp into the container or fill the sharps container beyond its recommended level.

Sharps safes should be placed in a secure location out of reach of children. When sharps containers reach their recommended limit, containers should be securely stored in the waste collection area.

## Spills of Blood and Other Bodily Substances

There are standard precautions used in medical environments when dealing with patients regardless of their infectious state or perceived risk to the health of others. The standard precautions apply to the handling of:

- Blood
- Dried blood
- Saliva
- All other bodily fluids, secretions, and excretions



- Non-intact skin
- Mucous membranes

The precautions staff must take when dealing with these substances include the following:

1. Wear latex gloves and use disposable hand towels to clean up blood spills or any other bodily substances.
2. Place the contamination in a biohazard waste container.
3. Clean the area thoroughly with detergent and apply undiluted disinfectant.
4. Dispose of the gloves and wash your hands thoroughly.

## **Disposal of Patient Specimens**

Separate infectious waste from other waste streams. The waste can then be treated on-site to reduce the concentration of the pathogen to an acceptable level (decontamination), or packaged in a way to prevent subsequent exposure of other persons having to handle the waste prior to terminal treatment. Identify packages of infectious waste with the universal biohazard symbol so that the potential hazard clearly can be recognized and understood by others.

### **Containment**

Infectious waste containers serve as primary barriers to protect the worker and to minimize the chance of environmental contamination. Use containers made from leak-resistant paper or cardboard, stainless steel, or temperature-resistant polymers. Package items as follows:

1. Package solid waste in sturdy bags or boxes.
2. Package pipettes and other laboratory supplies in flat trays with sealable lids during decontamination.

3. Collect bulk liquids in leak-proof containers, decontaminate them, and discharge the liquids into the sewer system. Store liquid infectious waste in plastic carboys designed for chemical disinfection.
4. Package sharps, such as broken glass, brittle plasticware, needles, and scalpel blades in rigid, puncture-resistant, sealable containers.
5. Package wet waste with sufficient absorbent materials to contain residual liquids and minimize leakage. Double-bag wet materials for transport, sealing each bag independently.
6. Place heavy waste, such as anatomical specimens, animal bedding, and laboratory specimens in rigid containers. Ensure that the weight of the waste load does not exceed the burst strength of the container.

Ensure the physical properties of the container are compatible with the treatment process. Waste placed in stainless steel pans, waxed-lined paper bags, tempered glass, and heat-resistant plastics can all be safely processed in an autoclave. Metal containers have been shown to enhance the transfer of heat to the waste load during autoclaving, whereas containers made of plastic retard steam penetration. Processing smaller waste loads and extending the treatment period can compensate for this feature of plastic containers.

Metal receptacles can be autoclaved and recycled but are not suitable for incineration. Ideally, waste should be packaged in disposable receptacles that minimize the handling of the waste and are suitable for the waste treatment method. Cleaning containers that are to be reused is labor intensive and increases the risk of occupational injuries and exposures to biohazards.

### **Personal Protection**

The most important precautions for all personnel handling infectious waste are the wearing of protective gloves and frequent handwashing. Gloves and a laboratory coat are provided for all activities involving manipulations of contaminated items.

1. Change gloves and clothing when soiled or damaged.
2. Wash hands thoroughly after working with infectious materials.

**Note:** Scavenging through waste—as well as eating, drinking, and smoking while working with waste—is prohibited.

## **Waste Collection**

CMG has engaged the services of Biohazard Waste Management Services for the disposal of sharps and other hazardous waste from the clinic.

Biohazard Waste Management Services collects and replaces sharps safes and bio-hazard waste containers on Tuesdays and Fridays.

If additional collections are required, call the service at 555-555-5555.

# Needlestick and Sharps Injuries

Following are guidelines for dealing with needlestick and sharps injuries.

## Treating the Contamination Site

If blood gets on the skin, irrespective of whether there are cuts or abrasions, wash the area well with medicated soap and water. Flush with a solution of one-part bleach to 20-parts water.

If the skin has been penetrated, allow the wound to bleed to assist in flushing out the contamination. If the eyes are contaminated, flush the eye area thoroughly with water or normal saline solution. If blood gets in the mouth, rinse the mouth with water several times.

It is important to deal with a needle stick injury immediately, as in some cases preventative medication can be offered to the affected individual to reduce the risk of infection.

## Reporting the Incident

1. Report the incident immediately to the Office Lead or senior physician in charge.
2. The physician in charge arranges for blood to be taken from the staff member as soon as possible.
3. If a known source individual is involved in the incident, blood should be taken from the source individual and tested for blood-borne viruses. This should be done with the informed consent of the source individual, unless state or local laws allow for testing without consent. This should be collected and processed immediately after the incident.
4. The physician makes the results of these tests available to the exposed worker and informs the worker of the laws and regulations about disclosing the source's identity and infectious status.

5. An injury/incident report must be completed, which includes:
  - Date and time of the incident.
  - How the incident occurred.
  - The nature of exposure (e.g., whether the affected person has been stabbed by a syringe or other sharp, or splashed in the eye).
  - Name of the source individual (if known).
6. When a worker experiences an exposure incident, the physician must make an immediate confidential medical evaluation and follow-up available to the worker.
  - This evaluation and follow-up must be made available at no cost to the worker and at a reasonable time and place, performed by or under the supervision of a licensed physician or other licensed health care professional, and provided according to the recommendations of the U.S. Public Health Service (USPHS) current at the time the procedures take place.
  - Laboratory tests must be conducted by an accredited laboratory and must be at no cost to the worker. A worker who participates in post-exposure evaluation and follow-up may consent to have his or her blood drawn for determination of a baseline infection status, but has the option to withhold consent for HIV testing at that time. In this instance, the employer must ensure that the worker's blood sample is preserved for at least 90 days in case the worker changes his or her mind about HIV testing.
  - The physician must offer post-exposure prophylaxis for HIV, HBV, and HCV, when medically indicated according to the current recommendations of the U.S. Public Health Service.
  - The physician provides counseling for the worker about the possible implications of the exposure and his or her infection status, including the results and interpretation of all tests and how to protect personal contacts.
  - The physician must evaluate reported illnesses that may be related to the exposure.

- The physician obtains and provides the worker with a copy of the evaluating health care professional's written opinion within 15 days of completion of the evaluation. According to OSHA's standard, the written opinion should only include: whether hepatitis B vaccination was recommended for the exposed worker, whether or not the worker received the vaccination, that the physician informed the worker of the results of the evaluation, and any medical conditions resulting from exposure to blood or PIM that require further evaluation or treatment. Any findings other than these are not to be included in the written report.

For more information, go to OSHA's Bloodborne Pathogens and Needlestick Prevention Safety and Health Topics web page at:

<https://www.osha.gov/SLTC/bloodbornepathogens/index.html>

# Medical Records

This section describes guidelines and information for medical records at CMG.

**Note:** This information is provided only as a guideline. Consult with legal counsel before finalizing any policy on the release of patient information.

# Requirements and Standards

All physicians maintain medical records in accordance with the most recent National Committee for Quality Assurance (NSQA) standard. A manner that is current, detailed, and organized permits effective patient care and quality review, and maintains confidentiality.

**Note:** All entries must be legible to someone other than the writer.

This includes the following steps:

1. File the medical record using a systematic method for easy retrieval, such as alphabetical or numerical filing, preferably color-coded to allow for prompt retrieval of medical records and availability to the physician at each patient encounter.
2. Use the medical record system to allow for the tracking of the record when it is out of the filing system and to have a system for the incorporation of information in the chart between visits as well as a system for the archiving of purged data.
3. Ensure medical records are inaccessible to patients and other unauthorized persons and are maintained to guard against unauthorized disclosure of confidential information.
4. Use contracts with physicians that explicitly state expectations about the confidentiality of patient information and records.
5. When a patient changes to a new Primary Care Physician (PCP) (prior to the patient's first visit with the new PCP), transfer medical records to the new physician. Safeguard the privacy of the medical record in transit. Deliver requested information in a timely manner to ensure continuity of care.
6. Maintain a medical record for each patient (not one per family).
7. Securely anchor all pages in the record, and file all pages chronologically.
8. Ensure each page in the record contains the patient's name or patient ID number for patient identification.



9. Regularly update personal/biographical and demographic data, including age, sex, address, telephone number, and marital status.
10. Maintain a copy of a consent to treat form in the medical record.
11. Document all aspects of patient care, including use of ancillary services.
12. Date all entries.
13. Identify the author of all entries, including the title.
14. Ensure the records are legible, documented accurately, and documented in a timely manner.
15. Ensure each medical record contains the following:
  - The patient's name, address, date of birth, Social Security number, subscriber identification numbers, work and home telephone numbers, emergency contact, marital status, employer, the name of any legally authorized representative, and health questionnaire (dated and initialed by the PCP) to establish baseline data.
  - A copy of a consent to treat form.
  - Physical examinations and follow-up care with appropriate subjective and objective information obtained from the presenting complaints.
  - Appropriate vital signs documented at each visit.
  - Allergies and adverse reactions prominently noted on the record. If the patient has no allergies, note absence of allergies (no known allergies or NKA).
  - Past medical history (for patients seen three or more times), including serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history related to prenatal care, birth, operations, and childhood illnesses.
  - For patients 13 years and older, appropriate notation concerning the use of cigarettes, alcohol, and substances. For patients seen three or more times, document any substance abuse history.

- Documentation of appropriate use of consultants. If a consultation is requested, the consultant adds a note in the medical record.
16. Prominently note allergies and adverse reactions on the record. If the patient has no allergies, note absence of allergies (no known allergies or NKA).
  17. Document a record of immunizations for all age groups. For immunizations you must document the lot number, date, time, site, and education given to parents.
  18. For pediatric records (age 12 and under), ensure there is an immunization record, plotted growth charts, and documentation of neurological milestones.
  19. For patients 12 years and older, you must include information provided concerning cigarettes, alcohol, substance use, and anticipatory guidance.
  20. For females, ages 47-57, you must include evidence that the physician has communicated to them their options for dealing with menopause.
  21. For medical records for diabetic members, you must include (1) the medical record that contains a diabetes flow sheet, (2) records of the physician using established diabetes practice guidelines, (3) records containing annual screenings for Hemoglobin A1c, LDL-C, Microalbuminuria, and (4) records containing evidence of annual optometrist/ophthalmologist referral and reason for the referral.
  22. For medical records for documented heart disease, you must include (1) records containing a problem list noting the diagnosis of hypertension, including the date of diagnosis as an entry, (2) records containing a blood pressure reading after the date of entry of the diagnosis of hypertension on the problem list, and (3) records containing evidence of an LDL-C screening performed after discharge for one of the following conditions/procedures: acute myocardial infarction, coronary artery bypass graft, or percutaneous transluminal coronary angioplasty.
  23. List all medications currently used. Medication information must include the name, date prescribed, dosage, frequency, and duration. Medications given on-site must list the name, dosage, date, and site given.

24. Identify current problems, significant illnesses, medical conditions, and health maintenance concerns in the medical record.
25. Note the reason (chief complaints) for the visit.
26. Include a medical history and physical examination with appropriate subjective and objective information for the presenting complaints.
27. Add diagnostic information and a plan of treatment for each visit. For more information, see ["Office Encounter Forms" on page 56](#).
28. Document treatments, procedures, and tests, including results.
29. Indicate if there is a specific follow-up date for a return visit or other follow-up plans for each encounter.
30. Add referrals to a specialist, a hospital, or home health care with corresponding specialist consultant reports, discharge summary, or home health reports, as applicable.
31. Provide evidence that there is continuity and coordination of care between the primary and specialty physicians.
32. Physicians must sign or initial lab, pathology, and x-ray reports filed in the chart to signify that they have been reviewed.
33. Ensure consultation and abnormal lab and/or imaging results have an explicit notation in the record for follow-up plans.
34. Physicians must include their review in all discharge summaries, emergency department reports, specialty consultation reports, and specialty follow-up care notes. The documents must be filed in the chart within two weeks of service.
35. Add evidence of follow-up on failed appointments.
36. Document patient health education, recommendations, instructions, and referrals.
37. Provide evidence that preventive services have been performed and done so appropriately.

38. Document whether the patient has executed an Advance Directive, which is a written instruction such as a Living Will or Durable Power of Attorney for health care relating to the provision of health care when the individual is incapacitated, or a notation that information about Advance Directives was given to the patient as required by federal law. For more information, see ["Advance Directives" on the next page](#).
39. If applicable, file a human sterilization consent form (PM330) in the patient's medical record.
40. Document initial health assessments and Child Health and Disability (CHDP) screenings.
41. Include a copy of the CHDP PM 160 form in the medical record (CHDP Physicians only).
42. Complete the Health Behavior Risk Assessment for each patient during the first appointment with the Primary Care Physician (Medi-Cal members only).
43. Include standard forms for documenting prenatal care. Forms include documentation of medical, psychosocial, nutritional, and educational assessments, interventions, and referrals for prenatal services (Comprehensive Prenatal Services Program [CPSP] Providers only).
44. Store adult medical records for seven (7) years. Store pediatric medical records until the child is 21 years of age per current state and federal requirements.

# Advance Directives

An Advance Directive is a written instruction, such as a Living Will or Durable Power of Attorney, for health care relating to the provision of health care when the individual is incapacitated or a notation that information about Advance Directives was given to the patient as required by federal law. An Advance Directive documents your wishes concerning medical treatments at the end of life.

Before your Advance Directive can guide medical decision making, two physicians must certify the following:

- You are unable to make medical decisions.
- You are in the medical condition specified in the state's Living Will law (such as "terminal illness" or "permanent unconsciousness").
- You meet other requirements from the state.

A medical Power of Attorney (or health care proxy) allows you to appoint a person you trust as your health care agent (or surrogate decision maker), who is authorized to make medical decisions on your behalf.

Before a medical Power of Attorney goes into effect, a person's physician must conclude that he or she is unable to make his or her own medical decisions. If a person regains the ability to make decisions, the agent cannot continue to act on the person's behalf.

Many states have additional requirements that apply only to decisions about life-sustaining medical treatments. For example, before your agent can refuse a life-sustaining treatment on your behalf, a second physician may have to confirm your physician's assessment that you are incapable of making treatment decisions.

Advance Directives are legally valid throughout the United States. While you do not need a lawyer to complete an Advance Directive, your Advance Directive becomes legally valid as soon as you sign it in front of the required witnesses. The laws governing Advance Directives vary from state to state, so it is important to complete and sign Advance Directives that comply with your state's law. Also, Advance Directives can have different titles in different states.

Emergency medical technicians cannot honor Living Wills or medical Powers of Attorney. Once emergency personnel have been called, they must do what is necessary to stabilize a person for transfer to a hospital, both from accident sites and from a home or other facility. After a physician fully evaluates the person's condition and determines the underlying conditions, Advance Directives can be implemented.

Some states do honor Advance Directives from another state. Others honor out-of-state Advance Directives as long as they are similar to the state's own law. Some states do not have an answer to this question. The best solution is to complete the Advance Directives for all the states in which you spend a significant amount of time.

Advance Directives do not expire. An Advance Directive remains in effect until you change it. If you complete a new Advance Directive, it invalidates the previous one.

You should review your Advance Directives periodically to ensure that they still reflect your wishes. If you want to change anything in an Advance Directive after you have completed it, you should complete an entire new document.

# Information Confidentiality and Access to Records

The medical records must be kept secure and accessible only to authorized personnel in order to prevent loss, tampering, disclosure of information, alteration, or destruction of the record. Authorized personnel are those employees within the physician's office, health plan, and medical group or persons authorized through a legal instrument, such as a subpoena.

This includes the following steps:

1. Store active medical records in one central area that is accessible only to authorized personnel.
2. Ensure only assigned personnel, responsible for the maintenance of medical records, have access to medical records.
3. Explicitly state expectations about the confidentiality of a patient's information and records in all physician contracts.
4. Ensure all staff with access to medical records have a signed confidentiality agreement on file in the physician's office.
5. Store and/or dispose of all inactive medical records and patient information in a manner that continues to protect confidentiality. A medical record is considered inactive when a patient has not attended the clinic for more than three years.
  - Physicians must confirm that a patient's medical record is inactive.
  - The physician produces a summary of the medical record and advises administration staff of the need for archiving.
  - Office staff arrange for archiving of inactive material that is to be retained by contacting a storage company.
  - Review archived records annually, and destroy as required.

- Dispose of or destroy all medical records and patient information in such a way that information is not identifiable (e.g., shredded) when it is no longer in use, unless it is retained for regulatory purposes (SB 19).
6. Unauthorized sharing of medical information is prohibited (SB 19). Physicians are expressly prohibited from the following:
- Negligent disposal of medical information.
  - Intentional sharing, sale, or use of medical information for any purpose other than to provide health care services to the patient, except as otherwise authorized.
7. Physicians are prohibited from requiring a patient, as a condition to receive services, to sign an authorization, release, consent, or waiver permitting the disclosure of any medical information in accordance with requirements to maintain confidentiality (SB 19).
8. A health care service plan or provider of health care may disclose medical information for the purpose of disease management if he or she is:
- An entity contracting with a health care service plan or the health care service plan's contractors to monitor or administer care of enrollees for a covered benefit, provided the disease management services and care are authorized by a treating physician.
  - A disease management organization that complies with the physician authorization requirements of Health and Safety Code Section 1399.902, provided that the health care service plan, or its contractor, provides or has provided a description of the disease management services to a treating physician or to the health care service plan's or contractor's network of physicians (AB 2414 - Confidentiality of Medical Information Act Civil Code Section 56.10(c)(17) ).
  - A provider of health care, health care service plan, or contractor is prohibited from disclosing medical information unless the patient has signed an authorization. In certain specific circumstances, disclosure of medical information by providers of health care, health



care service plans, or contractors is mandated under Civil Code Section 56.10(a) and Civil Code Section 56.10(b).

- Except to the extent expressly authorized by the patient or as provided in Civil Code Section 56.10(b) and (c), no corporation nor its subsidiaries and affiliates will intentionally share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient (SB1903) per Civil Code Section 56.10(d).

A provider of health care, health care service plan, or contractor is not permitted to disclose medical information without the patient's authorization to providers of health care, health care service plans, or contractors except:

- For purposes of diagnosis or treatment of the patient per Civil Code Section 56.10(c)(1).
- To an insurer, employer, health care service plan, employee benefit plan, governmental authority, contractor or any other person or entity responsible for paying for health care services rendered to the patient, to the extent necessary to allow responsibility for payment to be determined and payment to be made per Civil Code Section 56.10(c)(2).
- To an independent medical review organization and their reviewers (AB2094) per Civil Code Section 56.10(c)(4).
- Further disclosure of medical information regarding a patient or the provider of health care or an enrollee of a health care service plan (SB1903) per Civil Code Section 56.10(e).

9. Only release medical records under the following conditions:

- Patients, attorneys, or representatives of the patient or attorney receive a copy of the medical records only after presenting a signed authorization from the patient or his/her legal representative.

- The patient presents identification when requesting a copy of his or her medical record.
  - With patient authorization, outside health care providers, federal, state, county, or city agencies, employers, insurance companies, or their representatives may receive a copy of the patient's record.
  - With a subpoena, an officer of the federal, state, or municipal court may gain access to a patient's records.
  - Agencies, such as the FDA, or other authorities that comply with reporting requirements in Title 17 of the California Code of Regulations also may gain access to confidential information.
  - If a requestor receives a court order, the requester may gain access to confidential information. Any release of information in response to a court order or to other authorized persons is to be reported to the patient within five (5) working days.
10. Release patient records to qualified personnel for the purpose of conducting scientific research, whether or not authorized by the enrollee. However, to prevent divulging confidential information, the reports received for research are not to identify, directly or indirectly, any individual patient or otherwise disclose a participant's identity in any manner.
  11. For the purpose of sharing enrollee information with any organization with which the enrollee may subsequently enroll, the physician or organization must provide copies of all the patient's records to the new physician. Deliver the records in a timely fashion so that continuity of care is not impeded (QISMC 3.6.4).
  12. When requesting participation in outpatient behavioral health treatment, the requesting physician must submit a written request to the provider of services and notify the patient of the specific confidential information requested (AB416).
  13. Only assigned personnel responsible for the maintenance of medical records may provide written documents or copies of patient records.

14. Authorization forms permitting release of medical records specify to whom the information may be released, the type of information being requested, and the date and signature of the patient or representative. The patient's name, medical record number, name and organization of the requester, date of request, and the date the record was released is documented and filed in the patient's medical record.
15. Minors have the right to confidential services without parental consent. Therefore, medical records and/or information regarding medical treatment specific to defined confidential services cannot be released to parents without the minor's consent.
16. Ensure all medical records released to authorized parties are legible documents.
17. Patients are given the opportunity to approve or refuse the release of identifiable personal information, except when such release is required by law.
18. Do not disclose confidential patient information by means other than hard copies of medical records. Do not release information over the telephone.
19. All patient medical records obtained for use by the health plan or medical group for utilization management, quality management, or claims purposes are protected from disclosure.
20. Physicians can request a reasonable reimbursement for the cost of copying a patient's medical records.

You can see a sample ["Authorization for Release of Medical Information"](#) on page 213.

# Releasing Confidential Records

Medical records are kept confidential under the California statute “Confidentiality of Medical Information Act, Civil Code §56 et seq. This Act prohibits disclosure of medical information absent an authorization signed by the patient or the patient’s legal representative.

We make available to each employee certain information, including patients’ names, medical history and addresses, communications, files, bills and payment records, office forms or manuals, etc. These items are of substantial value, highly confidential, and constitute the professional and trade secrets of the physician. They are confidential and provided and disclosed to the employees solely for use in connection with their employment.

CMG maintains a policy of strict confidentiality regarding all patient care matters. Employees who handle confidential information are responsible for its security. Extreme care should be exercised to ensure employees safeguard confidential information to protect the patients, the practice, each staff member, the suppliers, and the employer. Any employee who violates this confidentiality and disclosure policy is subject to disciplinary action up to and including discharge, and in extreme cases, legal action. Personnel are required to follow these guidelines:

1. Provide patients access to their medical information.
2. Do not disclose medical information without the consent of the patient.
3. Allow adult patients who inspect their medical records pursuant to Health and Safety Code Section 123110 to provide a written addendum to the records if the patient believes the records are incomplete, inaccurate, out of date, or misleading. This addendum is limited to 250 words per incomplete or incorrect item and must be attached to the patient records and included when disclosed to other parties. Health care providers are not subjected to liability for the receipt and inclusion of these addenda in patient records (SB1903) per Health and Safety Code Section 123111.

- If a patient requests an amendment, the physician should add notes to the record to indicate the nature of the request and the changes made.
  - If a patient requests access to his or her medical record, this information can be provided by way of a summary. Provision of a medical record or summary should always be accompanied by an explanation from the physician and an offer to discuss any patient concerns.
  - On rare occasions, a physician can request that some information not be made available to a patient. This may be necessary if it is believed the information may be detrimental to a patient's health and well being if read by the patient.
  - If requested by a patient, the clinic transfers a copy of the medical record or summary to another medical clinic or physician.
4. Ensure authorization forms permitting release of medical records specify to whom the information may be released, the type of information being requested, and include the date and signature of the patient or representative. The patient's name, medical record number, name and organization of the requester, date of request, and the date the record was released is documented and filed in the patient's medical record.
  5. Do not disclose any psychotherapy outpatient treatment without written consent by the patient, and notify the patient of the request.
  6. Give patients the opportunity to consent to or deny the release of medical information, except as required by law.
  7. Physicians can disclose patient medical records without patient authorization when authorized by law.
  8. Disclose medical information as required to secure payment to insurers, employers, health plans, government entities, or others responsible for payment for services.
  9. Physicians can request a reasonable reimbursement for the cost of copying a patient's medical records.

10. Regard and preserve practice information as highly confidential and trade secrets of the employer. Do not disclose or permit to be disclosed any of this information to any person or entity. This includes the following:

- Do not discuss this information away from the premises or within hearing distance of any patient or unauthorized person.
- Do not photocopy or duplicate, and do not permit any person to photocopy or duplicate, any practice information without the employer's consent and approval.
- Continue to keep any information inviolate, even after termination of employment with the office.
- Only release personal information, such as telephone number, address, etc., about other staff members with the staff member's specific and prior approval in writing.

# Confidentiality Agreement for Physician Office Employees

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is United States legislation that provides data privacy and security provisions for safeguarding medical information. It is the intention of CMG to ensure the confidentiality and integrity of protected health information of both patients and employees, as required by HIPAA, professional ethics, accreditation standards, licensure requirements, and any other legal requirements. Employees, students, and volunteers are expected to follow CMG's policies, guidelines, and standards for workforce performance expectations, which are mandated by HIPAA. Violation of these rules and standards will constitute grounds for disciplinary action up to and including termination, professional discipline, and criminal prosecution.

Employees are required to comply with all relevant standards, including the following:

- An employee must not review employee or patient-protected health information for any purpose other than treatment, payment, or health care operations, and only with a legitimate need to know such information.
- An employee, student, or volunteer must not disclose to others employee or patient-protected health information for any purpose other than treatment, payment, or health care operations, and only with the others having a legitimate need to know such information.
- An employee, student, or volunteer must not discuss a patient's protected health information in a public area or outside of the office's premises.
- An employee, student, or volunteer must secure protected health information to avoid inadvertent disclosure.

- An employee, student, or volunteer must not intentionally access or disclose protected health information in a manner inconsistent with office policies and procedures, for personal gain, curiosity, concern, or any other reason not permitted by HIPAA.
- An employee, student, or volunteer must report to his or her supervisor his or her knowledge of any breach in HIPAA confidentiality standards.

CMG will not take disciplinary action against any employee, student, or volunteer who makes an internal complaint, participates in an investigation, or makes a disclosure to a federal or state oversight agency or public health authority authorized by law to oversee the relevant conduct of CMG or to an appropriate health care accreditation organization, when the employee is acting in good faith on the belief that the office has engaged in conduct that is unlawful or otherwise violates professional or clinical standards.

I, \_\_\_\_\_ acknowledge my understanding of my duties, as set forth herein. I further understand that these duties apply during work hours and during off duty time. I further understand that these duties and standards apply even after the termination of my employment with CMG. I understand that my failure to comply with these standards during my employment may result in disciplinary action, civil liability, and/or criminal prosecution. I understand that my failure to comply with these standards after my employment ends may result in civil liability and/or criminal prosecution.

_____	_____
Employee/Student/Volunteer Signature	Date
_____	_____
Witness	Date



# Model Letter to a Patient Who Requests Withholding of Information from Disclosure

10/30/2018

CONFIDENTIAL

Patient's Name

Address

City, State Zip

Re: Release of Medical Information

Dear Patient:

I am in receipt of both your general authorization for release of your medical records [insert entity name] and of your request that certain information in the record not be disclosed. I understand the need for confidentiality concerning the medical information in your file. The principal California statute governing confidentiality of medical information is the Confidentiality of Medical Information Act. Civil Code §56 et seq. This act prohibits disclosure of medical information absent an authorization signed by the patient or the patient's legal representative. Except as authorized by this statute and other relevant laws, I will not release information regarding your medical condition and treatment without having first obtained your prior written authorization.

However, you should be aware that if you refuse to permit disclosure of certain information to certain entities, this may make it impossible for me to respond to requests from such entities for your health care records. For example, if you apply for life or health insurance coverage, such insurers will, no doubt, ask you to authorize release of your health care records as part of the application process. If you then notify me that, despite the general authorization which you signed, you do not want selected information disclosed, I will

not be able to assist you in your effort to obtain insurance coverage. I cannot disclose only a portion of your medical information without notifying the insurer that a portion of the file has been withheld at the patient's request.

If the information you do not wish disclosed is covered by a special statutory confidentiality protection, the situation will be different. If that is the case, I may disclose your general medical information (without the specially protected information) and provide the entity with a boilerplate notification as part of the disclosure, which states:

"This disclosure does not contain information, if any exists, that is protected by special state and/or federal confidentiality requirements. Such information, if it exists, can only be released pursuant to special patient authorization."

If you believe that the information you wish to withhold is covered by such a special protection, please notify me of that protection immediately and, if appropriate, I will disclose the information other than that which is specially protected, along with the boilerplate notification listed above. You should be aware, however, that upon receiving such a notice, the insurer or other entity will almost certainly ask you to sign a specific authorization for disclosure of the otherwise confidential information.

Please note also that the law allows physicians to share medical information for both treatment and billing purposes, even absent a patient's written consent. Moreover, the law requires physicians to share medical information under some circumstances, such as pursuant to a valid court order.

# Authorization to Transfer Medical Records

I hereby authorize \_\_\_\_\_, M.D., to furnish medical information concerning \_\_\_\_\_ (patient's name) to Dr. \_\_\_\_\_.

\_\_\_\_\_ (physician's name and address).

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records, and/or HIV test results, if any, except as specifically provided below:

\_\_\_\_\_  
\_\_\_\_\_

[Optional: I understand and agree to pay a reasonable charge to cover the cost of the transfer. I understand the costs will be computed based on a copying fee of \$.25 per page for standard documents, actual costs for the reproduction of oversized documents or documents requiring special processing, and reasonable clerical costs for locating and making the records available.]

This authorization is effective now and will remain in effect until:

\_\_\_\_\_ (date)

I understand that I may receive a copy of this authorization.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

☐

Parent or guardian of minor patient

☐

Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient\*

**Note:** To be valid, this authorization must be handwritten by the person who signs it or in typeface no smaller than 8-point type. It must be clearly separate from other language on the page and executed by a signature, which serves no purpose other than to execute the authorization.

\* It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain specific records, such as the patient's mental health records and/or HIV test results.

# Authorization for Release of Medical Information

I hereby authorize \_\_\_\_\_, M.D., to furnish medical information concerning \_\_\_\_\_ (patient's name) to Dr. \_\_\_\_\_.

\_\_\_\_\_ (name and address of person to receive records)

Any and all information may be released, including, but not limited to, mental health records protected by the Lanterman-Patris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information may be used only for the following purposes:\*

\_\_\_\_\_

This authorization is effective now and will remain in effect until:

\_\_\_\_\_ (date)

I understand that I have the right to receive a copy of this authorization.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care)

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient \*\*

☐ Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

\* Signed (Physician): \_\_\_\_\_ Dated: \_\_\_\_\_

**Note:** To be valid, this authorization must be handwritten by the person who signs it or in typeface no smaller than 8-point type. It must be clearly separate from other language on the page and executed by a signature which serves no purpose other than to execute the authorization.

For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient, or representative, sign the authorization form before information can be released.

\*\* It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain specific records, such as mental health records covered by the Lanterman-Petris-Short Act and/or HIV test results.

# Privacy Complaints

The Medical Records Supervisor/Privacy Officer or appointed designee takes all complaints and/or allegations of non-compliance seriously and fully investigates the allegations to determine the course of corrective action.

1. The Medical Records Supervisor/Privacy Officer or appointed designee keeps a log of all complaints and/or allegations of non-compliance and the outcome of the internal investigation of the allegations.
2. CMG informs our patients of their rights under HIPAA's Privacy Rule to file a complaint with our Medical Records Supervisor/Privacy Officer and the Office of Civil Rights (OCR) when they have reason to believe we have violated their privacy rights.
3. The patient completes the Privacy Complaint Form detailing the specific possible violation of health information occurrences and dates. This form is reviewed by the Medical Records Supervisor/Privacy Officer or appointed designee to assist the patient to make sure that the most complete information is provided on the violation form.
4. The Medical Records Supervisor/Privacy Officer or appointed designee takes all complaints and/or allegations of non-compliance seriously and fully investigates the allegations to determine what course of corrective action, if any, needs to be taken.
5. The Medical Records Supervisor/Privacy Officer or appointed designee notifies the patient in writing of the outcome of the investigation and what corrective action, if any, was taken.
6. The OCR may also conduct compliance reviews to determine whether CMG is complying with the applicable requirements of this rule.
  - If the OCR initiates a compliance review of our practice, CMG complies with all requests for information and produces records and compliance reports to the OCR in a timely manner in order for the OCR to determine whether or not CMG is in compliance with the Privacy Rule.

- CMG provides the OCR access during normal business hours to our facility, books, records, accounts, and other sources of information, including Protected Health Information, that is pertinent to ascertaining compliance with the applicable standards.
- If the OCR determines that exigent circumstances may exist at the health center, such as when documents or patient's protected health information may be hidden or destroyed, CMG permits immediate access to the OCR at any time and without notice.
- If protected health information is required for the investigation and the information is the exclusive possession of any other agency, institution, or person and the other agency, institution, or person fails or refuses to furnish the information, CMG certifies what efforts were made to obtain the information.
- The OCR sends a written copy of the outcome of the review to the complainant and CMG.
- If CMG is found to be non-compliant, CMG attempts to quickly resolve the matter by informal means.



# Mitigation of Privacy Breaches

HIPAA privacy and security breaches can result in fines of \$100 to \$50,000 to covered entities (including health care providers and health plans) and their business associates. (45 CFR 160.404). If the violation resulted from “willful neglect,” the Office for Civil Rights (OCR) must impose a mandatory fine of \$10,000 to \$50,000 (45 CFR 160.404). Covered entities and their business associates must self-report breaches of unsecured protected health information (PHI) to the affected individual and to the U.S. Department of Health & Human Services (HHS) (45 CFR 164.400). Failure to do so may constitute “willful neglect” resulting in additional fines. The OCR may not impose a fine as long as the covered entity or business associate did not act with “willful neglect” and corrected the problem within 30 days. (45 CFR 160.410(b)).

Given the potential consequences, it is critical that covered entities and business associates respond appropriately to potential HIPAA breaches to avoid or minimize their liability. The following are steps that you can follow to help you identify and respond to HIPAA breaches:

1. Stop the breach. Immediate action may help avoid or mitigate the effects of a breach.
  - Terminate improper access to PHI.
  - Retrieve any PHI that was improperly disclosed.
  - Obtain assurances from recipients that they have not, or will not, further use or disclose PHI that was improperly accessed.
  - Document your actions.
2. Notify the privacy officer. Each covered entity must have a designated privacy officer who has the training and experience to properly investigate and respond to a potential breach. Deadlines for responding to breaches generally run from the date that anyone in the organization knew of the breach, except the person committing the breach (see 45 CFR 164.404(b); 78 FR

5647). Accordingly, workforce members should be trained to notify the privacy officer as soon as they become aware of a breach.

3. Respond promptly. Swift, appropriate action is critical for at least four reasons:

- Covered entities have an affirmative obligation to mitigate the effects of any breach (45 CFR 164.530(f)).
- Prompt action may help avoid or mitigate further breaches, which is an important factor in determining whether a breach is reportable (45 CFR 164.402).
- As discussed above, a covered entity or business associate may avoid penalties if they correct a violation within 30 days (45 CFR 160.410(b)).
- The breach notification rule requires that notice of reportable breaches be given “without unreasonable delay,” but no later than 60 days after discovery (45 CFR 164.404).

4. Investigate appropriately.

- Confirm the “who, what, when, where, why, and how” with persons involved, including persons who committed the alleged violation, persons who may have received PHI improperly, and other relevant witnesses.
- Confirm the nature and scope of the PHI that was accessed, used, or disclosed, and why they accessed or disclosed the PHI.

**Note:** Do not report a suspected breach before you have actually concluded that a reportable breach occurred.

5. Ensure there was no redisclosure and will not be any further redisclosure. In your discussions, ensure that you do not inadvertently disclose additional PHI.
6. Document your investigation, including obtaining witness statements or sending confirming letters as appropriate. For example, you may want to send a letter to alleged recipients confirming the extent of their access or disclosure of PHI, and warning them of the penalties that may apply if they further use or disclose PHI improperly (See 42 USC 1320d-6).

7. Mitigate the effects of the breach. HIPAA requires that a covered entity mitigate any harmful effects of a breach to the extent practicable. (45 CFR 164.530(f)). The response will depend on the circumstances. If a covered entity knows that a business associate is violating HIPAA, it must either take steps to cure the breach or terminate the business associate agreement (45 CFR 164.504(e)(1)). Mitigation may include:
  - Retrieving, deleting, or destroying improperly disclosed PHI.
  - Terminating access or changing passwords.
  - Remote wiping mobile devices.
  - Modifying policies or practices.
  - Warning recipients of potential penalties for further violations.
  - If applicable, paying for the cost of a credit monitoring service or similar action, and/or notifying affected individuals even if the breach is not reportable under the breach notification rules.
8. Correct the breach. A covered entity may avoid HIPAA penalties if it did not act with willful neglect and corrects the problem within 30 days (45 CFR 160.410(b)). Although you may not be able to “unring” the bell, you can ensure that the bell does not continue ringing by changing processes, implementing new safeguards, modifying policies, and/or training employees (See 75 FR 40879).
9. Impose sanctions. HIPAA requires that covered entities have, apply, and document appropriate sanctions against workforce members who violate HIPAA or privacy policies (45 CFR 164.530(e)). The sanction should fit the crime. It may range from a written warning and additional training to suspension or termination.
10. Determine if the breach is reportable to the individual and HHS. Under the breach notification rule, covered entities are only required to self-report if there is a “breach” of “unsecured” PHI (45 CFR 164.400 et seq.).

- **Unsecured PHI:** “Unsecured” PHI is that which is “not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology” specified in HHS guidance (45 CFR 164.402). Currently, there are only two ways to “secure” PHI: (1) in the case of electronic PHI, by encryption that satisfies HHS standards; or (2) in the case of e-PHI or PHI maintained in hard copy form, by its complete destruction (74 FR 42742). Breaches of “secured” PHI are not reportable. Most potential breaches involve “unsecured” PHI.
- **Breach:** The unauthorized “acquisition, access, use, or disclosure” of unsecured PHI in violation of the HIPAA privacy rule is presumed to be a reportable breach unless the covered entity or business associate determines that there is a low probability that the data has been compromised or the action fits within an exception (45 CFR 164.402; see 78 FR 5641). Thus, the covered entity or business associate must determine the following:
  - **Was there a violation of the privacy rule?** Breach notification is required only if the acquisition, access, use, or disclosure results from a privacy rule violation. No notification is required if the use or disclosure is permitted by the privacy rules (45 CFR 164.402). For example, a covered entity may generally use or disclose PHI for purposes of treatment, payment, or health care operations without the individual’s authorization, unless the covered entity has agreed otherwise (45 CFR 164.506). Disclosures to family members and others involved in the individual’s care or payment for their care is generally permitted if the patient has not objected and the physician otherwise determines that disclosure is in the patient’s best interest (45 CFR 164.510). HIPAA allows certain other disclosures that are required by law or made for specified public safety or government functions (45 CFR 164.512). Disclosures that are incidental to permissible uses or disclosures do not violate the privacy rule if the covered entity employed reasonable safeguards (45 CFR §§ 164.402 and .502(a)(1)(iii)). When in doubt as to whether a

disclosure violates the privacy rule, you should check with your privacy officer or a qualified attorney.

- **Does the violation fit within breach exception?** The following do not constitute reportable “breaches” as defined by HIPAA:
  - An unintentional acquisition, access, or use of PHI by a workforce member if such acquisition, access, or use was made in good faith and within the scope of the workforce member's authority and does not result in further use or disclosure not permitted by the privacy rules (45 CFR 164.402). For example, no notification is required where an employee mistakenly looks at the wrong patient's PHI but does not further use or disclose the PHI (74 FR 42747).
  - An inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate, and the PHI is not further used or disclosed in a manner not permitted by the privacy rules (45 CFR 164.402). For example, no notification is required if a medical staff member mistakenly discloses PHI to the wrong nurse at a facility but the nurse does not further use or disclose the PHI improperly (74 FR 42747-48).
  - A disclosure in which the person making the disclosure has a good faith belief that the unauthorized recipient would not reasonably be able to retain the PHI (45 CFR 164.402). For example, no notification is required if a nurse mistakenly hands PHI to the wrong patient but immediately retrieves the information before the recipient has a chance to read it (74 FR 42748).
- **Is there a “low probability that the data has been compromised?”** No report is required if “there is a low probability that the PHI has been compromised based on a risk assessment” of at least the following factors listed in 45 CFR 164.402:

- **The nature and extent of the PHI involved**, including the types of identifiers and the likelihood of re-identification. For example, PHI involving financial data (e.g., credit card numbers, social security numbers, or account numbers), sensitive medical information (e.g., mental health, sexually transmitted diseases, or substance abuse), or detailed clinical information (e.g., names and addresses, treatment plan, diagnosis, medication, medical history, or test results) create a higher probability that data has been compromised and must be reported (78 FR 5642-43).
- **The unauthorized person who impermissibly used the PHI or to whom disclosure was made**. For example, disclosure to another health care provider or a person within the entity's organization would presumably create a lower risk because such persons are more likely to comply with confidentiality obligations and are unlikely to misuse or further disclose the PHI. Similarly, there is a lower risk of compromise if the entity who receives the PHI lacks the ability to identify entities from the limited information disclosed (78 FR 5643).
- **Whether the PHI was actually acquired or viewed**. For example, there is likely a low risk if a misdirected letter is returned unopened or a lost computer is recovered and it is confirmed that PHI was not accessed. Conversely, there is a higher risk where the recipient opens and reads a misdirected letter even though she reports the letter to the covered entity (78 FR 5643).
- **Whether the risk to the PHI has been mitigated**. For example, there may be a lower risk if a fax is directed to the wrong number, but the recipient confirms that he or she returned or destroyed the PHI, the PHI has not been and will not be further used or disclosed, and the recipient is reliable (78 FR 5643). This factor highlights the need for covered entities and business associates to immediately identify and respond to potential breaches to reduce

the probability that PHI is compromised and the necessity of breach reporting.

The risk assessment should involve consideration of all of these factors in addition to others that may be relevant. One factor is not necessarily determinative, and some factors may offset or outweigh others, depending on the circumstances (78 FR 5643). If you conclude that the risk assessment demonstrates a low probability that the PHI has been compromised, you should document your analysis and you may forego breach notification. On the other hand, if the risk assessment fails to demonstrate a low probability that the PHI has been compromised, you are required to report the breach to the affected individual and HHS as described below.

11. If required, report the breach to the individual and HHS. If the breach notification rule requires a report, the covered entity and business associate must make the required reports. HHS has indicated that failure to do so will likely constitute “willful neglect”, thereby triggering mandatory penalties if discovered (75 FR 40879).
  - **Notice to covered entity:** Business associates must notify the covered entity within 60 days after discovery so that the covered entity may provide the required notices to others (45 CFR 164.410(c)). Covered entities may want to ensure their business associate agreements shorten the time for business associate reports to approximately three days, thereby allowing the covered entity to respond promptly to suspected breaches and minimize liability.
  - **Notice to individual:** Covered entities must notify the affected individual or his or her personal representative without unreasonable delay, but in no event longer than 60 days following discovery (45 CFR 164.404(b)). There are alternative notice procedures if the covered entity does not know the identity or contact information for affected persons. The notice must be sent by first class mail and contain the following information:

- A brief description of the breach, including the dates of the breach and its discovery.
  - A description of the types of unsecured PHI involved.
  - Steps the individual should take to protect himself or herself from resulting harm.
  - A description of the covered entity's actions to investigate, mitigate, and protect against future violations.
  - Procedures the individual may take to contact the covered entity for more information (45 CFR 164.404(c)-(d)).
- **Notice to HHS:** The timing of notice to HHS depends on the number of persons affected by the breach. If the breach involves fewer than 500 persons, the covered entity may wait to report the breach to HHS until no later than 60 days after the end of the calendar year (45 CFR 164.408(c)). If the breach involves 500 or more persons, the covered entity must notify HHS at the same time it notifies the individual (Id. at 164.408(b)). Covered entities should submit the report electronically using the form available at:

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html>

The OCR posts the names of entities with breaches involving more than 500 persons on the OCR's wall of shame at:

[https://ocrportal.hhs.gov/ocr/breach/breach\\_report.jsf](https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf)

- **Notice to media:** If the breach involves more than 500 persons in a state, the covered entity must also notify local media within 60 days of discovery (45 CFR 164.406). The notification must contain information similar to that provided to individuals (Id. at 164.408(c)).



- **Documentation:** A covered entity is required to maintain documentation concerning its breach analysis and/or reporting for six years (45 CFR 164.414 and 164.530(j)).
12. Log the breach in the Accounting of Disclosure log. Whether or not the breach is reportable to the individual or HHS, covered entities and business associates are still required to record impermissible disclosures in their Accounting of Disclosure log as required by 45 CFR 164.528. The log must record the date of the disclosure, name and address of the entity who received the PHI, a brief description of the PHI disclosed, and a brief statement of the reason for the disclosure (45 CFR 164.528(b)). If requested, the covered entity must disclose the log to the individual or the individual's personal representative within 60 days (Id. at 164.528(c)).

# Review of Test Results

Diagnostic tests are completed and reviewed by a physician in a timely manner. All abnormal and stat diagnostic tests are evaluated by a physician to determine the need for follow up.

Use the following steps:

1. The physician logs all laboratory specimens sent to outside laboratories with notation of the patient's name, the type of test, the ordering physician, lab name and location, and date sent (MM/DD/YYYY). The staff member responsible for logging out specimens add his or her initials.
2. The lab reports Panic Level results (potentially life threatening) to the physician immediately, and the physician takes immediate appropriate patient intervention action.
3. The physician logs written results upon receipt with the date of receipt and his or her initials before being placed in the patient's chart. All test results are required to reach the ordering physician for review within two (2) weeks after the completion of the test.
4. The physician notifies patients of routine test results or changes in the treatment plan by telephone, written notice, or in person at the next office visit. The physician documents notification/intervention in the patient's chart.
5. A designated staff member monitors the log. In the event the results are not returned within the expected time frame, he or she is responsible for following up with the lab, either by telephone or fax. Follow-up calls are noted with the date and staff initials.
6. The physician logs lab tests that require a referral for specimen collection outside of the office if the patient requires medication adjustments.
7. The physician only logs orders for routine testing associated with annual health physicals or preventive care visits if the patient must initiate test or test follow-up.

8. A qualified clinical staff member or the physician initials normal test results to indicate he or she reviewed the results. Patients are not normally notified of normal test results, unless they call to request results. Patients are informed of this procedure at specimen collection.
9. Abnormal test results are referred to the physician for review. The physician initials the results indicating his or her review and notes action taken in the medical record in the form of notes or on the lab report itself. All patients are notified of abnormal test results and given follow-up instructions.
10. Results for repeated tests, if indicated, follow the above procedures.

# Scanning Medical Records and Documents

When scanning documents, do the following:

1. Save documents with the patient's name (last name, first name).
2. Add additional information for each document as follows:
  - **X-rays/ultrasound/medical imaging:** If there is a summary, comment, or impression, include this information. If this information does not exist, you must type in the report text.  
  
**Note:** Sometimes two or more areas are reported on one x-ray report. It is important that staff record both and bold each area, so the physicians can see both easily.
  - **Consult from a physician:** Add the physician's name.
  - **Reports or records faxed to a lawyer or insurance company:** Add the date received, who the request was from, and what date it was faxed or mailed. The message can be archived right away as the physicians have seen it.
  - **ECG reports:** Add whether the report is Normal or Abnormal and any comments.
  - **Walk-in clinic reports:** Add the physician's name if legible or the name of the clinic and the reason for visit.

# Limited Data Set Records

A limited data set is a limited set of identifiable patient information as defined in the Privacy Regulations issued under the Health Insurance Portability and Accountability Act (HIPAA). A limited data set of information may be disclosed to an outside party without a patient's authorization if certain conditions are met. First, the purpose of the disclosure may only be for research, public health, or health care operations. Second, the person receiving the information must sign a data use agreement with CMG. This agreement has specific requirements which are shown below.

A limited data set is information from which identifiers have been removed. Specifically, as it relates to the individual or his or her relatives, employers, or household members, all the following identifiers must be removed in order for health information to be a limited data set:

- Names
- Street addresses (other than town, city, state, and zip code)
- Telephone numbers
- Fax numbers
- Email addresses
- Social Security numbers
- Medical records numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate license numbers
- Vehicle identifiers and serial numbers, including license plates

- Device identifiers and serial numbers
- URLs
- IP address numbers
- Biometric identifiers (including finger and voice prints)
- Full-face photos (or comparable images)

The health information that may remain in the information disclosed includes:

- Dates such as admission, discharge, service, date of birth, and date of death
- City, state, five-digit or more zip code
- Ages in years, months, days, or hours

**Note:** This information is still protected health information (PHI) under HIPAA. It is not de-identified information and is still subject to the requirements of the Privacy Regulations.

## Data Use Agreements

Because a limited data set is still PHI, the Privacy Regulations protect the privacy of individuals by requiring covered entities (CMG) to enter into Data Use Agreements with recipients of limited data sets. The Data Use Agreement must meet the following standards specified in the Privacy Regulations:

- Establish the permitted uses and disclosures of the limited data set.
- Identify who may use or receive the information.
- Prohibit the recipient from using or further disclosing the information, except as permitted by the agreement or as permitted by law.
- Require the recipient to use appropriate safeguards to prevent a use or disclosure that is not permitted by the agreement.

- Require the recipient to report to the covered entity any unauthorized use or disclosure of which it becomes aware.
- Require the recipient to ensure that any agents (including a subcontractor) to whom it provides the information to agree to the same restrictions as provided in the agreement.
- Prohibit the recipient from identifying the information or contacting the individuals.

The limited data set provisions also require covered entities to take reasonable steps to cure any breach by a recipient of the Data Use Agreement. If CMG determines that data provided to a recipient is being used in a manner not permitted by the agreement, it must work with the recipient to correct this problem. If these steps are unsuccessful, CMG must discontinue disclosure of PHI to the recipient under the Data Use Agreement and report the situation to the Privacy Office at 555-555-5555 or email@email.com.

## **Creating the Limited Data Set**

A covered entity (CMG) can use one of its own workforce to create the limited data set. The Department of Health and Human Services (DHHS) indicates that a covered entity may allow a person requesting a limited data set to create it, as long as the person is acting as a business associate of the covered entity. A business associate is someone who is not part of the covered entity's workforce but who will use the covered entity's PHI to perform some task on behalf of the covered entity. Examples of business associates include lawyers, accountants, and firms that analyze patient data. The covered entity (CMG) must enter into a separate business associate agreement with the entity, and the agreement must meet the requirements of the Privacy Regulations. After the limited data set is created under the business associate agreement, all of the PHI, other than the PHI qualifying as the limited data set under the data use agreement, must be returned to the covered entity.

Thus, it is possible that someone at the recipient will act as the covered entity's business associate to create the limited data set from a broader set of PHI. In such a case, the recipient must sign both the data use agreement and the business associate agreement.

## **Responsibility for Data Use Agreements**

Following are the responsibilities of Data Use Agreements.

### **When CMG is the Provider of the Data**

CMG has drafted a Data Use Agreement form document for use by those who wish to disclose a limited data set to recipients. This template may be accessed at HIPAA IRB Form 9. When CMG is providing the limited data set, if any material change is to be made to this template form, or if another party's version of a Data Use Agreement is to be used, the office must review and approve the terms of the agreement. See HIPAA Policy template AB.9.1b.

### **When CMG is the Recipient of the Data**

If a research at CMG is the recipient of a limited data set of PHI from a non-CMG office source, the office researcher will most likely be asked to sign the other party's Data Use Agreement. In such instance, the CMG researcher is responsible for reviewing the Data Use Agreement and determining if it complies in material terms with the CMG Data Use Agreement template. If the other party's Data Use Agreement differs materially from the CMG Data Use Agreement template, or if there is any uncertainty, the Office of Research Administration must be consulted.

## **Tracking and Accounting**

Disclosures of a limited data set are not subject to the HIPAA tracking and accounting requirements. The marginal increase in privacy protections that such an accounting would provide is outweighed by its burdens. DHHS has taken the position that the privacy of



individuals with respect to PHI disclosed in a limited data set can be adequately protected through a signed Data Use Agreement.

# Accounting of Disclosures

A disclosure is a release, transfer, access to, or divulging of information outside of CMG. In general, patients have the right to know who has received their health information for reasons other than treatment, payment, health care operations, or disclosures specifically authorized by the patient. Examples of this are public health activities (reporting vital statistics, communicable diseases, cancer/tumor registries), reports about victims of abuse, neglect, or domestic violence, releases as a result of a subpoena, disclosures about decedents to coroners, medical examiners, or funeral directors, and other disclosures required by law. Under HIPAA, disclosures that are not part of treatment, payment, and/or operations and that are not authorized by the patient must be tracked.

## Included in the Accounting

The following disclosures must be recorded using the Accounting of Disclosures System (ADS) if protected health information is disclosed. This list is designed to capture the most common disclosures, but there may be others that are not listed. If you are unsure whether a disclosure should be tracked, check with your supervisor or email [email@email.com](mailto:email@email.com).

Disclosure	Examples
For public health purposes	Immunizations  Infectious/communicable disease reporting (e.g., HIV, STD, TB, food-borne)  Vital statistics (e.g., birth and death certificates, fetal death, teen suicides)  Newborn screening  Oregon death with dignity (physician-assisted

Disclosure	Examples
	<p>suicide)</p> <p>Reports of death for purposes of organ donation</p> <p>Poison control</p> <p>Lead poisoning</p> <p>Suspected pesticide poisoning</p> <p>Animal bites</p>
<p>About victims of abuse, neglect, or domestic violence</p> <p>(This includes disclosure to Social Services or a protective service agency to report.)</p>	<p>Domestic violence and intimate partner violence</p> <p>Elder abuse</p> <p>Child abuse</p> <p>Abuse of mentally ill or developmentally disabled</p>
For health oversight activities	<p>Audits (e.g., by Center for Medicare and Medicaid services)</p> <p>Inspections (e.g., Dept. of Health and Human Services, Office for Human Research Protections)</p> <p>Oversight Reviews (e.g., OMPRO; OR Dept. of Health)</p>
For judicial or administrative proceedings	Court orders

Disclosure	Examples
	Subpoenas
For law enforcement purposes	Reporting of gunshot wounds
To coroners, medical examiners, or funeral directors	About decedents
For cadaveric organ, eye, or tissue donation and transplantation purposes	Activities related to Medicare conditions of participation
For human-subject research that does not obtain a subject's authorization	Research that receives a waiver of authorization by the IRB  Research involving the health information of decedents
To avert a serious threat to health or safety	
To the Food and Drug Administration (FDA) for purposes related to the quality, safety, or effectiveness of a FDA-regulated product or activity	To report adverse events  To track FDA-regulated products  To enable product recalls, repairs, or replacements
Otherwise required or permitted by law	For worker's compensation  To registries (external to OHSU) including: cancer (OSCaR), trauma (OTR), and immunizations (ALERT)  To advisory boards, such as the State Trauma

Disclosure	Examples
	Advisory Board Hospital holds for mental health To state crime lab Reports regarding Medical Marijuana Act Program
Unauthorized disclosures	Misdirected fax or email Release of information based on invalid authorization
Any other purpose that does not meet the “Not required” list below	

## Not Included in the Accounting

The following disclosures of protected health information do not need to be included in the accounting of disclosures:

Excluded Disclosures	Examples
To carry out treatment	Disclosures to other health care providers for their treatment activities.
To carry out payment	Disclosures to other health care providers and payers for their payment activities.
To carry out health care operations from academic health care centers	This includes: quality improvement, outcomes analysis, developing clinical guidelines, training or education, medical review, legal services, auditing functions, business planning and development,

Excluded Disclosures	Examples
	fraud and abuse detection, accreditation, licensing, certification, credentialing, and general administrative functions.
To carry out certain health care operations of another health care provider or health care payer if an academic health care center and the receiving entity has or had a relationship with the patient, the health information disclosed pertains to such relationship, and the disclosure is for one of the activities found in the <b>Example</b> column	Conduction quality assessment and improvement activities (including outcomes evaluation and development of clinical guidelines). Case management or care coordination. Professional performance review, health care provider training, accreditation, certification, licensing, or credentialing activities. Health care fraud and abuse detection or compliance.
Made as a result of a signed patient authorization	
That occurred prior to April 14, 2003	
To patients about themselves	
For the academic health care center facility directory	A listing of patients used to address inquiries from outside of academic health care center about patients' condition or location.
To persons (family, friends, etc.) involved in the care or payment of health care of the patient	
Made incidentally to a permitted or required use and disclosure	
As part of a limited data set	Health information that excludes specific direct identifiers of the patient.
For national security or intelligence purposes	
To correctional institutions or law enforcement officials having lawful custody of an individual	Custody of an inmate.

# Release of Information Under Permissive Disclosures

A covered entity is permitted, but not required, to use and disclose protected health information without an individual's authorization for the following purposes or situations:

- To the individual (unless required for access or accounting of disclosures).
- Treatment, payment, and health care operations.
- Opportunity to agree or object.
- Incident to an otherwise permitted use and disclosure.
- Public interest and benefit activities.
- Limited data set for the purposes of research, public health, or health care operations.

Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

# Disclosure to Families and Loved Ones

The HIPAA Privacy Rule at 45 CFR 164.510(b) specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient in the patient's care or payment for health care. If the patient is present or is otherwise available prior to the disclosure and has the capacity to make health care decisions, the covered entity can discuss this information with the family and these other persons if the patient agrees or, when given the opportunity, does not object. The covered entity can also share relevant information with the family and these other persons if it can reasonably infer, based on professional judgment, that the patient does not object. Under these circumstances, for example:

- A physician can give information about a patient's mobility limitations to a friend driving the patient home from the hospital.
- A hospital can discuss a patient's payment options with her adult daughter.
- A physician can instruct a patient's roommate about proper medicine dosage when she comes to pick up her friend from the hospital.
- A physician can discuss a patient's treatment with the patient in the presence of a friend when the patient brings the friend to a medical appointment and asks if the friend can come into the treatment room.

A covered entity also may leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care even when the individual is not present. However, covered entities should use professional judgment to ensure that such disclosures are in the best interest of the individual and limit the information disclosed.



# Disclosing Mental Health Information

Following are the guidelines for disclosing mental health information, both with and without consent.

## **With Consent**

Except for those situations listed below, a physician cannot release a patient's mental health records unless the patient has provided a valid written, signed, specific, and time-limited authorization. Specific authorizations must be given for psychotherapy notes and for documents with HIV-related information.

## **Without Consent**

The disclosure of mental health information is governed by both federal and state law. Federal law sets the minimum level of privacy protection. State laws may then go further, providing more or stricter levels of privacy and confidentiality for mental health information beyond the federal minimum. The HIPAA Privacy Rule governs this issue uniformly at the federal level, which may then be superseded by state laws of varying complexity and protection aimed specifically at mental health records and professionals or state confidentiality requirements in general.

While providing important privacy safeguards, the Privacy Rule does recognize certain instances when protected health information (PHI), including mental health information, may be disclosed by the physician or other covered entity without patient consent. In fact, with the exception of psychotherapy notes discussed below, mental health information is treated as a form of PHI, subject to all the permitted uses of PHI without patient consent,

such as treatment, payment, and health care operations. A patient can always consent to the release of PHI, including mental health information, but in the absence of such consent, HIPAA does permit many uses and disclosures without patient authorization.

One exception to this general rule of permitting the sharing of treatment information without consent is that psychotherapy notes receive special protection under the Privacy Rule and may only be disclosed with patient authorization, except if the notes are used for a covered entity's supervised mental health education and training purposes. The Privacy Rule defines psychotherapy notes as notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session that are separate from the rest of the patient's medical record. Psychotherapy notes do not include medication prescription and monitoring information, counseling session start and stop times, the types of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also do not include any information that is maintained in a patient's medical record.

Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes other than by the mental health professional who created the notes. Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to another physician. In general, the individual signing the authorization may revoke it at any time, a physician cannot condition treatment on the willingness of an individual to sign an authorization for the release of psychotherapy notes, and an authorization for the release of psychotherapy notes must be a separate and independent document. One important exception exists for disclosures required by other laws, such as for mandatory reporting of abuse and mandatory "duty to warn" situations regarding threats of serious and imminent harm made by the patient.

State laws vary as to whether such a warning is mandatory or permissible. Special protections apply to substance abuse records at certain substance abuse treatment programs under 42 C.F.R. Part 2, which may include mental health information.

Finally, as noted above, state laws can be stricter than HIPAA and provide greater protection for mental health information beyond the psychotherapy notes exception. All states have some form of medical record confidentiality law, some stricter than HIPAA, some equivalent to HIPAA, and some less stringent laws that are preempted by HIPAA.

Moreover, all states have laws governing mental health records taking one of four forms:

- Laws about the records of patients in state mental hospitals or programs.
- Laws controlling the records of specific types of mental health providers, such as psychologists, social workers, and counselors.
- Laws governing the records of those involuntarily committed to state mental institutions.
- Laws that generally control the records of all mental health patients.

# Mandatory Disclosures

Health care providers, insurance companies, and their contractors must disclose medical information when a patient or patient's representative requests the information, when they receive a court order, in civil and criminal legal proceedings, for many purposes involving death investigations, and when otherwise required by law.

# HIV Consent and Reporting

Health care providers must follow state law in reporting positive HIV test results. This includes required reporting to the state and any potentially infected partners.

# Reportable Diseases

A reportable infectious disease or condition is one for which regular, frequent, and timely information regarding individual cases is considered necessary for the prevention and control of the disease or condition. In 1961, the CDC assumed responsibility for the collection of data on nationally notifiable diseases.

Monitoring surveillance data enables public health authorities to detect sudden changes in disease or condition occurrence and distribution, identify changes in agents and host factors, and detect changes in health care practices. National-level surveillance data is compiled from case notification reports of nationally notifiable infectious diseases and conditions submitted from the state, territory, and selected local health departments to the CDC.

Physicians must report all reportable diseases to his or her county health department. Your county health department passes on the information to the CDC. For more information on reporting procedures, contact your county or state health department.

# Responding to Law Enforcement

The Privacy Rule is balanced to protect an individual's privacy while allowing important law enforcement functions to continue. The rule permits covered entities to disclose protected health information (PHI) to law enforcement officials, without the individual's written authorization, under specific circumstances summarized below. For a complete understanding of the conditions and requirements for these disclosures, please review the exact regulatory text at the citations provided. Disclosures for law enforcement purposes are permitted as follows:

- To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena (45 CFR 164.512(f)(1)(ii)(A)-(B)).
- To respond to an administrative request, such as an administrative subpoena or investigative demand or other written request from a law enforcement official. All administrative requests must include or be accompanied by a written statement that the information requested is relevant and material, specific and limited in scope, and that de-identified information cannot be used (45 CFR 164.512(f)(1)(ii)(C)).
- To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness, or missing person. However, the covered entity must limit disclosures of PHI to name and address, date and place of birth, Social Security number, ABO blood type and rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics. Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision but may be disclosed in response to a court order, warrant, or written administrative request (45 CFR 164.512(f)(2)).

This same limited information may be reported to law enforcement:

- About a suspected perpetrator of a crime when the report is made by the victim who is a member of the covered entity's workforce (45 CFR 164.502(j)(2));
- To identify or apprehend an individual who has admitted participation in a violent crime (45 CFR 164.512(j)(1)(ii)(A), (j)(2)-(3)).
- To respond to a request for PHI about a victim of a crime, and the victim agrees (45 CFR 164.512(f)(3)).

Where child abuse victims or adult victims of abuse, neglect, or domestic violence are concerned, other provisions of the Privacy Rule apply:

- Child abuse or neglect may be reported to any law enforcement official authorized by law to receive such reports, and the agreement of the individual is not required (45 CFR 164.512(b)(1)(ii)).
  - Adult abuse, neglect, or domestic violence may be reported to a law enforcement official authorized by law to receive such reports (45 CFR 164.512(c)):
  - If the individual agrees.
  - If expressly authorized by law, and based on the exercise of professional judgment, the report is necessary to prevent serious harm to the individual or others, or in certain other emergency situations (see 45 CFR 164.512(c)(1)(iii)(B)).

**Note:** Notice to the individual of the report may be required (see 45 CFR 164.512(c)(2)).

- To report PHI to law enforcement when required by law to do so (45 CFR 164.512(f)(1)(i)). For example, state laws commonly require physicians to report incidents of gunshot, stab wounds, or other violent injuries, and the Privacy Rule permits disclosures of PHI as necessary to comply with these laws.
- To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct (45 CFR 164.512(f)(4)).



- To provide information about a decedent with medical examiners or coroners to assist them in identifying the decedent, determining the cause of death, or to carry out their other authorized duties (45 CFR 164.512(g)(1)).
- To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the covered entity's premises (45 CFR 164.512(f)(5)).
- When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity, specifically, the commission and nature of the crime, the location of the crime or any victims, and the identity, description, and location of the perpetrator of the crime (45 CFR 164.512(f)(6)). This provision does not apply if the covered physician believes that the individual in need of the emergency medical care is the victim of abuse, neglect, or domestic violence. See information above regarding when reporting adult abuse, neglect, or domestic violence to law enforcement is allowed under 45 CFR 164.512(c).
- When consistent with applicable law and ethical standards:
  - To a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public (45 CFR 164.512(j)(1)(i)).
  - To identify or apprehend an individual who appears to have escaped from lawful custody (45 CFR 164.512(j)(1)(ii)(B)).
- For certain other specialized governmental law enforcement purposes, such as:
  - To federal officials authorized to conduct intelligence, counter-intelligence, and other national security activities under the National Security Act (45 CFR 164.512(k)(2)) or to provide protective services to the President and others and conduct related investigations (45 CFR 164.512(k)(3));
  - To respond to a request for PHI by a correctional institution or a law enforcement official having lawful custody of an inmate or others:

- If they represent such PHI is needed to provide health care to the individual.
- For the health and safety of the individual, other inmates, officers, or employees of others at a correctional institution or responsible for the transporting or transferring of inmates.
- For the administration and maintenance of the safety, security, and good order of the correctional facility, including law enforcement on the premises of the facility (45 CFR 164.512(k)(5)).

**Note:** Except when required by law, the disclosures to law enforcement summarized above are subject to a minimum necessary determination by the covered entity (45 CFR 164.502(b), 164.514(d)). When reasonable to do so, the covered entity may rely upon the representations of the law enforcement official (as a public officer) as to what information is the minimum necessary for their lawful purpose (45 CFR 164.514(d)(3)(iii)(A)).

Moreover, if the law enforcement official making the request for information is not known to the covered entity, the covered entity must verify the identity and authority of such person prior to disclosing the information (45 CFR 164.514(h)).

# Response to Private Investigators

Private investigators are not allowed to receive medical records without a subpoena or permission from the owner.

# De-identification of Records

The increasing adoption of health information technologies in the United States accelerates their potential to facilitate beneficial studies that combine large, complex data sets from multiple sources. The process of de-identification, by which identifiers are removed from the health information, mitigates privacy risks to individuals and thereby supports the secondary use of data for comparative effectiveness studies, policy assessment, life sciences research, and other endeavors. There are two methods to achieve de-identification: Expert Determination and Safe Harbor.

Satisfying either method would demonstrate that a covered entity has met the standard in §164.514(a). De-identified health information created following these methods is no longer protected by the Privacy Rule because it does not fall within the definition of PHI. However, de-identification leads to information loss which may limit the usefulness of the resulting health information in certain circumstances. As described in the forthcoming sections, covered entities may wish to select de-identification strategies that minimize such loss.

## Expert Determination

A covered entity can determine that health information is not individually identifiable health information only if:

- The covered entity has appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable.
- The covered entity determines that the risk is very small that the information could be used alone or in combination with other reasonably available information by an anticipated recipient to identify an individual who is a subject of the information.

- The covered entity documents the methods and results of the analysis that justify such determination.

## Safe Harbor

The following identifiers of the individual or of relatives, employers, or household members of the individual are removed:

- Names.
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:
  - The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people.
  - The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
- All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
- Telephone numbers.
- Vehicle identifiers and serial numbers, including license plate numbers.
- Fax numbers.
- Device identifiers and serial numbers.
- Email addresses.
- Web Universal Resource Locators (URLs).
- Social Security numbers.

- Internet Protocol (IP) addresses.
- Medical record numbers.
- Biometric identifiers, including finger and voice prints.
- Health plan beneficiary numbers.
- Full-face photographs and any comparable images.
- Account numbers.
- Any other unique identifying number, characteristic, or code, except as permitted by 164.514 (c).
- Certificate/license numbers.

The covered entity must not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

## Re-identification

The implementation specifications further provide direction with respect to re-identification, specifically the assignment of a unique code to the set of de-identified health information to permit re-identification by the covered entity.

For more information, see:

<https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html>

# Chart Review Protocol

Chart reviews are conducted for research purposes and to improve patient care. There are two primary types of data reviews:

- A retrospective chart review evaluates patient data that is existing at the time the project is submitted to the Institutional Review Board (IRB) for initial review.
- A prospective chart review evaluates patient data that does not yet exist at the time the project is submitted to the IRB for initial review.

## Final Evaluation Types

There are three types of evaluations:

- **Exempt:** An exempt review should only be requested if the information to be collected already exists and is publicly available or data will be recorded in such a manner that subjects cannot be identified, either directly or indirectly. As data must exist at the time the project is submitted to the IRB, this limits exempt review to retrospective chart reviews. In the majority of cases, chart reviews do not qualify for exempt status because most investigators need to retain identifiers at least through the data collection process. Even if an investigator plans to eventually discard all identifiers once data collection is complete, this is not sufficient for the project to qualify for exempt review.
- **Expedited:** Expedited review can be granted for retrospective and prospective chart reviews when the research involves materials (data, documents, records, or specimens) that have been collected or will be collected solely for non-research purposes (such as medical treatment or diagnosis). Most chart reviews fall into this category.
- **Full Board:** While rare, full board reviews may be required for both retrospective and prospective chart reviews. Some circumstances under which this occurs is if the investigator plans

to collect sensitive data or if the chart review results in a change in care for the patients whose data is being collected.

## Types of Consent

You must use one of three types of consents:

**Waiver of Consent:** In order for the IRB to approve a waiver of consent, the IRB must be satisfied that the following criteria are met:

- The research involves no more than minimal risk to the subjects.
- The waiver or alteration will not adversely affect the rights and welfare of the subjects.
- The research could not practicably be carried out without the waiver or alteration.
- Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

The waiver of consent is the most frequently requested type of consent for both retrospective and prospective chart reviews.

**Waiver of Documentation of Consent:** Under a waiver of documentation of consent, an investigator must still obtain consent from the subject. This type of consent is not usually requested for a chart review. However, the investigator does not need to obtain a signed consent form from subjects if the IRB agrees that the following criteria are met:

- The only record linking the subject and the research would be the consent document, and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject is asked whether the subject wants documentation linking the subject to the research, and the subject's wishes will govern.
- The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.



**Written Consent:** In certain instances, the IRB may determine that written consent is required if the investigator is unable to justify why it is impracticable to conduct the research without a waiver. This is more often the case for prospective chart review studies, but sometimes occurs in retrospective chart review studies. For example, an investigator wants to review the charts of all his patients who he refers for a colonoscopy to collect outcome measures. The IRB may determine that the investigator should obtain written consent since he or she will have the chance to obtain consent from the patients during their clinic visit with him or her.

## **Sample Chart Review Protocol**

**Principal Investigator:**

**Address:**

**IRB Project Title:**

**Site(s) Where Study will be Performed:**

**Protocol Version Date:**

1. Introduction: background and rationale (include references):
2. Hypothesis/key questions (the hypothesis being evaluated; the key questions being asked in the research):
3. Objectives (primary endpoints of study, listed and numbered individually):
4. Selection of patients:
  - Inclusion criteria:
  - Exclusion criteria:
  - Age range:

**Note:** Regarding research involving pregnant women, prisoners, or minors, the IRB must review the study in accordance with Subparts B, C, or D of the federal regulations. If it can be presumed that the subjects are not pregnant, incarcerated, or under the age of 18 during the conduct of the chart review, the Subparts do not apply. If, however, during the course of the chart review, the investigator becomes aware that the subjects meet one or more of these conditions, the principal investigator must either exclude such subjects from the data set, or the IRB must promptly re-review the proposal in accordance with the requirements of Subparts B, C, and D.

5. Indicate if this is a retrospective and/or prospective chart review:

- ☐ **Retrospective Chart Review:** Retrospective means the data is already in existence when the project is submitted to the IRB for initial review.
- ☐ **Prospective Chart Review:** Prospective means the data is not in existence when the project is submitted to the IRB for initial review.
- **Provide the date range of the chart review:** If this is a retrospective chart review, the end date must come before the IRB submission date: mm/dd/yyyy to mm/dd/yyyy.

6. Study methods:

- a. Provide the source (location) of the records to be reviewed:
- b. Describe how the charts to be reviewed will be identified:
- c. Describe who will identify charts to be reviewed:

7. Confidentiality of data:

- a. Describe how data (both paper and electronic) will be stored to safe-guard confidentiality (e.g., in a locked cabinet, on a password-protected computer):
- b. Specify who will have access to harvested patient data:

- c. Clarify how long harvested patient data will be stored and how it will be destroyed when no longer needed:
8. Consent: Describe the type of consent to be obtained and justification for the choice (written, waiver, or verbal). For additional information, please see the Guidance and Instructions at the end of the protocol.

**Note:** Illinois state law requires written consent for research which collects data related to HIV/AIDS, genetic information, mental health information, and substance abuse information.
9. Risks and benefits (modify as needed):
  - a. **Risks:** A confidentiality breach is a risk associated with chart review research.
  - b. **Benefits:** The subjects whose charts are reviewed are not likely to receive any benefit from the proposed research, but society and investigators will benefit from the knowledge gained.
10. Statistical considerations:
  - a. Proposed sample size (number of records to be reviewed):
  - b. Proposed time period to be evaluated:
  - c. How data will be analyzed and by whom:
11. Appendices: The following appendices must be attached to the protocol:
  - **Appendix A:** This form should list the data elements that will be collected from the medical record. It should not contain any direct or indirect identifiers, except for a unique subject code.
  - **Appendix B:** This form should serve as the link between the unique subject code and any identifiers you will need to conduct this chart review study (e.g., name, medical record number, date of birth, address, telephone number, Social Security number).

## APPENDIX A: DATA COLLECTION FORM

1. Unique subject code:
2. List all elements to be collected during the chart review:

## **APPENDIX B: CODED IDENTIFIER LIST**

1. Unique subject code:
2. List all identifiers to be collected or used in this study (e.g., name, medical record number, date of birth, address, telephone number, Social Security number):

# Financial Management

CMG finances are based on a Cost Sharing Agreement between CMG physicians. The Business Manager is responsible for managing and reporting on CMG finances as well as all bookkeeping activities.

# Coding and Billing Standards

Honesty and accuracy in billing for payment by a federal health care program or payment by any third-party payer is vital. Each physician employed by CMG is expected to monitor compliance with applicable billing rules. No office employee will submit, authorize, or sign a false claim for reimbursement in violation of applicable laws and regulations.

CMG-employed health care professionals will refrain from any of the following practices and work to identify and correct instances in which mistakes have occurred in the following areas:

- Billing for items or services not rendered or not provided as billed.
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary.
- Double-billing resulting in duplicate payment.
- Billing for non-covered services as if covered.
- Knowingly misusing provider identification numbers, resulting in improper billing.
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code).
- Failure to properly use coding modifiers.
- Falsely indicating that a particular health care professional attended a procedure.
- Clustering (billing all patients using a few middle levels of service codes under the assumption that it will average out to the appropriate level of reimbursement).
- Failing to refund credit balances.
- Upcoding the level of service provided.

If the patient has secondary insurance, the biller takes the amount left over after the primary insurance returns the approved claim and sends it to the patient's secondary insurance.

# Claim Denials

Denied claims are claims that were received and processed (adjudicated) by the payer and a negative determination was made. You cannot resubmit this type of claim. It must be researched in order to determine why the claim was denied, so that you can write an appropriate appeal or reconsideration request.

If you resubmit this type of claim without an appeal or reconsideration request, it will most likely be denied as a duplicate, costing you even more time and money the longer the claim remains unpaid.

Claim rejections are different than claim denials. Claim rejections are claims that do not meet specific data requirements or basic formatting that are rejected by insurance according to the guidelines set by the Centers for Medicare and Medicaid Services. These rejected medical claims cannot be processed by the insurance companies as they were never actually received and entered into the computer systems.

This type of claim can be resubmitted once the errors are corrected. These errors can be as simple as a transposed digit from the patient's insurance ID number and can typically be corrected quickly.



# Time of Service Payment Control

Payment is due from the patient at the time of check-in. Determine as much as possible the charges ahead of time so that you know how much the insurance will pay and the patient responsibility.

If more procedures are recommended at the visit than expected, the physician informs the customer of the additional amount due from the patient if the physician performs these additional procedures. If the patient gives permission to perform the procedures, the patient pays the additional amount when checking out.

# Internal Control Procedures

CMG has implemented the following internal controls to protect it from revenue loss and potential employee embezzlement:

1. Divide job responsibilities. Dividing the two duties prevents an employee from stealing money from the practice and then manipulating patients' accounts in the computer, usually by writing off balances as contractual adjustments or bad debts.
2. Require mandatory consent of the physician for write-offs.
3. Reconcile office visit payments received during the day from patients to source documents.
4. Pre-number all patients encounter forms, or Superbills, and make sure they are accounted for daily.
5. Monitor contractual adjustments for reasonableness.
6. Limit check-signing authority to the physician.
7. Attach a vendor invoice to each check when it is signed.

# Petty Cash

The following are steps to prevent mistakes and fraud related to petty cash and cash received from patients:

1. Have more than one person count all cash.
2. Keep a log for all cash collected.
3. Send a receipt for all cash received.
4. Have a set amount of petty cash in the office each day.
5. Confirm deposit amounts at your bank online.

# Medicare Advance Beneficiary Notice of Non-Coverage

Medicare's Limitation on Liability (LOL) protections apply when a physician believes that an otherwise covered Medicare item or service will be denied because the item or service is not reasonable and necessary or is for custodial care. In order to shift liability to the beneficiary, a physician is required to provide an Advance Beneficiary Notice (ABN) to a beneficiary in advance when he or she believes that items or services will likely be denied. If such notice is not given, physicians may not shift financial liability for such items or services to Medicare beneficiaries.

## Mandatory Use of the ABN

An ABN must be used to convey to the beneficiary that a physician believes that an item or service will not be covered when:

- The item or service is not reasonable and necessary.
- The item or service is provided in violation of the prohibition on unsolicited telephone contacts.
- The item or service is for medical equipment and supplies for which the supplier number is not provided.
- The item or service is for medical equipment and/or supplies denied in advance.
- The item or service is for custodial care.
- The item or service is for hospice care provided to a patient who is not terminally ill.

The ABN is not required for items and services that are never covered under the Medicare statute (statutorily excluded) or for items and services that do not meet a technical benefit requirement (such as a required certification by a physician).

With respect to hospice services and Comprehensive Outpatient Rehabilitation Services (CORF), if there is a complete cessation of all Medicare covered services, an Expedited Determination notice must be issued by hospice and CORF providers.

## **Voluntary Use of the ABN**

The ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered because it does not meet the definition of a Medicare benefit or for care that is explicitly excluded from Medicare coverage.

The Medicare Claims Processing Manual (Chapter 30) lists the following as examples of care that are explicitly excluded from coverage:

- Services for which there is no legal obligation to pay.
- Services paid for by a government entity other than Medicare. This exclusion does not include services paid for by Medicaid on behalf of dual-eligibles.
- Services required as a result of war.
- Personal comfort items.
- Routine physicals and most screening tests.
- Routine eye care.
- Dental care.
- Routine foot care.

# Charge Capture and Charge Entry

You must ensure all procedures are recorded on the Office Encounter form or another charge form.

Charges must then be entered in your billing system to be billed to insurance with accuracy. Otherwise, revenue for the office is lost.

# Claims Edits

Ineffective claims editing leads to a cascade of expensive problems, including high error rates, inaccurate and inconsistent assessment of claims, penalties for regulatory non-compliance, unnecessary overhead, and fraud and litigation costs. In addition, the ability to attract and retain participating providers depends in large part on the payer's ability to process and settle claims quickly and accurately.

The following are best practices for claims editing:

1. Use the rules in effect on the date of service.
2. Source edits at the code relationship level.
3. Provide full disclosure and transparency on web portals and explanations of benefits (EOBs).
4. Improve workflow efficiency by integrating rules engine capabilities.
5. Use the right rules for facility claims editing.
6. Customize rules to suit individual plans and lines of business.

# Billing

Following are guidelines for billing at CMG.

## Medicare Secondary Payer

Medicare is a secondary payer when the beneficiary is covered by group insurance, Workers' Compensation, or if other third-party liability (no-fault, liability) applies. For detailed information on CMS's Medicare Secondary Payer (MSP) guidelines, refer to the CGS web page:

[CMS Guidelines and Resources for Medicare Secondary Payer \(MSP\)](#)

The remittance file happens twice a month. It contains refused bills and updates to patient information, as well as the physician's pay statement and important updates to the MSP billing guide.

## Third-Party and Patient Bills (Uninsured Fee Schedule)

Physicians place their completed form in the "To Be Done" box.

Some physicians will have a bill prepared for the document already.

For any bills that are sent, print in the top right corner "Billed and sent via (fax/mail/medi express)" and the date. If the bill was given directly to the patient, indicate that. This makes it much easier to track when and where the bill was sent.

The physicians frequently reduce the amount they will bill the patient and that is at their discretion. Lawyers, insurance companies, and any other third party are always billed at the BCMA rate. Sometimes the insurance companies will indicate the maximum they will pay for a request.

The list of uninsured services is as follows:



Fee Schedule for Uninsured Services	Plan X Fee Guidelines	Clinic Standard Rate
Clinical Services		
Complete physical exam	149.00	
Office visit	69.10	
Missed appointment – regular appointment	69.10	
Missed appointment – physical	149.00	
Injection – subcutaneous or muscular	21.45	
Forms and Notes		
Insurance form – long	320.00	
Insurance form – short	153.00	
Occupational fitness assessment form	149.00	
Other miscellaneous forms or notes	n/a	
Physical fitness exams for schools, camps, etc.	66.10	
Sick note	39.15	

Fee Schedule for Uninsured Services	Plan X Fee Guidelines	Clinic Standard Rate
Industrial and Insurance		
Driver's medical exam and report – non-patient	183.00	
Driver's medical exam and report – patient	183.00	
General insurance exam	188.00	
Medical Legal		
Simple form/letter on patient condition	149.00	
Medical legal letter/form (short, factual)	320.00	
Medical legal report (includes symptoms, history, records, diagnosis, treatment, results, and present condition)	958.00	
Medical legal opinion (report plus expert opinion)	1,602.00	
Review of EMR records (15 min)	89.50	
Photocopying per page (first 10 pages)	1.45	
Photocopying per page (each additional page after 10 pages)	0.30	

## Billing Capitated Plans

Capitation is a system of payment to health care providers determined by the number of patients seen. Under a capitation system, health care providers are paid a set amount for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per a period of time. The amount of remuneration is based on the average expected health care utilization of that patient, with greater payment for patients with significant medical history. Since a capitation check is one large sum paid to the physician or office, it should not be applied to a single patient's account. You must create a system in your office for entering checks, applying payments as needed, and tracking capitation payments as it is being used in your office.

For Medicare-Medicaid plans, under the capitated model, the Centers for Medicare and Medicaid Services (CMS), a state, and a health plan enter into a three-way contract to provide comprehensive, coordinated care. Prior to enrolling or marketing under the capitated model, each health plan must pass a readiness review.

## Professional Courtesy

Professional courtesy means that cost should never play into taking care of other physicians or their families.

Communicate up front if you intend to charge a physician. If you do not collect the copay from the physician for your services, you cannot charge the insurance company. This is considered fraud.

If you are a physician and you visit another practice and that practice does not ask you for the copay at the date of service but later sends you the bill, you are obligated to pay it per the requirements of your insurance company contract.

## **Patient Bankruptcy**

If you just received a notice that your patient has filed for personal bankruptcy, your first step is to determine which chapter of personal bankruptcy has been filed. You must then take the necessary steps to file a proof of claim in a timely manner.

The primary criterium when deciding whether to file a proof of claim is whether the amount due by the patient is worth the effort. In many cases the answer is yes. However, the work necessary to file the proof of claim properly and follow up on the payment plan can be time consuming. For this reason, many physicians' offices choose to refer their patient bankruptcy cases to an attorney with bankruptcy experience.

The best course of action in the case of medical bankruptcies is to create strategies that help you get paid from patients in the future. At the first sign of difficulty paying, try to put your patient on a payment plan, and try to collect payments as soon as possible after treatments. If you follow a proactive collection strategy for all of your patients, you can help reduce potential losses from patient bankruptcies.

### **Do Not Call the Patient**

Upon receiving a notice that your patient has filed for bankruptcy, you must end all collection attempts for bills incurred before the bankruptcy filing date. Any attempt to collect a discharged bill puts you in violation of the court order that the patient received when he or she filed, and you can face punitive damages in the thousands of dollars. Terminating the patient-physician relationship for nonpayment can be seen as an attempt to collect on the debt, and attempts to collect could result in court costs, attorney fees, and punitive damages. Recovering money must be done through the proper channels.

### **Chapter 7 Bankruptcy**

A Chapter 7 is known as a liquidation bankruptcy. People who file a Chapter 7 have little, if any, assets, and in turn, you will likely receive very little money. The only money that is available for creditor payment is drawn from the debtor's assets that can be seized and

sold by the courts.

Despite the lower rate of recovery, it may be worthwhile to consider filing a proof of claim because assets may later be identified by the court which were not previously disclosed by a patient. In that case, money could be dispersed at a later date.

Since a primary residence and car often are exempted from seizure, there is usually little money available for credit payment. However, your patient's insurance company is not covered in the settlement and you can attempt to recover any monies owed to you by the patient's insurance company.

### **Chapter 13 Bankruptcy**

Patients with regular income may choose to file Chapter 13 bankruptcy, also known as a min-reorg. This option allows patients to create a repayment plan for their creditors over three to five years. The debtor's payments are made to a trustee, who then distributes them to creditors.

In the case of a Chapter 13 bankruptcy, you may have a better chance of recovering funds because the court tries to treat every creditor equally. Once your patient is in a repayment plan, your medical bills will be included with others in that plan. Just like with a Chapter 7, you must file a claim with the court within 120 days of the bankruptcy filing by the patient.

### **Medical Bills Owed by Deceased Patients**

If a patient died with medical bills, whether or not the medical office is paid depends on whether or not the estate is solvent.

A solvent estate is one that has enough assets to pay off the decedent's bills. In other words, when added up, the value of all the decedent's individual assets exceeds the amount of bills owed. If the estate is solvent, then the personal representative of the decedent's estate is responsible for paying all the bills from the assets owned by the estate.

For example, if all the decedent's individual assets equal \$100,000 and the credit card and medical bills equal \$50,000, then the decedent's estate is solvent and can be used by the personal representative to pay the bills in full. What's left, in the example, \$50,000, will go to the decedent's beneficiaries named in his or her Last Will and Testament or Revocable Living Trust if the decedent had an estate plan, or to the decedent's heirs at law if the decedent didn't have an estate plan.

An insolvent estate is one that does not have enough assets to pay off all of the decedent's bills. If the estate is insolvent, then the personal representative must prioritize payment of the bills as provided by federal law and the laws of the state where the decedent died.

For example, if all of the decedent's individual assets equal \$100,000 but the credit card and medical bills equal \$150,000, then the deceased person's estate is insolvent in the amount of \$50,000. In this situation, the personal representative must look to state and federal laws to determine which creditors will get paid in full, which creditors will receive only a partial payment, and which creditors will get nothing.

Using the example above, if the decedent's medical bills total \$50,000 of the total debt and were incurred within 60 days of the decedent's date of death and the credit card bills equal the remaining \$100,000 of the decedent's debt, then in Florida the personal representative will pay the medical bills in full and the credit card companies will have to proportionately share in the remaining \$50,000 of the decedent's assets.

The beneficiaries or heirs at law won't be responsible for paying off the balance of the decedent's unpaid debts (unless the beneficiary or heir at law was a co-signor or co-guarantor on the debt). The companies that were not paid in full will have to write off the bad debt.

A physician may secure a guarantee of payment from a spouse or an individual who jointly owns property with the patient before the patient dies. To guarantee a patient's obligations, a potential guarantor must execute a written guaranty. If a potential guarantor

executes the guaranty at the same time the patient contracts with the health care provider (e.g., upon the patient's admission), the services provided to the patient furnish sufficient consideration for the guaranty, and no additional consideration is required.

## **Using a Collection Agency**

Collection agencies can play a role in effectively managing accounts receivable. However, the proper role of a collection agency is to handle outstanding accounts receivable that have gone through the practices' established internal processes without success.

The cost of employing a collection agency is significant, generally ranging from 20% to as high as 50% of the amount collected.

It is important to understand how an agency will go about collecting delinquent balances. Because an agency represents the practice in the eyes of the patient, it is important to know what the agency will say to patients and what actions it may take to collect outstanding accounts.

Using a collection agency is different than other services. If the office's internal processes are well-designed and followed, then the collection agency should need to collect very little. The way to test an agency's effectiveness is to use two agencies, give each a similar blend of accounts, see which one collects more, and use that one.

The more important task, however, is to establish effective internal processes before turning accounts over to an outside collection agency. The internal processes should include a financial policy provided to each patient, in advance, so that expectations are clearly established.

### **Internal Processes**

Most bills should be collected through internal processes. These processes should include the following:

1. Flag charts so that when the patient is scheduled to return to the office, the office staff can speak to him or her about the overdue account.
2. Send statements as soon as any portion of unpaid patient responsibility is determined. Include dunning messages with monthly statements sent to the patient, and tailored to the age of the outstanding balance.
3. If a patient fails to pay after two statements are sent, send a series of more strongly worded letters. Letters should be in addition to statements so that they stand out. Letters need to go out consistently.
4. If allowed by your state, pursue revenue recapture from individual tax refunds, property tax refunds, and lottery or gambling winnings.

## **Non-sufficient Funds**

As long as CMG receives payment in the form of checks, there is a risk that some checks by accident or on purpose may have non-sufficient funds (NSF). The office has an upfront collection policy and warns up front of the charges for NSF checks. Whenever possible, ensure patients know charges that will be due at the time they make the appointment.

CMG will refuse to accept checks from patients with one NSF check or no more than two if they quickly noticed their mistake and made a cash payment immediately. In addition, do the following:

1. Call the patient. Most likely the patient will know before you do that he or she has a bounced check. Politely request that he or she resolve the matter as soon as possible. Offer to waive the NSF fee if he or she makes payment within five days.
2. Send a certified letter. Remind the patient that he or she is a valued customer and you would like him or her to resolve the matter without further incident. Be sure not to threaten the patient in any way.



3. If attempts to contact the patient are unsuccessful, wait a few days and contact the bank to find out if there is enough money to cover the check. If so, return the check to the bank and have it cashed versus depositing it in your account.
4. If necessary, forward the account to a collection agency.

## **Write-Offs**

A write-off is an amount CMG deducts from a charge and does not expect to collect, thereby “writing it off” the accounts receivable or list of monies owed them by payers or patients.

### **Necessary or Approved Write-Offs**

Necessary or approved write-offs are write-offs that you have agreed to, either in the context of a contract, or in terms of your practice philosophy. These include the following:

- Contractual write-offs are the difference between the practice fee schedule and the allowable fee schedule you have agreed to accept.
- Charity write-offs are the difference between the practice fee schedule and anything collected. Charity write-offs may be in accordance with a community indigent care effort, a policy adhered to in a faith-led health care system, or a financial assistance program.
- Small balance write-offs are amounts left on the patient’s account that may not warrant the cost of sending a bill, which has been estimated to cost about \$12.00 each when you take into account the statement process, as well as the cost to receive the check, post it, and deposit it. CMG writes off the small balance (usually \$15 or less) and collects it when the patient returns.
- Prompt payment discounts and self-pay (no insurance) discounts are write-offs for patients paying in full at the time of service, and/or patients who receive a discount off the retail price because they do not have insurance coverage.

## Unnecessary Write-offs

These are write-offs that you have not agreed to, but you reluctantly reduce the charge based on billing mistakes or situations that you should have been able to control. These include the following:

- Timely filing write-offs are caused by filing the claim past the date required by the payer. Medicare requires that claims be filed no later than 12 months after the date of service to be paid. Medicaid varies from state-to-state. Commercial payers usually have very tight timely filing limits and most average three months. Make sure you know your timely filing limits for each payer.
- Uncredentialed physician write-offs are those caused by filing a claim for a physician before they are credentialed with the payer.
- Administrative write-offs are those approved by the manager based on service issues. For example, if the practice assures the patient that they are participating with the patient's insurance, then it turns out that the practice is not in-network, the manager may approve a write-off based on the practice's error. If the patient has a very bad experience in the practice, the manager may want to discount the service or to write off the charge completely.

**Note:** If you do discount the service, remember to submit the claim for the altered fee, as you cannot discount the fee to patient and charge the payer the full fee.

- Bad debt write-offs are balances that you have decided to write off and not pursue further. These are balances that for whatever reason, you are forgiving forever.
- Collection agency write-offs are those that are written off the main A/R (accounts receivable) and transferred to a third-party collection agency to collect on your behalf. These balances are not forgiven. Some PM (practice management) systems maintain a separate collection bucket or A/R and others do not maintain collection accounts in the system. Most practices do not schedule appointments with patients that have a collection balance until that balance is satisfied or the patient is committed to a reasonable payment plan.

## **Guidelines for Managing Write-Offs**

Staff do not need to get approval for items in the “Necessary or Approved Write-Offs” section above.

Review all write-off categories monthly and pay attention to unusual spikes as well as creeping trends. If you raise your fees and do not renegotiate your contracts, your contractual write-offs are going to escalate, and you must account for that difference in your evaluation.

Audit write-offs periodically to make sure that they are being done correctly.

## **Overpayments and Refunds**

Before CMG processes a refund, all dates of service must be paid by the insurance company. The following are reasons why:

- The patient's insurance has termed, and he or she neglected to tell you. In this case, you can use the "overpayment" and apply it to any outstanding charges the patient has incurred.
- The insurance denies a claim, and you still have the "overpayment" that you can apply to that date of service.
- The insurance company reverses a charge either from your office or another physician resulting in the patient's deductible or out-of-pocket now not being completely met. This means that the "overpayment" can now be applied to the date of service you have outstanding, and you do not have to use your resources to bill the patient again.

Always communicate with your patient when there is an overpayment. Investigate it thoroughly, and explain to the patient that if he or she can make a few phone calls to the insurance company, it will help move the insurance payment and the refund more quickly. This will allow you to release any overpayment that there might be. The patient is the insurance company's customer and it wants to keep him or her happy, so asking the patient to step in and help get you paid is a great tool to utilize in situations like this.

CMG issues refunds within 60 days of determining a refund is due.

## Insurance Follow-Up

Most insurance companies use stall tactics to delay payment. Do not let them get away giving you inaccurate information. Do not be afraid to challenge the insurance representatives when you are certain about an incorrect denial. If you are not happy with the kind of response you got from the insurance representative, try to reach the supervisor. Check for missing or invalid items that could hold up the claim from immediate payment. If you develop good rapport with at least one insurance representative for each carrier, you may be able to convince him or her to give you more details about the claim than usual.

If it is more than 30 days from the billing date, contact the insurance company as follows:

1. Analyze the account and be well prepared before you call the insurance company.
2. Have all the possible requirements ready that can fix the claim at your disposal, such as medical records, W9 form, corrected claim, etc.
3. Ask one or more of the following questions:
  - What is the status of the claim?
  - When is the claim scheduled for payment?
  - Why is the claim taking so long to process?
  - Why is the claim pending or under review?
  - Where do I need to send medical records?
  - Who can I speak with to get this claim paid faster?
  - Why is the claim not being paid according to contract?
4. If applicable, remind the representative about the prompt pay law.
5. Send a bill to the patient so that he or she can call you or the insurance company.

## Posting Payments

Payments should be posted at the time they are received, but staff should review each transaction carefully before entering the payment into the ledger. An error in the posting process may cause the patient's account balance to be incorrect.

An insurance carrier normally sends an explanation of benefits (EOB) along with its payment. The EOB indicates how much of the charged fee was approved for payment, how much was applied to a deductible, how much was applied to a copayment, and how much was applied to other sources, such as a withhold in managed care plans. Most EOBs indicate how much of the charged fee the patient is ultimately responsible for paying. EOBs also provide data essential to the collection process in the office.

Before posting any insurance payment to the patient's account, perform and document the following:

1. Compare the EOB with the original insurance claim and review each carefully. All charges on the claim form must be included on the EOB. Look for changes in current procedural terminology (CPT) coding by the insurance company (e.g., determine if a service was down-coded). The goal is to identify charges that can be appealed.
2. Investigate all denied charges, and appeal them, if necessary (these appear as zeros on the EOBs.).
3. Appeal all usual, customary, and reasonable (UCR) reductions, if necessary. UCRs are filed when the insurance company reduces the physician's fee because the company feels it is too high for the practice area.
4. Respond quickly to any carrier request for additional information that appears on the EOB.

## **Unapplied Payments**

When payments are received that do not have complete or correct information, do not post them to an “Unapplied Payments” account. Investigate and post the payment to the correct accounts as soon as possible. The longer you wait to investigate and properly post the payments, the more time will be required to fix it later, and more time will be required due to wrong bills sent to patients.

# Purchasing and Inventory

Following are guidelines for purchasing and inventory at CMG.

## Monitoring Supplies Inventory

Staff monitor medical and office supplies on an ongoing basis and put forward purchase requests when supplies are running low. Ordering amounts should be established based on the supply order and inventory requirements.

## Purchase Requests

Staff can make verbal purchasing requests if supplies are running low. Written requests can be made on the white board behind the Utility Room if non-urgent, or in writing via email or messaging to the physician in charge of supplies.

Regular ordering items and preferred stock are listed in the Supply Order and Inventory Requirements document. This document includes the usual re-order company and usual cost, as well as areas to indicate who ordered the item and when, when the order was approved, when it arrived, and space for any comments. Only staff with ordering permission are allowed to make entries or changes to this document.

## Purchasing Controls

Purchasing controls are meant to ensure that physicians' offices only select suppliers, contractors, and consultants who have the capability to provide quality products and services.

The quality of the finished medical device depends on the quality of the components, raw materials, and services. Poor quality can cause:

- Injuries from the medical device
- Patient dissatisfaction

## Receiving

Use the following steps when received ordered items:

1. Staff check the accuracy of each shipment.
2. If the order received matches the original order, the staff initials the packing slip/invoice included with the shipment and places it in the Business Manager's inbox.
3. The staff notes that the order was received on the Supply Order and Inventory Requirements document.

## Medicare Recovery Audit Contractor Program

The Recovery Audit Contractor (RAC) program was created through the Medicare Modernization Act of 2003 (MMA) to identify and recover improper Medicare payments paid to health care providers under fee-for-service (FFS) Medicare plans.

For more information, see:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/index.html>

## Paying Invoices

The Business Manager pays invoices.



## Exam Room Supplies

The exam room supplies area should be kept clean and items should be organized and easily accessible. Items in the supply room should be organized as follows:

### Countertop

- Q-tips (long and short)
- Tongue depressors
- Sharps container
- Gloves
- Hand soap

### Cupboards – items too tall for drawers

- Chlorhexidine
- FOB cards and hemocult test solution
- Extra boxes of gloves (one of each size)
- Lube
- Cytology fixative spray
- Dixie cups for drinking
- Styro cups for LN2
- Wound cleanser/saline

### Top drawer with some sort of organizer – injections

- Needles: - 30g light brown (1/2", 1"), 27g (1 1/2"), 25g blue (1 1/2", 5/8"), 22g black (1"), 16g (1 1/2"),
- Syringes (1cc, 3cc, one 60cc)

- Alcohol swabs
- Spot bandages

#### Second drawer – wound care

- Bandages
- Scalpel blades (#10)
- Roll gauze
- 1x1 gauze
- Polysporin
- Paper tape
- Vet wrap (the ripply stuff that sticks to itself)

#### Third drawer – miscellaneous clinical supplies

- Tendon hammer
- Spare BP cuffs
- Tuning fork
- Monofilament for DM foot testing
- Thermometer with sleeves if oral thermometer
- Tape measure

#### Bottom Drawer

- If no space in bed for specs, can use this drawer for specs

#### Under Sink

- Extra towels, if necessary
- Spare paper towels

- Extra hand soap
- Spare sharps container
- Extra gloves

#### Exam table

- Gowns
- Sheets
- Specula
- Pap slides, pencil, blue cases
- HPV Focal Study supplies in main rooms
- Pap sticks and brushes
- Light source
- Pap forms
- Cervical swabs, C&S swabs, and viral swabs
- Panty liners
- Endometrial biopsy and 1 jar of formalin
- Anoscope x 3

#### Desk drawer

- Pens
- Pregnancy calculator

#### Desktop

- Lab requisition form stamped with physician's name
- X-ray request forms

- Mammogram referral forms
- Rx forms
- Physical therapy forms

## **Emergency Supply Kit**

There is an emergency supply kit located at the front of the supply closet. The office manager is responsible for maintaining the emergency supply kit.

# Office Budget Plan

Having and maintaining a budget is crucial to ensure CMG can well serve its patients and properly reimburse its staff. As with any business, there are three primary steps to good budgeting:

1. Track all expenses.
2. Use benchmarks to create the budget.
3. Regularly compare your budget's actual finances with your budget.