GUIDELINE
G-008

Business Practices

Quality Assurance Committee
Approved by Council: November 29, 2007
Amended: February 26, 2013, April 26, 2017

Note to readers: In the event of any inconsistency between this document and the legislation that affects chiropractic practice, the legislation governs.

INTENT

To advise members of acceptable business practices in a clinical practice, including but not limited to: the disclosure of fees to the patient for the delivery of care and services, unit billing, block fees and/or payment plans as they relate to care or a plan of care delivered to the patient; and the billing of third-party payors.

OBJECTIVES

- To clarify for members the sections of the Professional Misconduct Regulation 852/93 concerning Business Practices.
- To ensure members provide accurate, complete information to patients regarding fees, unit billing, block fees and/or payment plans, as they relate to the delivery of care.
- To ensure members clearly communicate to patients their right to choose and/or refuse block fees and/or payment plans and their right to opt out of such plans at any time during care.
- To ensure members understand, comply with and communicate with patients about the policies and procedures for billing third-party payors.

DESCRIPTION OF GUIDELINE

Fees

When creating and implementing fees for service in clinical practice, members must adhere to the following conditions:

- fees must be for care that is diagnostically or therapeutically necessary;
- fees must be fair and reasonable;
- billing practices, as they relate to patient care, must be disclosed to patients in advance of any care. This includes, but is not limited to:
  - the nature of the care or plan of care to be provided,
  - who is delivering the care,
  - if any care is to be delegated,
  - the use of any adjunctive therapies and/or services,

  - the sale of any products, and/or
  - practices relating to billing third-party payors (see section on "Billing Third Party Payors");
- an account for professional services must be itemized, if:
  - requested to do so by the patient or a person or agency who is to pay, in whole or in part, for the services, or
  - if the account includes a fee for a product or device or a service other than care;
- a re-assessment, as set out in Standard of Practice S-002: Record Keeping, must:
  - be conducted when clinically necessary and, in any event, no later than each 24th visit; and
  - be sufficiently comprehensive for the member to:
    - evaluate the patient's current condition;
    - assess the effectiveness of the member's chiropractic care;
    - discuss with the patient, the patient's goals and expectations for his/her ongoing care; and
    - affirm or revise the member's plan of management for the patient.

Fees for Service as Provided

A member charging and collecting a fee for the service as provided must comply with the conditions as set out above.

Unit Billing

Unit billing refers to charging and invoicing a patient for each component of the service performed at a single visit, as opposed to charging and invoicing the patient for the whole visit. A member engaging in unit billing shall:

- comply with CCO regulations, standards of practice, policies and guidelines relating to business and billing practices; and

- ensure that the unit billing is fair and reasonable and be aware that charging a fee excessive to the service performed may constitute professional misconduct.

Block Fees and/or Payment Plans

A block fee and/or payment plan is any fee where the patient is charged for multiple services and/or treatments at any time other than when the services and/or treatments are provided.

A member charging a block fee and/or payment plan must ensure that there is a signed, written agreement between the member and the patient, which includes the following provisions in which the member has:

- given the patient the option to pay for each service on a "pay per visit" basis;
- disclosed to the patient the regular unit cost per service and the unit cost per service established by the block fee and/or payment plan if the fees differ; and
- fully inform the patient of his/her right to opt out of a block fee and/or payment plan at any time during care, and the patient's right to a refund of any unspent portion of the block fee and/or payment plan, calculated by reference to the number of services provided multiplied by the block fee/payment plan unit cost per service.

A member shall not subject the patient to any undue pressure and/or duress when offering a block fee and/or payment plan.

Repayment of Unused Block Fee and/or Payment Plan

- A patient may choose to opt out of a block fee and/or payment plan at any time during care, even if an agreement has been previously signed.
- A member shall not subject the patient to any undue pressure and/or duress when the patient chooses to opt out of a block fee and/or payment plan.
- A member must fully refund to the patient any unused portion of the block fee and/or payment plan calculated by multiplying the number of services provided by the established unit cost per service of the block fee/payment plan agreement.
- If a patient opts out of the block fee/payment plan, a member may not charge a patient any additional fees for any treatments or services that were discounted or complimentary as part of the block fee/payment plan. A refund must reference the unit cost per service, which may be complimentary or discounted, of the block fee/payment plan agreement.

Example of Calculation of Refund of Block Fee/Payment Plan

Service	Fee for Service	Block Fee/Payment Plan Fee
Chiropractic Treatment	20 treatments at $50 per treatment = $1000	20 treatments at $45 per treatment = $900
2 Re-evaluations	2 re-evaluations at $75 per re-evaluation = $150	2 re-evaluations at $0 per re-evaluation = $0
Cervical Traction	$150	$0
Radiographs	$100	$0
Total Cost	$1400	$900

In this example, a patient under the block fee/payment plan pays $900 up front, and opts out of the block fee/payment plan after receiving 10 chiropractic treatments, 2 re-evaluations, cervical traction and radiographs.

Total amount of block fee ($900)

Services Received:
- Block fee unit cost per service ($45) x number of services received (10) = $450
- 2 Re-evaluations, cervical traction and radiographs = $0

Total Refund = $900 (total amount of block fee) - $450 (spent portion of block fee) = $450 (unused portion of block fee)

Billing Third-Party Payors

4 A member may not bill any third-party payor in excess of his/her usual regular fee billed to an uninsured patient for similar services.

The practice of having one fee for a patient and a different fee for a third-party payor, or various fees for different third-party payors (e.g., dependent upon the amount of coverage) is not permitted. There is an exemption to this restriction when a fee has been negotiated with a third-party payor such as the Workplace Safety and Insurance Board (WSIB), the Financial Services Commission of Ontario (FSCO) or a similar organization.

A member should have a discussion with a patient of the member's involvement with billing third-party payors to ensure the patient is fully aware of their own responsibilities regarding reimbursement from any third-party payor.

LEGISLATIVE CONTEXT

Regulation R-008: Professional Misconduct

1. The following are acts of professional misconduct for the purposes of clause 51(1)(c) of the Health Professions Procedural Code:

The Practice of the Profession and the Care of and Relationship with Patients

1. Contravening a standard of practice of the profession or failing to maintain the standard of practice expected of members of the profession.
11. Breaching an agreement with a patient relating to professional services for the patient or fees for such services
14. Providing a diagnostic or therapeutic service that is not necessary.

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23. Submitting an account or charge for services the member knows is false or misleading.
24. Failing to disclose to a patient the fee for a service before the service is provided, including a fee not payable by the patient.
25. Charging a block fee unless,
    i. the patient is given the option of paying for each service as it is provided,
    ii a unit cost per service is specified,
    iii. the member agrees to refund to the patient the unspent portion of the block fee, calculated by reference to the number of services provided multiplied by the unit cost per service.
26. Failing to itemize an account for professional services,
    i. if requested to do so by the patient or person or agency who is to pay, in whole or in part, for the services, or
    ii. if the account includes a fee for a product or device or a service other than a treatment.
27. Selling any debt owed to the member for professional services. This does not include the use of credit cards to pay for professional services.

Miscellaneous Matters

28. Contravening the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
29. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a hospital within the meaning of the Public Hospitals Act, if the contravention is relevant to the member's suitability to practise.
33. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

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[1] A block fee and/or payment plan is any fee where the patient is charged for multiple services and/or treatments at any time other than when the services and/or treatments are provided.