BUSINESS PRACTICES

Guideline G-008
Quality Assurance Committee
Approved by Council: November 29, 2007
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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, billing/financial arrangements 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 *Professional Misconduct Regulation 852/93* concerning Business Practices.

- To ensure members provide accurate and complete information to patients regarding fees, unit billing, and/or billing/financial arrangements, as they relate to the delivery of care and services.

- To ensure members clearly communicate to patients their right to choose and/or refuse billing/financial arrangements 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

Fees for chiropractic care must reflect and be congruent with the examination and care that is recommended, provided and documented in the patient health record.

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

- fees must be for ~~care~~ services that ~~is~~ are rendered, diagnostically or therapeutically necessary, and provided in accordance with accepted CCO regulations, standards of practice, policies and guidelines;
- 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 consultation, examination or care or plan of care or other services to be provided,
    - who is delivering the care,
    - if any care is to be delegated, assigned or referred,
    - 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~~ comparative reassessment, as set out in standard of practice S-002: Record Keeping and Guideline G-013: Chiropractic Assessments, must:
    - be conducted when clinically necessary and, in any event, no later than each 24th visit;
    - 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;

Billing/Financial Arrangements[1]

A billing/financial arrangement, which includes a block fee or any other payment plan ("billing/financial arrangement"), is any fee arrangement 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 offering a billing/financial arrangement must comply with the requirements of Regulation R-008: Professional Misconduct:

i. the patient is given the option of paying for each service as it is provided,
ii a unit cost per service is specified,
ii. 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.

A member must be sensitive that a patient, in the early stages of care, may be in a vulnerable position, have little knowledge about chiropractic care and may not be in a position to enter into a billing/financial arrangement which goes beyond the initial stage of care/first comparative reassessment. **For these reasons, a member must not offer any billing/financial arrangement option until after completing an initial course of care, which includes conducting the first comparative re-assessment. The first comparative re-assessment must be conducted when clinically necessary and, in any event, no later than each 24th visit.**

At the first comparative re-assessment, a member must review:

- the patient's progress as it relates to the initial, plan of care recommendation,
- the patient progress to date, and

[1] A Billing/Financial Arrangement is any fee arrangement where the patient is charged for multiple services and/or treatments at any time other than when the services and/or treatments are provided.

- the patient's objectives and goals at this point compared to the initial presentation.
- the appropriate recommendation for continued care, referral or discharge

Following the first comparative re-assessment, and if continued care is recommended, the member and patient may then discuss the appropriateness of a billing/financial arrangement for chiropractic care. It is important to note that any comparative reassessment should follow the protocols laid out in CCO Guideline G-013: Chiropractic Assessments.

In offering a billing/financial arrangement, a member must:

- consider the appropriateness of offering a billing/financial arrangement to reflect that the plan of care, the objectives and planned outcomes of care, the ability to prognosticate the appropriate length of a care plan, patient goals and requests, and patient comfort. **As such, a member is prohibited from offering a billing/financial arrangement that provides for care beyond the next recommended comparative assessment, which must be conducted when clinically necessary and, in any event, no later than each 24th visit.**

- discuss with the patient the appropriateness of a billing/financial arrangement, including but not limited to, the nature of the treatment plan, the health care goals and objectives for the patient, the patient's comfort in agreement to a billing/financial arrangement, the value and outcomes of the billing/financial arrangement, and any billing or reimbursement from insurance companies or third party payors that would be affected by a billing/financial arrangement;

- ensure that the patient is comfortable with and understands all aspects of the billing/financial arrangement, including the right of the patient to pay for each services as it is provide and the right to opt out of the billing/financial arrangement at any time and receive a refund for the unspent portion of the billing arrangement, calculated by reference to the number of services provided multiplied by the unit cost per service.

- not subject a patient to any undue pressure or duress to agree to a billing/financial arrangement, or opt out of a billing/financial arrangement;

- refrain from using any language that is or could be perceived as coercive or which suggests that without agreeing to a billing/financial arrangement, services will be limited or reduced, or that quality of care provided may suffer;

- ensure there are protections for the patient to receive a refund for any unused portion of the billing/financial arrangement in case of bankruptcy, death, dissolution of practice and other incidences which may interrupt a course of care;

- respect a patient request to pay for each service as it is provided;

A member charging a billing/financial arrangement 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 billing/financial arrangement if the fees differ; and
- fully inform the patient of his/her right to opt out of a billing/financial arrangement at any time during care, and the patient's right to a refund of any unspent portion of the billing/financial arrangement, calculated by reference to the number of services provided multiplied by the billing/financial arrangement unit cost per service.

A member shall not subject the patient to any undue pressure and/or duress when offering a billing/financial arrangement.

Repayment of Unused Billing/Financial Arrangement

- A patient may choose to opt out of a billing/financial arrangement 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 billing/financial arrangement.
- A member must fully refund to the patient any unused portion of the billing/financial arrangement calculated by multiplying the number of services provided by the established unit cost per service of the billing/financial arrangement.
- If a patient opts out of the billing/financial arrangement, a member may not charge a patient any additional fees for any treatments or services that were discounted or complimentary as part of the billing/financial arrangement. A refund must reference the unit cost per service, which may be complimentary or discounted, of the billing/financial arrangement agreement.

Example of Calculation of Refund Billing/Financial Arrangement

Service	Fee for Service	Billing Arrangement
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 billing/financial arrangement pays $900 up front, and opts out of the billing/financial arrangement plan after receiving 10 chiropractic treatments, 2 re-evaluations, cervical traction and radiographs.

Total amount of billing/financial arrangement ($900)

Services Received:

- Billing/financial arrangement 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 billing/financial arrangement) - $450 (spent portion of billing/financial arrangement) = $450 (unused portion of billing/financial arrangement)

Billing Third-Party Payors

A member may not bill any third-party payor in excess of his/her 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 CONTENT

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.

Business Practices

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,

    ii. 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.