BUSINESS PRACTICES

Guideline G-008
Quality Assurance Committee
Approved by Council: November 29, 2007
Amended: February 26, 2013, April 26, 2017, November 29, 2018, February 26, 2020 and August 12, 2020 (amendments from February 26, 2020 and August 12, 2020 came into effect September 12, 2020), September 9, 2022 (came into effect November 24, 2022)

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 establish requirements for members to 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 establish requirements for members to clearly communicate to patients their rights when discussing fees for service provided. This includes the patient's right to choose and/or refuse billing/financial arrangements (as outlined below) and their right to opt out of such plans at any time during care.

- To establish requirements for members to 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 consistent 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 services that are 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, 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");

- fees must be documented in the financial record and invoice and consistent with the member's fee schedule;

- fees, including the documentation of fees in a financial record, invoices and itemization of an account for professional services, must not be false or misleading.

- an account for professional services must be itemized and readily available, 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
    - the account includes a fee for a product or device or a service other than care;

- a comparative re-assessment, 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, which includes a discussion of any billing/financial arrangement.

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 (i.e. all components of a visit billed as one item). 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 Arrangements

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, including the pre-payment of fees, 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,
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.

Any billing/financial arrangement must be directly representative of and connected to the treatment/care plan agreed upon by the member and patient. This includes considerations of:

- the patient's complaint, symptoms and/or reasons for visiting a chiropractor;
- the patient's diagnosis or clinical impression;
- the informed consent process;
- the nature of the treatment plan;
- the patient's objectives and goals for treatment;
- the type of care plan (e.g. acute, preventative, wellness, etc.); and
- the patient's comfort level in agreement to a billing/financial arrangement.

Periodic reassessments are a mandatory part of any care/plan of care and are based on the same clinical judgement components used in all phases of patient care. Additionally, periodic reassessments are valuable opportunities to revisit informed consent with the patient. The timing and reason for each comparative assessment depends on:

- patient progress;
- expectations of progress;
- presentation of new conditions; and
- requests from third-party payors such as WSIB, etc.

Any billing/financial arrangement must include regular re-assessments, as described in Guideline G-013: Chiropractic Assessments, which must be conducted when clinically necessary and, in any event no later than each 24th visit. At every comparative re-assessment, a member must review:

- the patient's progress as it relates to the plan of care recommendation;
- the patient progress to date;
- the patient's objectives and goals at this point compared to the initial presentation;
- the appropriate recommendation for continued care, referral or discharge; and
- discussion /review and documentation of any billing/financial arrangements for payment of care/treatment/services.

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

- consider the appropriateness of offering a billing/financial arrangement which reflects: the plan of care, the objectives and planned outcomes of care, patient goals and requests, patient comfort, and the member's ability to provide a prognosis of the length of time required to reach the stated outcomes;

- discuss with the patient the appropriateness of a billing/financial arrangement as it relates to a plan of care, prior to the offering of a billing/financial arrangement, including but not limited to:
    - informed consent to care, as described in Standard of Practice S-013: Consent
    - 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;

- make all reasonable efforts to ensure 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 provided 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;

- offer the option to pay for each service, which must be clearly communicated to the patient and not affect a patient's ability to access chiropractic care. A member must never deny a patient chiropractic care if a patient does not agree to billing/financial arrangement;

- 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;

- if a discount is offered as part of the billing/financial arrangement, it must be clear, agreed upon by the member and patient and applied contemporaneously with the agreement of the billing/financial arrangement – i.e. at the beginning of the treatment plan;

- notify the patient if any additional services or products are not covered under the billing/financial arrangement; and

- provide the patient with monthly written updates upon request from the patient, which includes how much of the billing/financial arrangement the patient has used, and the fees that the patient has paid.

When charging a billing/financial arrangement, the member must have a written agreement signed by the member and the patient. The written agreement must include:

- details the billing/financial arrangement;

- includes a link to the CCO website www.cco.on.ca;

- includes the following provisions, that 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 informed 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 must provide a patient with:

- a copy of the signed, written agreement relating to a billing/financial arrangement; and
- an itemized account of the billing/financial arrangement upon request by the patient.

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

Repayment of Unused Billing 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 within 30 days of the patient request.

- A member must ensure they have the resources to provide the patient with a refund for any unused portion of a billing/financial arrangement, upon request of the patient, within 30 days of the patient request. Any fees collected by the member through a billing/financial arrangement for future care is in a sense held in trust by the member, until the care is provided.

- 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

Example of Calculation of Refund Billing/Financial Arrangement (which include additional services)

Guideline G-008: Business Practices provides the following example for a patient who wants to opt out of a billing/financial arrangement and how to provide a refund to a patient who opts out.

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.