2025

University of Western States Health Center Policy Procedure Manual

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Policy 1402 Reporting Compliance Concerns

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 patient compliance concern is received by a staff member, the staff member will forward the patient compliance-related concern to the clinic office manager and/or the CO.

Policy 1403 Compliance Records Maintenance

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 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.

Policy 1404 Compliance Training

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

Policy 1405 Records Maintenance

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 documents the chief complaint, history, physical examination, procedures and treatments, progress notes, orders, and summary. In the instance that students are participating in patient care, the overseeing clinician verifies in the medical record any student documentation of components of E/M services, rather than re-documenting the work.

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

Policy 1406 Medical Records Request

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 Signature Authentication and Verification

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.
- An annual audit of the signature log is completed by the clinic office manager 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 Timely Documentation and Amendments

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 addendums.
- 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

- 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

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 (OCPUG Full doc 05-19-20-22.pdf).

Policy 1411 Documentation Standards

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 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

- 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 that 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

- 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

The Patient Service Representatives (PSR) will be 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 will 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 Patient Service Representative 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 forms are completed by the patient:

- 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 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 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 into the patient's EHR.

Policy 1415 Medical Record Audits

Chiropractic clinicians will have four (4) random notes reviewed monthly by a peer using an internal chart audit tool specific to chiropractic services.

Naturopathic clinicians will 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 will be developed based on this annual audit, error type and rate.

Provider education will be 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 the scheduling of all audit activities and maintaining a dashboard for internal review by providers to see their error rate relative to established benchmarks. This report will be completed immediately after the annual audit activities.

Policy 1416 Daily Charge Entry

- 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 to make sure 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 to make sure 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

- 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

The treating doctor will obtain a complete history and provide a thorough examination in order to establish a diagnosis.

Documentation will include 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.