Connected Whole Health
at University of Western States

Health Center Policy and Procedure Manual

Updated 11/13/2025

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INTRODUCTION

This policy and procedure manual is specific to the clinic of University of Western States (UWS), Connected Whole Heath clinic.

The associate vice president of clinic services resides over the operations of Connected Whole Health. Clinic policies are developed within the clinic, then approved by the UWS policy committee, UWS Leadership Cabinet and, in some cases, The Community Solution Education System Office of Legal Affairs.

University related policies can be found here.

DEFINITIONS

- **Amendment to Documentation:** Corrections or additions to the health record that are added after the documentation has been signed. These corrections or additions must be dated, timed, and legibly signed or initialed by the author. Incorrect information is stricken through or deleted. The reason for the amendment should be clear.
- **Chiropractic Manipulative Therapy (CMT):** CMT is sometimes also referred to as an adjustment. It can be performed using a wide range of techniques but ultimately the goal of the CMT is to increase range of motion, improve function, and reduce nerve irritability. A CMT can be performed on one or multiple spinal regions including: cervical, thoracic, lumbar, sacrum, and/or pelvis. Adjustments are also commonly performed on a patient's ribs or extremities.
- **Current Procedural Terminology (CPT):** Code that is maintained and copyright protected by the American Medical Association (AMA) that describes medical services and procedures. It is used by physicians, coders, patients, and payers for administrative, financial, and analytical purposes.
- **Compliance Concerns:** A situation, action, or potential violation that risks the organization's adherence to applicable laws, regulations, industry standards, or internal policies, potentially leading to legal, financial, or reputational damage.
- **Compliance Officer (CO):** The assigned person responsible for the implementation and maintenance of the compliance program for the UWS campus health center.
- **Contemporaneous:** Existing or occurring in the same period. When speaking of healthcare documentation, it means, according to Medicare guidelines, within 24-48 hours of the end of the encounter.
- **Electronic Health Record (EHR):** Patient medical information stored in a digital format.
- **Electronic Medical Record (EMR):** An electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider.
- **Evaluation and Management (E/M):** The components that make up the E/M procedure include a medically appropriate patient history and physical exam, and the level of medical decision making (MDM) and/or time.
- **Healthcare Common Procedure Coding System (HCPCS):** A standardized coding system with 3 levels for reporting procedures, goods, and services.
    - Level I HCPCS consists of Current Procedural Terminology (CPT) codes.
    - Level II HCPCS are used for various medical supplies and ambulance services.
    - Level III codes were for local codes but have been discontinued since 2003.
- **Health Insurance Portability and Accountability Act (HIPAA):** Law that provides privacy and security for a patient's PHI.
- **Hours**: Refers to business hours.

- **International Statistical Classification of Diseases (ICD)**: A standardized system used to code diseases and medical conditions (morbidity) data.
- **Medical Necessity:** Medical services that are justified as reasonable, necessary, and/or appropriate based on evidence-based clinical standards of care. The exact definition may vary slightly among various third-party payers and professional organizations.
- **Modalities:** Any physical agent applied to produce therapeutic changes to biologic tissue; includes, but not limited to, thermal, acoustic, light, mechanical, or electric energy.
    - Supervised modalities do not require direct (one-on-one) patient contact, for example, hot-cold therapy, mechanical traction, and unattended electrical muscle stimulation (e-stim).
    - Constant attendance modalities do require direct (one-on-one) patient contact, for example, attended electrical muscle stimulation (e-stim) and therapeutic ultrasound.
- **National Committee for Quality Assurance (NCQA):** Organization dedicated to improving health care quality through the administration of evidence-based standards, measures, and accreditation.
- **One-on-one Contact:** Maintaining visual, verbal, and/or manual contact with the patient during the provision of the service, with the provider attending to one patient individually for each minute counted toward the required minutes to bill the CPT code for that service.
- **P.A.R.T Documentation:** An acronym for pain, asymmetry/misalignment, range of motion, and tissue tone changes, documentation that is required to support the presence of a region(s) of segmental dysfunction and medical necessity of the treatment for Medicare patients.
- **Passive modalities:** Treatments in which the patient does not actively participate. Examples include treatments such as, but not limited to, low-level and high-intensity laser therapy, shockwave therapy, mechanical traction, electrical stimulation, therapeutic ultrasound, high-voltage galvanic stimulation, therapeutic heat, cryotherapy, hydrotherapy, passive assistive exercise, cupping, dry needling, moxibustion, traction, diathermy, and massage.
- **Payment Posting:** The act of applying payments or zero-pays to a patient's account ledger in order to reflect balance due or a properly paid date of service.
- **Primary Region of Dysfunction:** Also commonly referred to as a misalignment, restriction, or malposition. A primary region of dysfunction is an area of complaint where a pathological/dysfunctional process originates.
- **Protected Health Information (PHI):** Any information in a health record that can be used to identify an individual, and that was created, used, or disclosed while providing care to a patient.
- **Routing Slip:** A paper system of indicating services rendered, which follows the patient through the campus health center and is returned to the front desk for posting services rendered. The routing slip can also be used to add services and compare with data entry for balancing purposes.
- **Secondary Compensation:** A secondary spinal or body region that is affected negatively by a primary region of dysfunction. The patient may or may not complain of dysfunction in this region but over time, a compensation may become a primary region of dysfunction.
- **Signature Authentication:** An attestation that a provider's signature is the true signature. May also include initials in the provider's handwriting.
- **S.O.A.P. Note (Treatment Note):** Treatment note written and signed by the clinician on each patient visit, which includes four main sections: Subjective, Objective, Assessment, and Plan (S.O.A.P). This note is individualized for each patient encounter and provides sufficient documentation to support the medical necessity of the visit.
- **Therapeutic Procedures:** Clinical services aimed at improving patient function. Physicians or other qualified health care professionals (i.e., therapists) are required to have direct (one-on-one) patient contact. Examples include therapeutic exercise, neuromuscular re-education, manual therapy, and therapeutic activities.

- **Timed Treatment Code:** A CPT code for services requiring direct one-on-one contact between the patient and the provider. These include various rehabilitation, soft tissue, and passive treatment modalities. A minimum of eight minutes of direct contact with the patient is required to code a timed procedure. Additional rules apply when multiple timed treatment codes are performed during the same visit.
- **Treatment Plan:** Written plan of the various treatments and modalities prescribed by the clinician for a set period and includes short and long-term goals.

POLICIES AND PROCEDURES

Policy 1401 Privacy and Security of Protected Health Information

Adopted: 11/6/2024
Revision Dates: N/A

University of Western States (UWS) protects the privacy and security of protected health information (PHI) as mandated by the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations. This policy establishes guidelines and procedures to ensure the confidentiality, integrity, and availability of PHI maintained or transmitted by UWS and to comply with HIPAA privacy and security rules.

Scope

This policy applies to all institutional members, including employees, students, volunteers, trainees, and contractors, who have access to PHI in any form (electronic, paper, oral) within UWS.

HIPAA Privacy and Security Rules Compliance

UWS complies with the HIPAA privacy and security rules as described below.

1. Privacy Rule Compliance
    - UWS complies with the HIPAA privacy rule by implementing appropriate administrative, technical, and physical safeguards to protect PHI.
    - PHI is used or disclosed only as permitted or required by law, for treatment, payment, or healthcare operations, or with patient authorization.
2. Security Rule Compliance
    - UWS complies with the HIPAA security rule by implementing safeguards to protect the confidentiality, integrity, and availability of electronic PHI (ePHI).
    - Security measures include access controls, encryption of ePHI, audit controls, and regular risk assessments.
3. Compliance Officer
    - UWS designates a compliance officer, responsible for developing and implementing HIPAA policies and procedures, overseeing compliance efforts for privacy and security, and handling complaints and security incidents.
4. Training and Awareness
    - All members of the workforce receive training on HIPAA policies and procedures upon hire and annually thereafter. A record of these training courses is kept with the UWS Office of Human Resources and the Compliance Officer.
    - Training includes the importance of protecting PHI, permissible uses and disclosures, and individual rights under HIPAA.

5. Business Associates
    - UWS enters into written agreements with business associates who handle PHI on behalf of the university.
    - These agreements require business associates to safeguard PHI and comply with HIPAA requirements.
6. Breach Notification
    - The university promptly investigates and mitigates any breaches of unsecured PHI.
    - If a breach compromises the privacy or security of PHI, affected individuals, the Department of Health and Human Services (HHS), and, in some cases, the media are notified as required by HIPAA regulations.
7. Records Retention
    - PHI is retained in accordance with federal and state laws and university policies.
    - Records containing PHI are securely disposed of when no longer needed, in compliance with HIPAA requirements.

References

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- HIPAA Privacy Rule (45 CFR Part 160 and Part 164, Subparts A and E)
- HIPAA Security Rule (45 CFR Part 160 and Part 164, Subparts A and C)
- HHS Office for Civil Rights (OCR) Guidance on HIPAA Privacy and Security Rules

Policy 1402 Reporting Compliance Concerns

Adopted: 6/10/2025
Revision Dates: N/A

Scope

This policy addresses how to report potential compliance concerns related to the UWS campus health center and clarifies that reporting will not result in any form of retaliation.

Policy

All employees and patients have the right and responsibility to report any alleged compliance concerns or breaches and can expect to do so without any fear of retribution.

Employees are expected to report alleged compliance breaches to the compliance officer within 24 hours of an alleged breach.

All employees and patients may report compliance concerns or breaches directly to the compliance officer for the UWS campus health center in person, by phone or by email.

Procedure

To report compliance concerns in the UWS health center, staff members are to contact the Compliance Officer (CO) with any clinical compliance-related concern by one of the following means:

- Face-to-face, utilizing the CO’s open-door policy
- By email: pbattaglia@uws.edu or phone: 971-449-9268

If a staff member receives a patient compliance concern, they will forward it to the clinic office manager and/or the CO.

Reference Documents

- PHI Compliance Incident Log

Policy 1403 Compliance Records Maintenance

Adopted: 6/10/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus health center employees who are responsible for the maintenance of compliance-related records, including but not limited to the compliance officer (CO).

Purpose

Maintaining compliance-related records in a secure and protected manner ensures the integrity of the compliance program.

Policy

The UWS campus health center maintains written records of all reported or known compliance-related issues in an organized, secure manner.

The CO is responsible for collecting and maintaining digital compliance records in the UWS campus health center. Compliance records will be managed in the following ways:

- All alleged complaints received by the CO will be recorded in the Compliance Incident Log stored on UWS servers.
- Should the compliance incident involve a breach of protected health information (PHI), additional details will be documented in the PHI Compliance Incident Form.
- A working file will be established for each alleged complaint, providing full documentation of actions taken to investigate and resolve the issue.
- The CO will provide annual reporting to the UWS leadership cabinet of all compliance-related concerns.

Procedure

Compliance records will be maintained under the control of the Compliance Office (CO) and will be stored in an encrypted folder within the internal server. Management of all documents, reports, telephone calls, correspondence, and conversations related to compliance issues will be handled in a manner to prevent the erroneous disclosure of information.

- The CO will handle all alleged compliance-related complaints.
- The CO will assign a numerical reference number to each alleged compliance complaint case.
- The Compliance Incident Log will contain the following information:
    - Date the alleged complaint was discovered
    - Numerical reference number
    - Brief description of alleged complaint
    - Date investigative actions initiated
    - Initial investigative action taken
    - Date of alleged complaint resolution
- The protected health information (PHI) Compliance Incident Report Form contains the following information:

    - Date the incident occurred
    - The Compliance Incident Log reference number
    - The type of data that was exposed
    - How the data was transmitted
    - Name(s) of staff, student, or faculty involved
    - Name(s) of patient(s) involved
    - What actions were taken to resolve the incident
    - Date of resolution
- Any documentation maintained electronically will be password-protected under the control of the CO.
- The CO will present an annual report to the leadership cabinet evaluating the compliance program. This report should be detailed and include number of alleged complaints received, investigative actions taken, result of the investigation, date investigation was concluded, and recommendations to improve the alleged complaint reporting and investigative process of the compliance program.

Reference Documents

- PHI Compliance Incident Log
- PHI Compliance Incident Form

Policy 1404 Health Center Compliance Training

Adopted: 6/10/2025
Revision Dates: N/A

Scope

Applies to all new and existing UWS campus health center employees.

Purpose

The purpose of compliance training is to ensure all providers understand and comply with federal and state laws, statutes, and regulations applicable to the delivery of healthcare in a clinical environment. All employees are expected to participate in the campus health center compliance training as assigned according to their position.

Policy

UWS provides internal compliance education at least annually, and more frequently as needed. Training topics include HIPAA, OIG compliance, OSHA regulations, CPR/BLS certification, quality improvement (e.g., best practices), and other subjects necessary to meet state and local licensure requirements. Additionally, training on UWS campus health center policies and procedures is provided whenever new or updated policies are implemented. This education is in addition to any training mandated by the University of Western States' Office of Human Resources.

UWS campus health center employees are required to attend compliance educational programs. Education will be offered with frequency to ensure all personnel are aware of changes or additions to laws, statutes, and regulations concerning the delivery of healthcare in a clinical environment.

All new University of Western States campus health center personnel must complete compliance training within 30 days of their start date. This training is conducted during onboarding and within regularly scheduled hours of operation, as defined by UWS operational needs.

UWS conducts additional training as needed to specifically address compliance concerns found on audits and other internal monitoring. The UWS leadership cabinet evaluates and makes recommendations to the CO regarding educational opportunities available to personnel that may be provided by other entities, especially in the context of any audit findings. Information obtained through these outside, additional training sessions will be conveyed to the CO to consider needed changes in policy. The CO will update internal policies and related procedures in accordance with changes in state and federal laws and statutes.

Procedure

All new University of Western States campus health center employees will be given compliance training to complete within 30 days of their hire date.

- Compliance training courses for new employees include, but are not limited to, HIPAA privacy and security, fraud, waste, and abuse, OIG, FERPA, OSHA, CPR/BLS, and Title IX.
- For clinicians, the Office of Human Resources obtains a copy of licensure during employee hiring and documents completion of the training.
- All campus health center employees complete mandatory annual compliance training.
- The Compliance Manual contains a Compliance Training Log where employees sign off after completing the required training module(s).
- The Compliance Training Log includes the date, course name, employee's signature, and the signature of the employee's supervisor.
- Documentation of course completion certificates, if provided, and other required licensure materials are kept in the Compliance Manual.

Failure of an employee to complete the mandatory compliance training can result in disciplinary actions as defined in the UWS employee handbook and/or the CBA when appropriate.

Reference Documents

- Compliance Manual
- Compliance Training Log

Policy 1405 Medical Records Maintenance

Adopted: 6/10/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus health center employees responsible for maintaining, retaining, releasing, and destruction of all patient records, including, but not limited to, clinicians and the office staff.

Purpose

This policy supports adherence to all applicable federal and state laws, statutes, and regulations regarding managing patient health records and Protected Health Information (PHI).

Policy

UWS manages patient health records and Protected Health Information (PHI) according to HIPAA regulations and Oregon laws and regulations that govern patient record maintenance, retention, release and destruction. As such, the campus health center:

- Creates physical records for new patient registration, orders, and referrals.
- Creates electronic records during medical examinations and treatments.
- Maintains medical records electronically in HIPAA-compliant EMR software.

- Scans and uploads physical records into the EMR software or an encrypted folder on a secure university internal server.
- Destroys any physical copies of records containing PHI by shredding once uploaded into the EMR.

The clinic office manager serves as the medical records custodian and oversees the maintenance, release, and destruction of medical records in accordance with HIPAA and the medical records release policy.

Medical records are kept and maintained in electronic form for ten years, or if the patient was less than 18 years at the time of services, they are kept until the patient reaches the age of 28.

Procedure

The patient's clinician is responsible for completing medical records. In addition, any other clinician or student responsible for providing or evaluating the service provided will complete and authenticate those portions of the record that pertain to their portion of the patient's care.

The patient's clinician or other clinicians (e.g., staff radiologist) who participated in patient care document the chief complaint, history, physical examination, procedures and treatments, progress notes, orders, and summary. When students participate in patient care, the overseeing clinician verifies any student documentation of E/M service components in the medical record, rather than re-documenting the work.

All medical records are signed, dated, and authenticated by the licensed clinician.

References

- OAR 333-505-0050 – Medical Records
- CMS Electronic Health Records
- Summary of the HIPAA Privacy Rule | HHS.gov

Policy 1406 Medical Records Request

Adopted: 6/10/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus health center employees responsible for processing medical records requests, including, but not limited to, clinicians and office staff. Medical records include patient treatment notes, imaging and laboratory test results, prescription and medication history, billing and claims information, and any other record containing identifiable health information.

Purpose

This policy supports adherence to all applicable federal and state laws, statutes, and regulations regarding the release of patients' medical records to patients, other healthcare providers, third-party payers, and other authorized individuals.

Policy

The UWS campus health center maintains all patient health records safely and confidentially. UWS campus health center employees respect the confidentiality of physician-patient communications, information obtained in the course of diagnosing and treating patients, and in all medical records. Patients have access to their own records through a copy, inspection, or a summary, in accordance with the law governing patients' access to their records. Health information may not be disclosed without the patient's written permission, except when the law allows for disclosure. Exceptions allow disclosure without authorization to:

- Internal office personnel involved with patient examination, treatment, and financial recordkeeping.

- Internal office personnel and third-party payers involved with third-party reimbursement.
- The university's auditor, attorney, and liability insurer operating under a business associate agreement.
- Practice administration personnel, when reviewing quality of care, including quality review staff.
- Law enforcement, with a subpoena signed by a judge.

The campus health center office does not provide medical records to anyone other than the parties noted above without written authorization from the patient or the patient's parent or guardian. Release of information contained in a patient's medical record is not released until signed written consent from the patient has been obtained.

The UWS campus health center is entitled to charge reasonable processing and copying fees in accordance with state law (OAR 847-012-0000). Copying fees are charged for records as noted in our procedures. Third-party requests for records greater than 50 printed pages are charged a flat rate of $25 per request. The patient may obtain one copy of their record at no charge. However, additional requests within the calendar year are charged at the rate equal to third-party requests.

The UWS campus health center will not withhold the release of a patient's medical records due to any outstanding charges on the patient's account or inability to pay processing fees.

Procedure

Upon receiving a request for the release of medical records, a UWS campus health center staff member will determine if proper authorization has been obtained.

- If authorization has been obtained, the campus health center will make available the requested information in paper format or via a secure fax within 30 calendar days from the time of receipt.
- Any applicable charges are billed to the requesting party and are due within 30 days of the release of medical information.
- The written authorization and a log of what information was released and to whom is kept in the patient's chart for future reference.

Policy 1407 Health Center Signature Authentication and Verification

Adopted: 6/10/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus health center employees responsible for signature authentication, including, but not limited to, clinicians and office management staff.

Policy

UWS campus health center employs the following guidelines to ensure all information entered into a medical record is signed by the person making the entry:

1. The clinician who delivered patient care or ordered the service signs/authenticates the documentation for that date of service.
2. Signatures are handwritten and electronic, depending on the document. All Electronic Health Record (EHR) documentation includes an electronic signature with the typewritten name of the provider below it. Personal correspondence may contain a handwritten signature.
3. All signatures must be legible. If the signature of a provider is illegible for any reason, a signature log or attestation statement will be maintained and provided to ensure the authenticity of the identity of the author of the medical record entry.

4. If necessary, a signature attestation statement will be included if records are requested for notes that may not contain an appropriate signature.

Procedure

During onboarding of new UWS campus health center employees, a copy of their physical signature is obtained by the clinic office manager and stored in a secure physical location.

- During offboarding, the signature log is edited to remove the signature of UWS campus health center employees no longer employed by UWS.
- The clinic office manager completes an annual audit of the signature log to ensure that all UWS campus health center employees have a signature on file.
- Patient charts are signed with an electronic signature, and any related files (e.g., imaging and lab reports) are physically signed and scanned into the patient chart.

Policy 1408 Medical Record Timely Documentation and Amendments

Adopted: 6/10/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus health center employees responsible for ensuring that timely documentation guidelines are met, including, but not limited to, clinicians and office management staff.

Purpose

This policy supports adherence to all applicable federal and state laws, statutes, and regulations regarding the timely documentation required to provide patients with excellent care, support medical necessity of treatment, and to remain compliant.

Policy

Timely documentation describes the events of a patient encounter, supporting the care with subjective and objective clinical rationale, assessing the effectiveness of the encounter, and certifying that the services were rendered within the legally mandated medical guidelines within a contemporaneous (reasonable) period. UWS campus health center clinicians and student interns will meet the following timely documentation requirements. Students will complete the health record within 48 hours of the patient encounter, and the clinician will sign it within 72 hours.

If completion and certification of the medical record cannot be accomplished within 72 hours following the encounter, the clinician will explain in written detail the reasoning for the delayed entry and place it in the medical record.

Procedure

Clinicians monitor all scheduled encounters and ensure that students complete all health records within 48 hours of the encounter.

- Clinicians are responsible for signing the encounter within 72 hours.
- The clinic office manager runs a weekly report on all open encounters and notifies clinicians of any that are overdue. The clinician will then have 24 hours to sign the encounter.
- The clinic office manager monitors and notifies clinicians of any errors that require editing or addenda.
- If an amendment needs to be made, the clinician creates an addendum in the EHR for the patient and includes the date, reason for the addendum, any additional notes, and their signature.

- The ESA will omit any encounters that were created in error after fully investigating the nature of the error and after confirming the error with the clinician.

Policy 1409 Compliant Treatment Plans - Chiropractic

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for the creation and evaluation of chiropractic patient treatment plans, which includes but is not limited to clinicians and office management staff.

Purpose

This policy provides guidance regarding the creation of patient treatment plans. It is based on applicable state laws, statutes, and regulations. Compliant treatment plans uphold high standards of quality patient care and demonstrate medical necessity through documentation.

Policy

The UWS health center adheres to the requirement of having written treatment plans for all patients who are in an active episode of care. As a rule, this health center uses standards established by the Oregon Board of Chiropractic Examiners (OBCE). In the absence of specific documentation requirements set forth by OBCE, Medicare's documentation requirements are followed.

These standards include:

- Frequency and duration of each treatment
- Evaluation of treatment effectiveness
- Short- and long-term goals
- Date of the treatment plan

University policy is to separately and clearly identify any treatment given on the date of the Evaluation and Management (E/M) service within the daily note.

Clinicians:

- Create a treatment plan based on the criteria listed in the policy above once the appropriate exam has been conducted and any necessary imaging or diagnostic testing has been evaluated, and add the treatment plan to the patient's chart in the EHR software.
- Note any alterations to the treatment plan in the case that prior to the plan's expiration date the patient is not progressing as expected.
- Document any changes to the treatment plan, including reasoning for the change.
- Use the prior treatment plan to assess whether treatment goals have been reached and if the patient has been compliant with all the clinician's treatment recommendations and to inform subsequent treatment plans.
- Perform and document a written informed consent process [PARQ (Procedures, Alternatives, Risks, and Questions) conference] when treatment plans are initiated or modified.

The health center maintains and keeps current documentation standards.

Procedure

- Once the appropriate exam has been conducted and any necessary imaging or diagnostic testing has been evaluated, the clinician will create a treatment plan based on the criteria listed in the policy above.

- A treatment plan will be added to the patient's chart in the EHR software.
- A treatment plan may be altered prior to the expiration date if the patient is not progressing as expected.
- Any changes to the treatment plan will be documented with reasoning for the change.
- The subsequent treatment plan will use the prior treatment plan to assess whether treatment goals have been reached and if the patient has been compliant with all the doctor's treatment recommendations.
- A written informed consent process [PARQ (Procedures, Alternatives, Risks, and Questions) conference] is performed and documented when treatment plans are initiated or modified.

Policy 1410 Periodic Re-Evaluation - Chiropractic

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center chiropractic clinicians who are responsible for re-evaluation documentation.

Purpose

This policy provides guidance regarding the performance and documentation of periodic patient re-evaluations. It is based on applicable state laws, statutes, and regulations. By complying with this re-evaluation policy, the university affirms medical necessity documentation, maintains compliance with various third-party and government regulations, and assesses if the patient's treatment goals are being met.

Policy

UWS health center clinicians appropriately and formally re-evaluate patients actively engaged in an ongoing episode of chiropractic care. Intervals between re-evaluations should not exceed 12 visits or 6 weeks, depending on the patient's current condition.

These services are coded with the appropriate Evaluation and Management (E/M) code for established patients, according to the E/M documentation guidelines.

Procedure

Formal re-evaluations after 12 visits or 6 weeks of treatment will include the following:

- Subjective Progress (ex: reduction in pain, compliance)
- Objective Progress (ex: structural exam, notation of lesions, ROM, functional improvement)
- Progress toward treatment goals
- Additional treatment required to reach treatment goals
- Discharge plans and date, if appropriate

Reference Documents

- Oregon Chiropractic Practices and Utilization Guidelines

Policy 1411 Documentation Standards

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for documentation standards, including but not limited to clinicians and office management staff.

Purpose

Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. Medical record documentation guidelines vary between state boards and with university risk management insurance. The UWS health center has adopted standards using the National Committee for Quality Assurance (NCQA) Guidelines to assist in defining university documentation standards for practice.

Policy

UWS health center clinicians and team members document the following in the Electronic Health Record (EHR):

- The patient's name or ID number is included on every page of the health record.
- Author identification is included in all medical record entries and may be in the form of a handwritten signature, unique electronic identifier, or initials.
- The date (All entries must be dated).
- Significant illnesses and medical conditions are indicated in the health record.
- Past medical history is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- The history and physical examination identify appropriate subjective and objective information pertinent to the patient's presenting complaints.
- Working diagnoses are consistent with the findings.
- Treatment plans are consistent with the diagnoses.
- The request or referral if a consultation is requested, or the patient is referred elsewhere.
- There is no evidence that the patient is subject to inappropriate risk by a diagnostic or therapeutic procedure through the informed consent process.
- Personal biographical data includes the address, employer, home and work telephone numbers, and marital status.
- Follow-up care, calls, or visits when indicated on encounter forms or as notations in notes. The specific time of return is noted in weeks, months, or as needed.
- Unresolved health concerns from previous UWS health center visits are addressed in subsequent visits.
- Consultation and diagnostic testing (e.g., imaging, labs, electrodiagnostic) reports filed in the chart are signed by the practitioner who ordered them to signify review. Review and signature or initial by professionals other than the ordering practitioner do not meet this requirement. If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal test results have an explicit notation in the record of follow-up plans.
- Evidence that preventive screening and services are offered in accordance with the treating clinicians' professional standards.

Procedure

It is everyone's job to make sure that our office's documentation standards are met or exceeded when entering information into a patient's chart. Training will be provided to all staff to improve our documentation standards.

- Outside reports (e.g., diagnostic imaging, laboratory results, consultation notes, or other health care records) will be reviewed by the treating clinician, initialed, and scanned into the patient's chart. The treating clinician will also document that they have reviewed the outside reports in the patient treatment note on that date of service, as well as any relevant changes to their decision-making.
- The Compliance Officer (CO) will randomly review five (5) charts per provider as a baseline audit on a yearly basis and additional charts based on the office's level of performance during the initial audit. The CO will check the charts for the criteria outlined in the policy above.
- Any non-compliant findings will be documented, and corrective action will be taken to include additional training in documentation procedures.

Policy 1412 Minimum Documentation Requirements for Chiropractic Services

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for ensuring that minimum documentation requirements are met, including but not limited to clinicians and office management staff.

Purpose

This policy provides guidance regarding the minimum documentation required to provide patients with excellent care, demonstrate medical necessity of treatment, and to remain compliant. It is based on applicable state laws, statutes, and regulations.

Policy

The UWS health center has a minimum documentation requirement for all patient encounters. This standard is set by the Oregon Board of Chiropractic Examiners (OBCE). In the absence of specific documentation requirements set forth by the state licensing board, Medicare's documentation requirements are followed. The clinician may freely document above the minimum at their discretion.

In accordance with Oregon state requirement (OAR 811-015-0005), UWS health center documentation includes the following minimum requirements:

- Maintain complete, accurate, clear, and legible patient records to ensure continuity of care. Records must:
    - Be individualized for each patient, include identifiable patient and clinic information, and document all clinical services, diagnoses, treatment plans, and informed consent.
    - Be retained for a minimum of seven years (or until a minor patient turns 25).
    - Include billing records with appropriate details for services rendered, if applicable.
    - Be accessible upon request by authorized parties.
    - Be securely destroyed when no longer required, in compliance with state and federal laws.
- Provide clear, legible, complete, accurate, and minimally competent records containing the following:
    - A description of the chief complaint or primary reason the patient sought treatment.

- Documentation of any significant event that affects the chief complaint of the patient or the general history of the health of the patient.
- An accurate record of the diagnostic and therapeutic procedures employed in providing chiropractic services to the patient, including, but not limited to:
  - Height, weight, blood pressure, and pulse at the initial examination. If the initial examination is via telehealth, record patient height and weight by patient report. Record blood pressure and pulse if patient is able to obtain remotely. Height, weight, blood pressure and pulse is recorded on subsequent visits, as clinically indicated.
- Examinations and the results of those examinations.
- Diagnoses.
- Treatment plan, any subsequent changes to the treatment plan, and the clinical reasoning to support changes.
- Dates on which the clinical services were provided to the patient, as well as the services performed, and clinical indications for those services.
- Regions of the patient's body where care was provided.
- Patient's response to treatment.
- Therapeutic procedures are clearly described, including information such as providers involved, timing, setting, and tools used, as appropriate.

- Document written informed consent to include a PARQ (Procedures, Alternatives, Risks, and Questions) conference has been obtained in the chart.
- Document other clinically relevant correspondence, including, but not limited to, telephonic or other patient communications, referrals to other practitioners, and expert reports.

The UWS health center routinely checks for changes to the state minimum documentation standards at an annual interval.

Procedure

- Documentation will follow the S.O.A.P. format in the EHR that this office utilizes. The patient's name, chart number, birthdate, and date of service will be on each page.
- The patient will be asked about their pain level or a functional subjective measure prior to receiving any treatment for the day and if there is anything new about their condition that they need to report.
- PART will also be documented.
- The treatment note will reference the long-term and short-term goals stated in the patient's most recent treatment plan, especially if the patient is making progress toward reaching those goals or the reason that the patient is not progressing as planned.
- All services rendered will be documented in the EHR note.
- Start and stop times of timed therapy codes are also reported.
- The note will include the treating clinician's signature and the date the note was written.
- If additional information is to be documented after a note is completed, an addendum is added to the note with the time/ date of addition, and the signature of the clinician is noted. Under no circumstances should information from a note be removed or altered.
- The CO is responsible for auditing documentation on at least an annual basis for compliance.
- Any person who is aware of unethical or non-compliant medical documentation should report it to the compliance officer immediately.

Policy 1413 Minimum Documentation Requirements for Naturopathic Services

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for ensuring that minimum documentation requirements are met, including but not limited to clinicians and the office management staff.

Purpose

This policy provides guidance regarding minimum documentation to provide patients with appropriate care and support the medical necessity for treatment.

Policy

The UWS health center has a minimum documentation requirement in the Electronic Health Record for the patient encounter. The clinician may freely document above the minimum at their discretion.

Naturopathic doctors provide documentation in accordance with the following standards:

- Complete, accurate, clear, and legible patient records to ensure continuity of care. Records must:
    - Be individualized for each patient, including identifiable patient and clinic information, all clinical services, diagnoses, treatment plans, and informed consent.
    - Be retained for a minimum of 7 years (or until a minor patient turns 25).
    - Include billing records with appropriate details for services rendered, if applicable.
    - Be accessible upon request by authorized parties.
- Clear, legible, complete, and accurate records contain the following:
    - A description of the chief concern or primary reason the patient sought treatment from the licensee.
    - Documentation of any significant event that affects the chief concern of the patient or the general history of the health of the patient.
    - An accurate record of the diagnostic and therapeutic procedures that the clinician employed in providing medical care to the patient, including, but not limited to, blood pressure, heart rate, and respiration.
    - Examinations and the results of those examinations.
    - Diagnoses.
    - Treatment plan, any subsequent changes to the treatment plan, and the clinical reasoning for those changes.
    - Dates on which the clinician provides services to the patient, the services performed, and clinical indications for those services.
    - Patient’s response to treatment.
    - Therapeutic procedures are clearly described, including information such as providers involved, timing, setting, and tools used, as appropriate.
- Other clinically relevant correspondence, including, but not limited to, telephonic or other patient communications, referrals to other practitioners, and expert reports.

Procedures

Documentation will follow the S.O.A.P. format in the EHR that this office utilizes. The patient’s name, chart number, birthdate, and date of service will be on each page.

- The patient will be asked their pain level prior to receiving any treatment for the day and if there is anything new about their condition that they need to report.
- The treatment note will reference the long-term and short-term goals stated in the patient's most recent treatment plan, especially if the patient is making progress toward reaching those goals or the reason that the patient is not progressing as planned.
- All services rendered will be documented in the EHR note. Start and stop times of timed therapy codes are also reported.
- The note will end with the treating doctor's signature and the date the note was written.
- If additional information is to be documented after a note is completed, an addendum is added to the note with the time/ date of addition and the signature of the rendering physician noted. Under no circumstances should information from a note be removed or altered.
- Medical documentation will be audited at least annually for compliance.

Policy 1414 Patient Intake and History

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for issuing and documenting the patient's medical history and other important information on the initial visit, including but not limited to clinicians and office management staff.

Purpose

This policy provides guidance regarding the proper recording of the initial patient intake and medical history. It is based on applicable state laws, statutes, and regulations.

Policy

The UWS health center employs best practices to gather required intake information, including ancillary intake information, to ensure that clinicians have all the necessary information to determine the next steps for each patient. HIPAA guidelines are followed to ensure the protection of protected health information (PHI) contained on the intake forms throughout the patient encounter and thereafter.

All new patients complete a standard set of intake forms, which include, but are not limited to, registration, medical history, financial policy, patient rights, and HIPAA acknowledgment. Patients with Oregon Health Plan coverage also complete an OHP Client Agreement. New and existing patients complete additional treatment-specific questionnaires as needed.

A Patient Service Representative reviews forms for completeness and ensures proper entry into the electronic health record (EHR). Clinical forms are provided to the attending clinician for review and returned to the PSR for final upload to maintain accurate and compliant records.

Procedure

The patient service representatives (PSR) is responsible for collecting and managing the new patient's intake paperwork documents. All HIPAA guidelines will be followed to ensure the protection of PHI contained on the intake forms throughout the patient encounter and thereafter.

All patients complete the following forms:

- New Patient Registration
- New Patient History and Intake
- Financial Policy

- Patient's Rights and Responsibilities
- HIPAA Notice of Privacy Practices
- Acknowledgement of Receipt of Notice of Privacy Practices
- Additional Questionnaires for Modality Specific Treatment (if applicable)
- Oregon Health Plan (OHP) Client Agreement (if applicable)

A PSR will review the forms prior to the patient meeting with the clinician. If any sections are left blank, the PSR will ask the patient to complete the missing information, answering the patient's questions or providing clarification if necessary.

Once the patient completes the forms:

- A PSR enters the New Patient Registration data into the patient's electronic health record (EHR).
- The New Patient History and Intake form, and any additional questionnaires, e.g., for Modality Specific Treatment, are organized into a file system for pick up by the attending clinician at the time of the new patient appointment.
- Other forms, including the Registration, Financial Policy, Patient's Rights and Responsibilities, and HIPAA documents, are scanned and uploaded through OnBase (in Epic), where they are indexed and committed to the patient's EHR.
- Once the appointment is complete, the attending returns the History and Intake form and all additional forms to the PSR team for scanning, indexing, and committing them into the patient's EHR.

Policy 1415 Medical Record Audits

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for conducting a medical records audit for clinical services, analyzing the results, or implementing follow-up procedures, including but not limited to clinicians and office management staff.

Purpose

This policy provides guidance regarding the proper documentation, billing, coding, and collections process utilized in this clinic. It is based on applicable state laws, statutes, and regulations. Current best practices are followed and outlined the UWS health center's procedures for conducting baseline and follow-up audits to ensure compliance.

Policy

The UWS health center recognizes that a medical record audit provides insight to possible risk areas during the patient care experience, potential inappropriate behavior or conduct associated with the clinical services provided, documentation of the medical record, and billing and coding practices.

Clinicians will conduct a monthly peer-review audit to support continuous quality improvement. Additionally, a comprehensive annual audit will be conducted by either the compliance officer (CO) or a third-party compliance consultant, consisting of medical records of each provider, and representative of the demographics of the health center patient population.

The necessity for subsequent internal follow-up audits from the annual audit is determined according to errors identified in the baseline audit. Medical records are randomly selected with dates of service from the clinician's last educational session.

Policies associated with the audit of medical records are reviewed and updated as necessary.

Procedures

- Chiropractic clinicians have four (4) random notes reviewed monthly by a peer using an internal chart audit tool specific to chiropractic services.
- Naturopathic clinicians have one (1) randomly selected note reviewed monthly by a peer using an internal chart audit tool specific to naturopathic services.
- All clinicians will have five (5) patient charts reviewed annually by either the compliance officer (CO) or third-party compliance consultants using internal chart audit tools.
- An audit report is developed based on this annual audit, error type, and rate.
- Provider education is conducted for identified errors during monthly peer review or annual audits.
- Recommendations for follow-up audit activity based on the findings from the *annual chart audit* are:

Error Rate	Schedule for follow-up Audit
10%	Annual
20%	Eight months
30%	Seven months
40%	Six months
50%	Five months
60-70%	Four months
80%	Three months
90%	Two months
100%	One month

An audit report from annual chart audits will be made available to each provider for educational purposes with the assigned training. The Compliance Officer (CO) will be responsible for scheduling all audit activities and maintaining a dashboard for providers to review their error rates relative to established benchmarks. This report will be completed immediately after the annual audit activities.

Policy 1416 Daily Charge Entry

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for recording charges on routing slips and/or entering charges into the billing software, including but not limited to clinicians and office management staff.

Purpose

This policy provides guidance for the coding and billing that UWS health center employees use related to services rendered and supplies/materials provided to a patient.

Policy

The UWS health center clearly and accurately communicates between the clinicians who render services to the patient and the patient service representative who collects payments and is responsible for charging appropriately for all services rendered. In the case of imaging services, a routing slip is used to identify completed procedures, and the Electronic Health Records (EHR) system automatically selects the corresponding codes. UWS health center employees double-check patient records and, where appropriate, ensure that the coding used best describes services rendered on the day of service.

Policies associated with entering daily charges are reviewed at least annually and updated as necessary.

Procedures

- Verify that the patient has a signed Financial Policy and Acknowledgement of Receipt of Notice of Privacy Practices.
- For X-Ray imaging services and orthotics:
    - Review the routing slip to confirm accuracy. Check that all services are selected on the routing slip and that the billing and coding information is correct. If any discrepancies are discovered, return the file to the treating doctor for correction.
- For apothecary items:
    - Review the patient's after-visit summary (AVS) for the apothecary items list. Check that all items received are included on the AVS and match the physical items being sold. If any discrepancies are discovered, return the AVS and apothecary items list to the treating doctor for correction.
- File or dispose of paper routing slips according to campus health center policy.

Policy 1417 Payment Posting

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center employees who are responsible for entering payments into the billing software, including but not limited to clinicians and office management staff.

Purpose

This policy provides guidance regarding consistent and compliant billing practices used by UWS health center employees. It is based on applicable state laws, statutes, and regulations. Efficient and accurate payment posting reduces errors and ensures patients' financial responsibilities are handled in a confidential, timely, and appropriate manner.

Policy

UWS health center employees post self-pay payments at the time of receipt and from third-party payers weekly. Checks are posted as they are received and within a maximum of five business days. Payments posted are carefully reviewed to determine if the bill has been paid in full, requires a contracted write-off, or has a left-over balance to be applied to patient responsibility. Any errors are immediately tagged for follow-up and appeal if necessary.

Procedures

- Checks from third-party payers are received via postal service.
- A Patient Service Representative (PSR) will post the third-party check payment to the patient's account. If there is a write-off to be taken, it should be done immediately. This is categorized as a contractual write-off. The patient is never billed for the contractual write-off amount.
- Once complete, the PSR will make sure the account balances.
- The PSR will then prepare the check for deposit. A printed batch report will be attached to the deposit at the end of day.

- Self-pay payments are collected by the PSR at the time of service and processed through Square POS Register. Once the payment has been processed, it is posted in the patient's Epic HER account if applicable.
- Examples of payments that are posted in the EHR include: outstanding statement balances, orthotics, X-ray imaging services, electrodes, heel lifts, and other miscellaneous items for chiropractic services.
- Examples of payments that are not posted in the EHR include: apothecary items for naturopathic services.

Policy 1418 Segmental Dysfunction Documentation for Administering Chiropractic Manipulative Therapy

Adopted: 8/19/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) health center members who are responsible for documenting a patient's region(s) of segmental dysfunction for the purpose of providing chiropractic adjustments (i.e., chiropractic manipulative therapy, (CMT) in the patient's medical record.

Purpose

This policy provides guidance regarding the complete and accurate documentation of a patient's region(s) of segmental dysfunction. It is based on applicable state laws, statutes, and regulations.

Policy

The UWS health center utilizes a wide range of chiropractic techniques. Because some technique protocols involve treatment of the full spine, regardless of the patient's presenting chief complaint, clinicians use the criteria below to delineate the difference between a primary region of dysfunction and any secondary compensation that may be addressed and managed during the patient visit.

1. The clinician obtains a complete history and conducts a thorough examination in order to establish a diagnosis.
2. The clinician documents the following in the patient record:
    - Active condition being treated.
    - The primary areas of segmental dysfunction, established via the PART criteria, are clearly defined/identified in the treatment plan
    - The primary regions of dysfunction are identified and differentiated from other areas of compensation that need to be addressed to stabilize, reduce, and/or remove the primary regions of dysfunction.
    - Levels of segmental dysfunction.
    - Levels of primary regions of segmental dysfunction treated are matched with the appropriate Current Procedural Terminology (CPT) code for the Chiropractic Manipulative Treatment (CMT) that was chosen.

For patients being seen for maintenance/wellness purposes, the documentation meets minimum level documentation requirements for the university (See Policy 1412).

Procedures

The treating doctor obtains a complete history and provides a thorough examination in order to establish a diagnosis.

Documentation includes the following:

- Treating for an active condition.
- Clearly define/identify in the treatment plan the primary areas of segmental dysfunction, established via the PART criteria.
- Identify and differentiate primary regions of dysfunction from other areas of compensation that need to be addressed to stabilize, reduce, and/or remove the primary regions of dysfunction.
- Identify the levels of segmental dysfunction
- Match the levels of primary regions of segmental dysfunction treated with the appropriate Current Procedural Terminology (CPT) code for the Chiropractic Manipulative Treatment (CMT) that was chosen.
- For patients being seen for maintenance/wellness purposes, the documentation will be at the level of our minimum documentation requirements.

Policy 1419 Coding Healthcare Common Procedure Coding System (HCPCS) Level II

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus clinic employees responsible for coding, including but not limited to clinicians and office management staff.

Purpose

The purpose of this policy is to support adherence to all applicable federal and state laws, statutes, and regulations regarding the use of Healthcare Common Procedure Coding System (HCPCS) codes.

Policy

The UWS clinic assigns HCPCS codes in accordance with definitions of each code established and maintained by the Center for Medicare and Medicaid Services (CMS). A current HCPCS level II manual is maintained in the office manager's office. The office manager is responsible for monitoring HCPCS code updates and implementing necessary changes immediately when they affect any service, supply, or product used in the clinic.

Clinic Employees Responsibilities

- All services, dispensed supplies, and products provided during patient encounters are documented factually in the patient record, proving medical necessity for all assigned HCPCS.
- The clinic uses accurate and up-to-date HCPCS level II codes for all services, supplies, and products currently offered or introduced in the future.

Policy 1420 Coding Therapies, Modalities, and Therapeutic Procedures

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus clinic employees responsible for coding therapies, modalities, and procedures performed in the clinic. This includes, but is not limited to, clinicians and office management staff.

Purpose

The purpose of this policy is to support adherence to all applicable federal and state laws, statutes, and regulations regarding the proper use of CPT and/or HCPCS coding guidelines for the services provided and details the procedure used to verify compliance.

Policy

- All modalities and therapeutic procedures are coded accurately, reflecting the actual service performed, in alignment with CPT and/or HCPCS coding guidelines.
- Services assigned a constant attendance CPT code are performed while the provider maintains direct one-on-one contact with the patient.
- The clinic adheres to state board regulations regarding provider qualifications for administering therapies.
- Properly timed coding rules for constant attendance therapies are followed, unless otherwise specified by the state board.

Clinician Responsibilities

- Modalities and/or therapeutic procedures provided are based on the treating clinician's recommendations outlined in the patient's treatment plan.
- All therapies and modalities performed are documented in the patient's chart, including details and total time.
- CPT codes will be assigned based on the services and details noted in the documentation.

Clinic Personnel Responsibilities

- Coding and proper documentation of the various procedures performed in this clinic are audited during monthly note spot-checks and annual chart audits.
- Appropriate coding training will be conducted as needed.

Policy 1421 Patient Financial Responsibility Management

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all campus health center employees involved in the development and implementation of office fiscal procedures, including but not limited to, clinicians and office management staff.

Purpose

To establish standards for managing patient financial responsibilities in a confidential, timely, and appropriate manner.

Policy

Patient financial responsibilities are managed in a confidential and consistent manner. All payment, collection activities, or procedures are applied equally to all patients, regardless of handicap, age, sex, color, race, national origin, or method of payment. Financial communications and assistance are conducted professionally, effectively, and efficiently. Outstanding balances over 90 days are written off after three documented collection attempts

Patient Financial Requirements Enforced by Health Center Employees

The health center employee is responsible to communicate to the patient and require that:

- The patient signs the UWS clinic financial policy form at their new patient appointment.

- Accepted payment methods include credit/debit cards and checks; cash is not accepted.
- Charges for apothecary items must be paid at check-out before items are dispensed.
    - Items are not released prior to payment.
    - All sales are final and non-returnable, unless an error was made by clinical staff. In such cases, a refund is issued upon receipt of the returned item. Refunds are issued within 30 days of identification of the error.
- Charges for external imaging services are collected at check-in on the date of service.
    - If payment is not received, a note is made in the patient's chart and the patient is contacted by phone to request for payment.

Reference Documents

- Financial Policy
- Financial Policy for External Imaging Referrals

Policy 1422 Patient Conduct Discharge

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus clinic employees responsible for discharging patients from care due to inappropriate conduct.

Purpose

To outline patient discharge policy for reasons of conduct in compliance with all federal and state laws, statutes, and regulations regarding the discharge of a patient from care due to inappropriate patient conduct. This policy supports accurate medical necessity, regulatory compliance with various third-party and government regulations, and a smooth transition of care for affected patients.

Policy

Patients may be administratively discharged from care when noncompliant with their treatment plan, exhibiting behavior that is considered inappropriate or hostile, repeatedly violating the UWS clinic's no-show expectations, or failing to adhere to the Patient Rights and Responsibilities agreement. All discharges will follow the procedures outlined below.

1. **Continuous No-shows**
    - Each missed appointment is documented in the patient's Electronic Health Record (EHR) and communicated to the patient.
    - After three no-shows, the patient will be put on a six-month probationary period and will not be able to schedule.
    - Following the probationary period, the patient may resume scheduling as normal.
2. **Inappropriate Behavior**
    - For one or two incidents of inappropriate verbal or physical behavior, the patient receives a verbal warning, and each incident is documented in their EHR.
    - Upon a third incident, the patient receives a formal written discharge notice, which is documented in their EHR.
    - In cases of severe inappropriate behavior, including but not limited to violent words or actions, the patient is immediately discharged. Security will escort the patient from the premises, and a formal written discharge is provided and documented in their EHR.

3. **Discharge Process**
    - The written discharge notice provided to the patient will include three suitable referral options for continued care.
    - If deemed clinically appropriate, the patient may receive essential medical services, at the discretion of their primary care provider, for up to 30 days from the date of discharge to support their transition from care.

References

- OAR 811-035-0005 – Duties and Obligations of Chiropractic Physicians to Their Patients
- The American Association of Naturopathic Physicians (AANP), Code of Ethics, Section 7c "Discrimination"

Related Documents

- Patient Rights and Responsibilities
- Discharge Summary
- Discharge Letter Template

Policy 1423 Practice Billing Standards

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus health center employees responsible for the billing standards, including but not limited to clinicians and the office management staff.

Purpose

To establish a clinic-wide policy for office personnel to perform billing and coding practices in accordance with federal and state laws, statutes, and regulations applicable to the delivery of healthcare, including radiology and laboratory services.

Policy

All clinicians and office management staff receive training on UWS clinic billing standards to support compliance with federal and state laws, statutes, and regulations. The Compliance Officer (CO) is responsible for assigning education.

Billing standards include the following principles:

- Medical record documentation is comprehensive, legible, and serves as support documentation for billed medical services.
- Documentation is completed in a timely manner.
- Clinical services are reasonable and medically necessary.
- Providers select appropriate Current Procedural Terminology (CPT), International Statistical Classification of Diseases (ICD), Healthcare Common Procedure Coding System (HCPCS) codes, apply correct modifiers, and ensure appropriate code linkage.
- Medical records are stored securely and confidentially.
- All personnel report suspected inappropriate behavior, conduct, or activities to the CO.
- Education and training are conducted at least annually to ensure personnel have current information regarding laws, statutes, and regulations. New personnel receive training within 60 days of their start date.

- All personnel are expected to perform their job responsibilities in accordance with all federal and state healthcare laws, statutes, and regulations.

Procedure

1. The Financial Policy is reviewed and updated annually with patients.
2. Most services are complimentary and provided at no cost.
3. For goods and services with fees greater than $0, a good-faith estimate is provided.
4. Third-party billing is not permitted.
5. All fees are collected from the patient at the time of service.
6. Payment processing is completed daily through the front desk operations.
7. In the teaching clinic setting, students completed all visit documentation within 48 hours of the visit, and attending clinicians sign off within 72 business hours.

Policy 1424 Staff Training Modalities

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all UWS campus health center employees responsible for training staff and students in the use of passive modalities, including but not limited to clinicians.

Purpose

To support adherence to all applicable federal and state laws, statutes, and regulations regarding the proper technique used for passive modalities and training the equipment used in this office. This policy supports improved patient outcomes and a consistent standard of care.

Policy

All clinicians and students who are enrolled in the clinical internship program and have completed foundational coursework covering passive modalities and are involved in patient care demonstrate appropriate competency in the application and use of passive modalities. A UWS faculty member with relevant content expertise assesses competency using clinic equipment.

- Newly hired clinician: complete a competency assessment within 30 days of hire.
- Students: complete a competency check-off prior to administering passive modalities in clinic. The competency check-off includes knowledge of the modality purpose, contraindications, and safety, demonstration of equipment setup and use, and communication with supervising clinicians and patients.

Policies associated with office staff training in passive modalities are reviewed and updated as necessary.

Procedure

<u>For newly hired clinicians</u>:

- During onboarding, the clinic office manager notifies the designated UWS faculty member with content expertise.
- A passive modality competency check is scheduled to occur within the clinician's first 30 days of employment.
- The competency check includes:
    - Indications and contraindications for each passive modality offered at the clinic
    - Demonstration of safe and effective equipment setup

    - Application
    - Emergency protocols or adverse event procedures, if applicable.
- The faculty member completes a standardized competency checklist.
- The completed checklist is retained in the clinician's personnel file.
- If competency is demonstrated, the clinician is cleared to independently use passive modalities.
- If not, remediation is scheduled, followed by reassessment within 10 business days.

For qualified students:

- Students must be enrolled in the clinical internship program and have completed foundational coursework covering passive modalities.
- Eligibility is confirmed by clinical faculty or administration before scheduling a competency assessment.
- A UWS faculty member with content expertise coordinates with eligible students to schedule competency assessments.
- These sessions may occur in small groups or individually prior to clinic rotation start.
- Competency Evaluation check-off includes:
    - Knowledge of modality purpose, contraindications, and safety.
    - Demonstration of equipment setup and use.
    - Communication with supervising clinicians and patients.
    - A standardized rubric is used to evaluate performance.
- Successful completion is documented in the student's clinical file or LMS.
- Students may not use passive modalities until this step is completed.

Reference Documents

- Employee Training Log
- Passive Modality Competency Checklist
- Passive Modality Competency Rubric

Policy 1425 Coding Timed Treatment Codes

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus clinic employees responsible for performing, documenting, and/or coding timed treatment modalities.

Purpose

To ensure compliance with all applicable federal and state laws, statutes, and regulations regarding the proper documentation and coding of timed treatment codes.

Policy

The UWS clinic adheres to AMA CPT and Center for Medicare and Medicaid Services (CMS) guidelines for timed treatment coding. All timed procedures are properly documented to support medical necessity and billing accuracy.

- Timed procedures are documented with the total time spent and the body area treated.
- Timed codes are not to be billed for treatments lasting less than 8 minutes.

- Clinicians must not intentionally reduce treatment time to avoid coding; doing so is considered fraudulent and may compromise patient care.

When multiple timed procedures are performed during a single visit, the total time will be used to determine the number of billable units.

Through the use of internal documentation and coding auditing processes, the UWS clinic regularly reviews and evaluates all use of timed codes.

Procedure

- Therapies, modalities, and/or procedures performed based on the treating clinician's recommendations outlined in the patient's treatment plan.
- All procedures performed are documented in the patient's chart.
- For timed therapies and procedure codes, document in the patient's chart, including:
    - Total minutes performed.
    - Area of the body where treatment was applied.
- When multiple timed procedures are performed during the same visit, the following chart is used to determine the correct number of units to bill for the date of service:

Units	Time Window
1	Greater than or equal to 8 minutes through 22 minutes
2	Greater than or equal to 23 minutes through 37 minutes
3	Greater than or equal to 38 minutes through 52 minutes
4	Greater than or equal to 53 minutes through 67 minutes

Policy 1426 Diagnosis (ICD-10) Coding

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus clinic employees responsible for ICD-10 coding.

Purpose

To ensure accurate, ethical, and compliant ICD-10 coding for all patient encounters in accordance with applicable federal and state laws, regulations, and professional standards. This policy supports clinical documentation integrity, enhances data quality for reporting and analytics, and promotes continuous improvement in patient care.

Policy

UWS clinic personnel must code ethically and accurately for every patient encounter, following guidelines established by the World Health Organization (WHO), American Medical Association (AMA), and Centers for Medicare & Medicaid Services (CMS).

- This clinic monitors annual updates to ICD-10 codes via CMS website and communications from national and state associations.

Internal and external audits are conducted in accordance with Office of Inspector General (OIG) regulations.

Any identified coding errors are corrected immediately, and appropriate training and/or disciplinary actions are taken.

Procedure

- A baseline audit will be conducted using 5-10 randomly selected charts, and subsequent audits will be performed annually, and part of that audit includes a review of most commonly used ICD codes.
- Annually, gather statistics about the various codes used in our clinic to determine the frequency that each code is used and if it is in alignment with national averages for other providers.
- Based on all the information gathered from internal and external audits as well as our coding statistics, our Compliance Officer will identify areas of non-compliance and develop an action plan to correct those offenses.
- Training will be conducted with all pertinent staff members regarding compliant coding procedures on an annual basis or sooner if warranted.
- To monitor the CMS website for coding changes:
    - Navigate to the official **CMS ICD-10 webpage**.
    - Scroll down the page until you see the section for the **2026 ICD-10 CM & PCS files**.
    - Under the heading **2026 ICD-10-CM files**, you will find a list of downloadable ZIP files for the diagnosis codes. The files typically available are:
        - 2026 POA Exempt Codes (ZIP)
        - 2026 Conversion Table (ZIP)
        - 2026 Code Descriptions in Tabular Order (ZIP)
        - 2026 Addendum (ZIP)
        - 2026 Code Tables, Tabular and Index (ZIP)
        - FY 2026 ICD-10-CM Coding Guidelines (PDF)
    - **Click** on **2026 Addendum (ZIP)** to begin the download. This will download a ZIP folder to your computer.
    - Open the ZIP. There will be multiple files. Find the file titled **"...tabular_addenda_2026;"** it contains all the additions, deletions, and revisions for the upcoming FY (10/1/-9/30/).

Policy 1427 Patient Discharge - Chiropractic

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus health center chiropractic clinicians responsible for discharging patients from care.

Purpose

To ensure compliance with government regulations and provide patients with a smooth transition to the appropriate level of care when discharge from chiropractic services is indicated.

Policy

All patient encounters are properly documented. When appropriate, a formal discharge summary is completed, including the patient's status at discharge, achievement of treatment goals, and any referrals made.

Patients may be discharged under the following situations:

- Resolution of the patient's condition
- Achievement of treatment goals
- Failure to respond to a reasonable trial of care

- Referral to another provider is needed
- Patient misconduct (see Policy 1422 Patient Conduct Discharge).

Discharge related policies are reviewed and updated as necessary.

Procedure

In the scenarios listed above, the patient will receive a formal discharge summary that will include the following:

- Treatment Start Date for This Episode of Care
- Discharge Date
- Total number of Encounters
- Functional Goals Achieved
- Functional Goals Not Achieved (ADL status)
- Final Status

If a referral to another provider is necessary, UWS chiropractic clinicians will counsel the patient on the reasons for the referral, submit the referral when appropriate, or direct the patient to their primary care provider for further management. All referrals will be documented appropriately.

In the case where the patient chooses to end treatment prior to the end of the recommended treatment plan, this office will follow the procedure below:

- If a patient missed a scheduled appointment, a Patient Service Representative (PSR) will contact them to follow up. This outreach will be on the same day as the missed appointment.
    - With No-Shows, a PSR will attempt to call the patient to let them know they missed their appointment and ask if they want to reschedule.
    - With cancellations, the PSR will attempt to reschedule the patient at the time of cancellation and give them the option to call back at a later date if preferred.
    - The PSR will document the outcome in the appointment cancellation notes.
    - The PSR will notify the clinician(s) by sending an Epic chat message.
- Upon completion of the missed appointment contact procedures without results, and at least four weeks have elapsed since the last appointment, it will be assumed that they have discontinued care.
- If the patient returns for care after the four weeks have elapsed since their last appointment, they will be formally re-evaluated, and a new care plan will be established.

Related Documents:

- Patient Rights and Responsibilities
- Formal Discharge Summary

Policy 1428 Evaluation and Management (E&M) Coding

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus clinic employees responsible for coding Evaluation and Management (E/M) services.

Purpose

To ensure accurate and compliant coding of E/M services in accordance with applicable federal and state laws, statutes, regulations, and professional standards. This policy supports proper documentation, enhances data quality, and promotes continuous improvement in patient care.

Policy

All clinic employees involved in E/M coding are familiar with the 2021 Evaluation and Management (E/M) documentation guidelines, including revisions made in 2023. Code selection reflects the services rendered and is based on the level of MDM and/or time, as appropriate.

- Providers and staff receive ongoing training to ensure accurate application of E/M coding guidelines.
- Code selection considers whether the patient is new (not seen in the practice within the past three years) or established (seen within the past three years).
- Monthly peer-review audits of E/M coding are conducted to ensure compliance.
- Any identified errors are corrected immediately, and targeted training is provided to prevent recurrence.

Related Documents:

- 2021 Time-based Guidance EM_AMA.pdf
- 2021 with 2023 Update MDM Guidance EM_AMA.pdf

Policy 1429 Full Spine Adjusting and Coding for CMT procedures

Adopted: 11/13/2025

Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus clinic employees responsible for coding Chiropractic Manipulative Treatment (CMT) procedures.

Purpose

To ensure ethical, accurate, and compliant use of Current Procedural Terminology (CPT) codes for CMT procedures in accordance with federal and state laws, statutes, regulations, and professional standards. This policy also outlines the process for distinguishing primary dysfunction from secondary compensation to support proper documentation and coding.

Policy

UWS clinicians code ethically and accurately for each patient encounter, using CPT codes 98940, 98941, 98942, and 98943 as defined by the American Medical Association (AMA). Clinicians differentiate between primary regions of dysfunction and secondary compensatory areas when documenting and coding CMT procedures.

- A complete history, examination, and clinical decision-making process is conducted to determine the diagnosis and treatment plan.
- The treatment plan clearly identifies primary dysfunctions and any secondary compensations addressed.
- All regions are documented in the S.O.A.P. note, with clear identification of primary versus secondary areas.
- Each patient encounter is documented thoroughly to support medical necessity for all CMT codes or indicate if the visit is maintenance or wellness in nature.
- Documentation is encounter-specific and able to stand alone as justification for services rendered.

Procedure

Monthly peer-review audits include random note spot-checks for evaluation

- Medical necessity of CMT
- Appropriateness of treating primary regions of dysfunction and secondary regions of compensation.
- Accuracy of CPT code selection

Policy 1430 Investigating and Reporting Non-Compliance Incidents

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus clinic employees.

Purpose

Detailed and swift investigation of alleged non-compliance incidents or discovery of erroneous internal procedures preserves the integrity of the compliance program and allow for the implementation of corrective measures.

Policy

The UWS health center properly investigates any alleged non-compliance incident or violation and installs corrective actions immediately. The Compliance Officer (CO) is responsible for investigative procedures at the clinic, and for reporting to the UWS leadership cabinet.

The investigative process is as follows:

- Every alleged incident is evaluated to determine whether a violation of the compliance program or other state or federal healthcare law, statute or regulation has occurred.
- All investigations include the assessment of monetary loss to any healthcare program and whether regulatory disclosure is required.
- Erroneous overpayments are disclosed, and funds returned to the identified carrier or payer within 60 days of discovery based on the Patient Protection and Affordable Care Act (PPACA).
- The effectiveness of the compliance program is evaluated for each allegation of non-compliance, allowing for implementation of corrective actions if necessary.
- Compliance program policies and procedures are reviewed at least annually to detect any procedural weakness and make appropriate improvements.

Policies associated with swift investigation of incidents are reviewed at least annually and updated as necessary.

Procedure

If the CO is made aware of alleged non-compliance of any kind, the following procedure will take place:

1. Within 48 hours of receipt of alleged non-compliance incident, the CO will assign the case a reference number, establish a working file and initiate investigative procedures per the Non-Compliance Reporting policy.
2. Per the Compliance Records Maintenance policy, these records are stored and maintained securely on an internal server.
3. Initial investigation will include an evaluation of the incident to determine if a violation of the compliance program or any other state or federal healthcare law, statute or regulation has occurred.

4. All investigations will be detailed, comprehensive, and appropriate to the alleged violation. Legal counsel may be utilized to determine liability and need for case referral to law enforcement agencies.
5. Erroneous overpayments will be disclosed and refunded to identified carrier or payer within 60 days of discovery or sooner if law requires.
6. Disclosure will be made within 60 days of discovery of any violation that does not include monetary loss but does involve program contractual violations.
7. The CO will provide quarterly reporting of investigative activities to the UWS leadership cabinet. This report should include number of alleged complaints received, investigative actions taken, result of the investigation, date investigation was concluded and recommendations to improve the alleged complaint reporting and investigative process of the compliance program.
8. All investigations will be handled in an in-depth, methodical fashion ensuring incident resolution or implementation of corrective actions in a timely manner.
9. During the investigative process, applicable policies and procedures of the compliance program will be reviewed and modified to prevent any recurrence of non-compliant behavior, conduct or activities.

Policy 1431 Non-Compliance Reporting

Adopted: 11/13/2025
Revision Dates: N/A

Scope

This policy applies to all University of Western States (UWS) campus clinic employees who are responsible for identifying and reporting any non-compliant behaviors including but not limited to the compliance officer.

Purpose

A component of the compliance program is to immediately identify and correct any activity or conduct that can be considered non-compliant in accordance with applicable state and federal healthcare laws, statutes, and regulations. This policy outlines the procedures used for identifying and responding to any non-compliant behaviors.

Policy

Any employee, contracted agent, or vendor of the UWS campus health center failing to report suspected behavior, conduct, or activity that can reasonably be considered non-compliant may be subject to disciplinary action up to termination.

Punishment or retaliatory actions are not imposed on any person reporting suspected non-compliant activity, behavior, or conduct.

- Personnel are required to meet with the CO to report alleged non-compliant activities, behavior, or conduct.
- Personnel are required to provide a written report summarizing alleged non-compliant activities, behavior, or conduct to the CO.
- Reporting is required as soon as reasonably possible after observing or obtaining knowledge of suspected inappropriate activities, behavior, or conduct.
- Personnel may have to meet with UWS Office of Human Resources for further discussion.

Policies associated with non-compliance reporting are reviewed at least annually and updated as necessary.

Procedure

If non-compliant activity, behavior, or conduct is suspected, the follow steps should be taken:

- Personnel are required to report alleged non-compliant activities, behavior, or conduct to the CO.
- Upon reporting a concern, the CO will provide the Compliance Incident Report for the reporting party to write a brief description of the alleged compliance violation/incident and return it to the CO.
- The brief description will summarize alleged non-compliant activities, behavior, or conduct to the CO. If needed, copies of any information relevant to the complaint can be added.
- The CO will log the incident in the Compliance Incident Log, share the information with the Office of Human Resources, and proceed with corrective actions.

Related Documents:

- Compliance Incident Report
- Compliance Incident Log