

Ninilchik Traditional Council

Governing Body of The
Ninilchik Village Tribe



Ninilchik Traditional Council Community Clinic (NTCCC) Policies & Procedures Manual

Approved by the Quality Assurance Committee

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SECTION 1: CLINIC OPERATIONS

1.1: CLINIC HOURS

PURPOSE:

It is the policy of NTCCC to establish working hours by staffing requirements and patient needs.

PROCEDURE:

1. Clinic hours are normally 9:00 a.m. to 5:00 p.m. Monday through Friday. Although employees may have flexible or staggered working hours, NTCCC maintains staff coverage during all clinic hours.

1.2: CLINIC OPENING

PURPOSE:

It is the policy of NTCCC that clinical and registration staff complete opening procedures prior to 9:00 a.m.

PROCEDURE:

1. All doors must be unlocked, front and back of building.
2. Staff will look at schedule prior to opening to ensure that the rooms are prepared for patient appointment.
3. To ensure that the patients will be roomed without a wait time.
4. Phone messages checked and appointment schedule open, prior to opening.

1.3: CLINIC CLOSING

PURPOSE:

It is the policy of NTCCC that staff will following closing procedures at the end of each day.

PROCEDURE:

To ensure that the clinic is cleaned and organized at the end of each day:

1. Rooms will be cleaned and sanitized.
2. Landry will be cleaned, dried, folded and put away.
3. Waiting room lights and television will be turned off.
4. X-Ray machine will be turned off.
5. All windows closed and locked. All doors will be closed, breezeway back doors will be locked.
6. Alarm will be set and front door locked.

SECTION 2: SCHEDULING

2.1: APPOINTMENT SCHEDULING

PURPOSE:

It is the policy of NTCCC to schedule all appointments in the scheduling module of the practice management system in a consistent manner.

PROCEDURE:

1. The Tribal Health Director or designee manages the scheduling template. Any changes to the template must be requested and approved no later than 60 days prior to the effective date of the change.
2. Employees who schedule patient appointments must receive training and authorization from the Tribal Health Director or designee. Training and authorization are required because of the complex nature of scheduling and the problems that occur if an appointment is scheduled incorrectly.
3. Employees can schedule an appointment either by telephone or in person. The following information must be obtained from the patient or referring physician's office to schedule an appointment:
 - a. Patient name (first and last)
 - b. Status with NTCCC (new or established)
 - c. Telephone number
 - d. Reason for visit
 - e. Date of birth
 - f. Insurance coverage, including guarantor, policy number, and group number. (The Tribal Health Director and the business office determine the minimum information required based on data necessary for insurance verification.)
4. NTCCC employees use the appointment-scheduling module to assign a date and time for the appointment.
5. At the time of scheduling, a mini-registration is performed by telephone for all new patients, and limited registration information is verified for established patients. The business manager or designee determines this process and it may change periodically due to insurance changes. Specific procedures are outlined in staff training manuals in Allscripts.
6. A NTCCC employee reviews the appointment details with the patient prior to hanging up the telephone or patient leaving the office. If the patient is present, the employee completes and presents an appointment card to the patient before the patient leaves the office.
7. The script of the appointment scheduling phone call is conducted as printed below, or as modified by the Tribal Health Director or designee.

- a. Greet the caller: “NTC Clinic, this is [your name], how may I help you?”
- b. Identify the nature of the complaint or problem that the patient is having.
- c. If the patient was not referred to a specific provider, determine appropriate provider based on the patient’s complaint.
- e. Ask for the patient’s name and verify the correct spelling.
- f. Determine if this is an established or new patient to NTCCC. Ask the caller, “Have you ever been seen here?”
- g. If an established patient, verify the patient’s identity by confirming the patient’s birthday, address, or another identifying characteristic.
- h. For non-beneficiaries, say to the patient, “While I’m looking for the best appointment for you, please go ahead and locate your insurance card so that after we make the appointment, I can collect your correct insurance information.” (This allows time for the patient to retrieve his or her insurance card.)
- i. Locate the appropriate appointment slot by reviewing the schedule. Offer the first available appointment to the patient and continue to offer appointments until the patient accepts one that meets his or her needs.
- j. Conduct a mini-registration according to the protocols established by the business office. Confirm that the name under which you registered the patient matches the name as it appears on the patient’s insurance card.
- k. Determine the source of the referral, if applicable, by asking, “How were you referred to our NTCCC?”
 - i. Record the referral source in the appropriate field in the practice management system.
- l. Ask for the patient’s daytime phone number and where the patient can be reached in the event of an emergency.
- m. When an appointment is made, slowly restate the date of appointment, time, office location, and provider name to the patient. This ensures all information was accurately communicated to and received by the patient.
- n. Ask the patient if he or she has any questions.
- o. Thank the patient for choosing NTCCC, conclude the call, and hang up the telephone.

2.2: APPOINTMENT REMINDERS

PURPOSE:

It is the policy of NTCCC to remind patients of their appointments the day of up to 48 hours in advance of the scheduled appointment.

PROCEDURE:

1. Each appointment is confirmed via phone call 24 to 48 hours prior to the scheduled appointment and the day of the appointment. The confirmation is documented in the practice management system and/or a manual copy of schedule.
2. Staff members are instructed to record the confirmation, and if applicable, any requests for rescheduling. Staff members should reschedule cancelled appointments immediately, thus opening appointment slots for other patients who call and/or are on the wait list (see related policy on Appointment Waiting List). If NTCCC utilizes an automated reminder system, such protocols should be implemented for the automated system.
3. To preserve the patient's confidentiality, the script for reminder calls is: "You have an appointment with [Provider's Last Name] on [day of the week and time]. Please call our office at [567-3970] if you have any questions or need to reschedule the appointment." The specialty of the provider (i.e.: CHAP, NP, PA or MD) is not to be revealed unless the staff member speaks directly to the patient, and only then if it is relevant to the conversation.
4. NTCCC also reminds the patient to bring his or her insurance card(s) at time-of-service payments. If the patient has an outstanding balance, the staff member confirming the appointment requests payment to be made before or when the patient arrives for the appointment. The staff member confirming the appointment reminds the patient that NTCCC would appreciate payment and provides the phone number and extension of the patient-account representative/biller to contact with questions.
5. For patients requiring a CDL exam and this is their first appointment at NTCCC, they need to be told to bring a copy of their medical records with them or notify last previous provider to send a copy to NTCCC.

2.3: WALK-INS

PURPOSE:

It is the policy of NTCC that patients presenting to the office with no appointment (walk-in) should be handled in an appropriate manner, following a standard protocol.

PROCEDURE:

1. A front-office staff member responds to a walk-in patient in the following way:
2. Ask the patient to explain his or her problem or condition. If the problem or condition is an emergency, immediately contact the clinical team for assistance. As appropriate, the team may instruct the patient to proceed to the nearest emergency room. The clinical team is responsible for determining if the patient can be seen that day.
 - a. If the patient can be seen and his or her condition is not an emergency, ask the patient to please contact the NTCCC prior to walking in next time. Explain that an exception will be made in this circumstance, however, and that he or she will be seen when the clinical team has a break in their schedule.
 - b. If the patient cannot be seen, inform the patient that his or her request cannot be accommodated. Offer to schedule a future appointment. Provide information about the closest emergency department or treatment center. Document the instructions in the patient's record, under the message tab.
3. Register the patient, collect any time-of-service payments, schedule the patient for the next available slot; double-book, if necessary.
4. Record the patient's walk-in status in the practice management system.
5. Ask the patient to be seated, indicating that there will be a wait.
6. Inform the triage nurse or appropriate provider that a walk-in patient is waiting to be seen.
7. Prepare the patient's chart.

2.4: LATE ARRIVALS

PURPOSE:

It is the policy of NTCCC that a patient who arrives more than 15 minutes after his or her appointment time is handled as a late arrival.

PROCEDURES:

1. If the delay is the responsibility of NTCCC, the patient is received and registered as usual.
2. If the patient has arrived more than 15 minutes after his or her scheduled appointment and is late for reasons not considered to be the responsibility of NTCCC, a staff member follows these steps:
 - a. Informs the patient that he or she is late for the appointment.
 - b. Registers the patient.
 - c. Tells the patient that he or she will be worked in as soon as possible, and may take a seat until he or she is called.
 - d. Informs the personnel assisting the appropriate provider that the late patient has arrived.
3. If the patient arrives more than 30 minutes late, a staff member reschedules the patient.

2.5: APPOINTMENT NO-SHOWS

PURPOSE:

It is the policy of NTCCC to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment is considered a “no-show.” A no-show non-beneficiary patient, after two consecutive no shows, will be considered a chronic no-show. This will be based on whether the patient was given a reminder call and or has cognitive impairments.

PROCEDURES:

1. A chronic no-show patient will be notified of the no-show policy at the time of initial registration. The no-show policy is provided in writing upon the patient’s arrival, along with the NTCCC’s registration forms. The policy is also displayed on NTCCC’s website/patient portal.
2. A patient’s appointment status is automatically or manually updated by marking the system for no-show when the patient does not show or cancel their appointment.
3. By the end of the same day the appointment is missed, the clinical assistant and the scheduled provider review the chart of the patient who failed to present for his or her appointment.
4. “No show” is denoted in the patient’s chart. The clinical assistant/case manager and the provider determine one of the following actions, which is documented in the patient’s chart:
 - a. No follow up necessary
 - b. Follow up urgent – locate patient immediately
 - c. Follow up necessary – contact patient and schedule visit in ____ days
 - d. Follow up advised – contact patient and schedule visit in ____ weeks
5. Action must be taken according to the decision of the clinical team reviewing the chart. If necessary, responsibility is assigned for follow-up. If the patient is to be contacted in the future, a recall is generated in the practice management system to alert NTCCC that the contact should be made in the specified time period. For non-urgent recalls, NTCCC will send correspondence to the patient via **secure** e-mail or letter in the format below, two times only.

NO SHOW CORRESPONDENCE

Name _____

We noticed that you missed your appointment!

Provider _____

Date _____

Time _____

Your provider has recommended that you return to NTCCC so that effective health care can be provided to you.

Please contact us at 907-567-3970 to schedule another appointment.

Thank you, _____

6. A patient who fails to present for his or her scheduled appointment more than three times in a row is considered a chronic no-show. This type of patient will not be given an appointment slot.
7. A patient who fails to present for his or her scheduled appointment more than three times without the requested advanced notification will be informed that they will only be able to come as a walk-in and that if there aren't any open slots can either wait until there is an available opening or come another day.

2.6: CANCELLATIONS

PURPOSE:

It is the policy of NTCCC that patients requesting appointment cancellations will be accommodated as efficiently as possible.

NTCCC has an established secure website, through the patient portal, available 24 hours per day, seven days a week. The phone number and website will be published for patients on all appointment-related material in NTCCC. A staff member responsible for scheduling will be responsible for checking the voicemail regularly.

PROCEDURES:

1. Request the date and time of the appointment that the patient wants to cancel.
2. Cancel the appointment in the practice management system.
3. Reschedule the patient visit at the first available appointment time that is convenient for the patient.
4. Refer to policy: Appointment no shows.

SECTION 3: BUSINESS OFFICE

3.1: FEE SCHEDULE

PURPOSE:

It is the policy of NTCCC to maintain a consistent and current schedule of fees for every service it renders.

PROCEDURES:

1. NTCCC establishes its fee schedule based on the National Fee Analyzer from the prior year. NTCCC uses this factor for sets of services, such as procedures, surgeries, lab, imaging, evaluation and management, and so forth. The methodology is clearly documented and filed in the NTCCC's permanent records.
2. The fee schedule is analyzed and updated, if necessary, on an annual basis on or about October 1. Changes to fees are applied January 1.
3. The biller/coder alerts the Tribal Health Director and providers of any change in the fee schedule that increases the accounts receivables. An alert is provided, as this change in receivables may otherwise be considered a reflection of poor performance. To the extent possible, the Tribal Health Director and/or designee identifies the expected impact on the receivables indicators (e.g., days in receivables outstanding).
4. At the time of the fee schedule analysis, NTCCC analyzes its reimbursement from all payers to:
 - a. Ensure that the payer is making payments based on expected reimbursement, and
5. NTCCC biller/coder engaged in payment posting promptly alerts the Tribal Health Director or designee of any claims adjudicated at 100 percent of NTCCC fee. At that time, the biller/coder and the Tribal Health Director confer to decide if raising the fee is appropriate. If so, the fee is raised consistent with the methodology listed above (using units multiplied by a conversion factor). Notably, the conversion factor may, indeed, vary if only one code is targeted for an increase.
6. For all new services performed, NTCCC uses the Fee Analyzer for that particular procedure code factor. If the service has never been billed, NTCCC staff communicates the new service and designated fee to the Tribal Health Director or designee for review.
7. NTCCC uses its fee schedule for all providers without exception. Fees may be discounted according to agreements with participating third-party payers, prompt payment at the time of service, and financial hardship (see related policies on Financial Hardship).

3.2A: CODING GUIDELINES

PURPOSE:

It is the policy of NTCCC that procedures and diagnosis codes, Evaluation and Management (E&M) codes are accurate and complete at the time of service. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and review of correct coding practice.

PROCEDURES:

1. Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices to produce quality health care data.
2. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable health care settings.
3. Coding professionals should only assign and report codes that are clearly and consistently supported by provider documentation in the health record.
4. Coding professionals should consult providers for clarifications and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.
5. Coding professionals should not change codes or the narratives of codes in the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected.
6. Coding professionals, as members of the health care team, should assist and educate providers and other clinicians by advocating proper documentation practices, further specificity, and re-sequencing or inclusions of diagnoses or procedures when needed, to more accurately reflect the acuity, severity, and the occurrence of events.
7. Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.
8. Coding professionals should strive for optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to optimize payment by means that contradict regulatory guidelines.
9. Regarding the internal, inter-department customer service, the entire Business Office staff needs to work as a team to provide, on behalf of the facility, accurate documentation and billing to the insurer. Without this team approach, the written documentation could not be transferred to applicable coding and subsequently, billed correctly to the insurer. The team needs to build strong, collaborative working relationships where everyone relies on the previous person to perform their function.

Selecting the Appropriate Code for Provider Services:

These are the steps for selecting the appropriate code for provider services:

1. Did counseling and/or coordination of care require more than fifty percent of the face-to-face time of the total service?
 - If yes, select a code based on total face-to-face time.
 - If no, continue with steps 2-5.
2. Look at the complexity of the provider's medical decision-making, based on information and data from the examination and history.

Select the level of medical decision-making, recalling that two of three elements must be met or exceeded for the selection.

3. Evaluate and determine the level of examination and history.
4. Determine the level of service according to whether two or three of the three key components are required in the code description.

Determine whether the required number of key components is met and/or exceeded for the category of codes.

Validate the provider's code selection by referring to the "nature of the presenting problems list". Compare the nature of the patient's problem with this list, select the type of problem, and then match it to the type of problem noted in the provider's medical decision-making and to the description of the type of problem in the code that was tentatively selected.

5. Review documentation in the patient record. It should support the tentative evaluation and management code selection.

If the documentation is incomplete and does not support the code level selected, have the provider complete the documentation before making a final code selection. This is a critical step. You cannot select an evaluation and management code without documentation that supports it and demonstrates its key components as described for the code you have chosen.

Key components must be documented in the patient record along with other contributory factors to qualify for payment and to protect against audit liability

Coding Directly from the Record

When coding directly from the patient record or the electronic health record, take these steps:

1. Review the relevant portion(s) of the patient records, as necessary.
2. Return to that part of the record from which the service must be coded.

3. Identify what was done.
4. Jot down each procedure or service identified.
5. Select the main term and any modifying or descriptive terms for each procedure that must be coded.
6. Turn to the CPT index and locate the main term.
7. Scan any modifying terms listed below the main term.
8. Turn back to the body of the text and find the code or code range referenced.
9. Locate the heading and subheading under which the code is listed.
Verify that this is the correct body part and the correct type of procedure (e.g., excision versus incision).
10. Read any applicable annotations under the heading, subheading, and codes.
11. Return to the referenced code.
If the code is part of a CPT code family, read the un-indented code and the indented codes below it. Look for the semicolon in the un-indented code first, and then go on to read the indented codes below it.
12. Apply all appropriate coding guidelines
13. Select the code.

Assignment Rules:

1. Diagnosis and procedure codes are assigned to the highest level of specificity (the fourth and fifth digits are mandatory when available), based on provider documentation.
2. Outpatient diagnoses documented as *rule out*, *probable*, *questionable*, *suspected*, or *working diagnosis* should not be coded; instead, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
3. Acute and chronic conditions should be specified and differentiated. Chronic conditions that are still being treated should be referenced on the claim form.
4. Code all documented conditions that coexist at the time of the encounter and that affect patient treatment or management.
5. The acute nature of any emergency needs to be identified, such as hemorrhage, concussion, loss of consciousness, and such.
6. Primary diagnosis codes should be listed first, followed by secondary, tertiary, and so on. The first diagnosis code should be the diagnosis, condition, or problem that is the reason for the patient encounter for that day as documented in the medical record. Other diagnoses can be listed and sequenced in order of importance.

7. Previous conditions, not being treated during the current clinic visit, should be coded as historical.
8. When a patient encounter is only for a pre-op evaluation, list first the appropriate ICD-10 code that specifically describes the medical necessity for the pre-op evaluation. List second the V code that best describes the pre-op evaluation.
9. Beware of the *Rules of Nines* – 9s usually, but not always, indicate “not specified elsewhere” or “unspecified condition.” Unspecific codes may not clearly identify the medical necessity and should not be used as the sole or primary diagnosis code unless there is no other diagnosis code to use to describe the patient encounter. State of Alaska Medicaid denies most unspecified codes.
10. Coder/Biller has the capability to adjust the order/priority of the ICD10 codes according to the documentation that is provided.

3.2B: CHARGE CODING

PURPOSE:

It is the policy of NTCCC that procedures and diagnosis codes, Evaluation and Management (E&M) codes are accurate and complete at the time of service.

PROCEDURES:

Providers and Billers:

When selecting codes,

1. **Do** submit a diagnosis code for the chief complaint. If a diagnosis cannot yet be made, submit a diagnosis code for symptoms and signs, if that is the highest level of certainty that can be reached at the time of visit.
2. **Do** use a diagnosis code for a chronic condition treated on an ongoing basis as many times as the patient receives treatment and care for the condition.
For example, when treating rheumatoid arthritis, use the same diagnosis code for each visit for that condition, regardless of the frequency of visits.
3. **Do** code all conditions that exist at the time of the visit and that affect patient care treatment and management, but not past problems that have been resolved.
4. **Do** document medical necessity, in general. The following information must be apparent from the medical record:
 - a. the severity of the patient's complaint or condition
 - b. the emergent nature of the condition, if it is emergent
 - c. a description of the reason for the care – signs, symptoms, complaints, or background facts, such as required for follow-up care
5. Upon Registration: **Do** have each patient sign a general release – before care is initiated – authorizing the clinician to provide a copy of the medical record documentation to the insurer.

When selecting codes:

1. **Do not** submit a complicated diagnosis when that diagnosis is not well supported in documentation
2. **Do not** submit the diagnosis codes out of appropriate order. The rule is: List the diagnosis code first for the condition chiefly responsible for the services provided.
3. **Do not** submit a “rule out” diagnosis as a definitive diagnosis. Instead, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
4. **Do not** submit a diagnosis for a problem that has been resolved. The rule is: Do not code a diagnosis that is no longer applicable.

The paper-based or electronic health record needs to reflect a Chief Complaint (CC).

The CC, Review of Symptoms (ROS) and Past, Family, and/or Social History (PFSH) may be listed as separate elements of the history or may be included in the description of the History of Present Illness (HPI). Allergies and Medications should be reviewed and reconciled with each visit.

An ROS and/or PFSH obtained during an earlier encounter need not be re-recorded, if there is evidence that the provider reviewed and updated previous information.

If the provider is unable to obtain a history, the record should describe the patient's condition or circumstances.

Each element of the patient history can only be counted once.

History of Present Illness

The **History of Present Illness (HPI)** uses eight elements to identify the patient's present illness, signs, and/or symptoms:

ELEMENT	DESCRIPTION
Location	The area of the body where the problem, pain, or discomfort is located.
Quality	The quality can be related by the patient's sensation of what he/she is experiencing.
Severity	The level of magnitude of the presenting problem.
Duration	When the symptoms first occurred up to the present encounter.
Timing	Whether the sign or symptom occurs intermittently or at a specific time during the day.
Context	The situation surrounding the problem, episode, or condition. Sometimes this is referred to as the "big picture."
Modifying Factors	These include remedies or interventions that the patient has used for the specific problem or symptoms to relieve discomfort.
Associated Signs and Symptoms	Additional signs and symptoms presented by the patient.

A brief HPI would include 1-3 elements and an extended HPI would describe 4-8 elements.

Review of Systems

The **Review of Systems (ROS)** is of the most poorly documented portion of the patient history; however, it is essential. Several of the higher levels of E&M cannot be documented without this information.

Review of Systems include eyes, ears, nose, mouth and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or

breast); neurological; psychiatric; endocrine; hematologic/lymphatic; and allergic/immunologic systems.

There are three categories of ROS:

CATEGORY	DESCRIPTION
Problem Pertinent	Positive and negative responses for at least one system.
Extended	Positive and/or negative responses for 2-9 systems.
Complete	Positive and/or negative responses for all systems.

Past, Family, and/or Social History (PFSH)

The **Past, Family, and/or Social History (PFSH)** are described in two levels:

LEVEL	DESCRIPTION
Pertinent	Describes one of the three PFSH components.
Complete	Describes all the components.

Examination Component of E&M

The examination component describes the extent of the examination performed. The guidelines are based on the number of body areas and organ systems examined and documented.

A notation of “abnormal” without elaboration is insufficient. Any abnormal or unexpected finding of the examination, or any asymptomatic body area(s) or organ system(s) should be described.

A brief statement or notation indicating “negative” or “normal” is sufficient to document normal finding related to unaffected areas.

There are four types of examinations

TYPE	DESCRIPTION
Problem Focused	A limited examination of the affected body area or system, one area or system.
Expanded Problem Focused	A limited examination of the affected body area or system that includes 2-7 areas or systems.
Detailed	An extended examination of the affected body area or system that includes 2-7 areas or systems.
Comprehensive	A general multi-system examination or complete examination of a single organ system that includes an exam of 8 or more systems or a complex system examination.

The following table lists the body areas and organ systems.

BODY AREAS	ORGAN SYSTEMS
Head, including the face	Eyes
Neck	Ears, Nose, Mouth, and Throat
Chest, including the breasts and axillae	Cardiovascular
Abdomen	Respiratory
Genitalia, groin, buttocks	Gastrointestinal
Back	Genitourinary
Each extremity	Musculoskeletal
	Skin
	Neurologic
	Psychiatric
	Hematologic/Lymphatic/Immunologic

Medical Decision-Making component of E&M

Medical decision-making should be considered the thought process of the Provider. For each encounter, an assessment, clinical impression, or diagnosis should be documented.

For a presenting problem...	the...
with an established diagnosis,	record should reflect <ul style="list-style-type: none"> • improvement, • well controlled, • resolving or resolved, or • inadequately controlled, worsening, or failing.
without an established diagnosis,	assessment of clinical impression may be stated <ul style="list-style-type: none"> • in the form of a different diagnosis or • as a “possible,” “probably,” or “rule out.”

The initiation or changes in treatment should be documented.

If referrals are made, specialty consult location will be decided based on insurance carrier and preference, requested or advice sought, the record should indicate this information.

There are four levels of decision-making:

- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity

In determining the level of medical necessity, the following three elements are considered:

1. The number of diagnoses or management options
 - Documentation should include all established problems pertinent to the visit whether they are stable, improved, worsening or resolved.
 - Management options should include changes or initiations of new treatment plans and medications.

- The number of diagnosis or management options is defined as:
 - Minimal – self-limited or minor problem
 - Limited – one or two established problems
 - Multiple – two or three problems worsening or exacerbated
 - Extensive – three or more diagnoses or new problems.
- 2. The amount and/or complexity of the data, diagnostic tests, and/or other information that must be obtained and reviewed.
 - The amount or complexity of data is based on the types of diagnostic testing ordered and reviewed. Discussion of test results should be documented.
 - A decision to review old medical records should be noted. Relevant findings from old records should be documented. A notation that “old records reviewed” is insufficient without further documentation. Historical data should be updated along with review of records by the provider.
 - Data is defined as none or minimal, limited, moderate, or extensive.
- 3. The risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the presenting problems, diagnostic procedures and/or possible management options.
 - Risk is related to the presenting problem to the disease process anticipated between the present encounter and the next one.
 - The highest level of risk in any one category determines the overall level of risk.
 - If a surgical or invasive diagnostic procedure is performed during the encounter, it should be documented.
 - The referral for a procedure to be performed should be documented.

3.3: CHARGE ENTRY

PURPOSE:

It is the policy of NTCCC that charges for services rendered are accurately posted and balanced in a timely manner.

PROCEDURES:

1. Charges are posted in the practice management system at the point of service through:
 - a. Data entry by a staff member from a paper charge ticket (superbill) for self-pay patients when the coder/biller is out of the office;
 - b. Direct interface with the electronic health record (EHR) system's coding.
 - c. Direct interface with a charge capture program on our EHR.
2. Regardless of the method of charge entry, charges are captured and balanced in a timely manner. This ensures that revenue is credited to the correct accounting period
3. Charges are posted to the patient encounter and added to the current balance.
 - a. The staff member who balances each individual patient account at the end of each day will run the following reports:
 - b. An audit report with cash totals is used to balance the batch patient accounts.
 - c. All patient accounts with conflicting balances are resolved immediately.
4. Providers are responsible for documenting and coding all procedure and diagnosis codes on the charge ticket (superbill) or the patient's account in the EHR. Procedure and diagnosis codes are created for each unique patient visit.
5. Charge tickets with incomplete or illegible charge data are flagged or returned to the originating provider for completion to ensure expedient billing and collection. This process occurs on the same day as the service. Exceptions for unusual circumstances may be granted for up to three business days.

3.4: MEDICARE NON-COVERED SERVICES ADVANCED BENEFICIARY NOTICE (ABN)

PURPOSE:

It is the policy of NTCCC to communicate all non-covered services to Medicare beneficiaries. If NTCCC performs a service that is non-covered, that fact is communicated to the patient prior to treatment. Documentation of his or her acceptance of financial responsibility is obtained prior to providing the service.

PROCEDURES:

1. When a patient attempts to schedule an appointment for a service not covered by Medicare, the patient is informed that Medicare does not cover the service requested.
2. When NTCCC decides to perform a service that is identified as non-covered, a completed Advance Beneficiary Notice (ABN) (see below) is provided to the patient. The patient is asked to sign the ABN as his or her acceptance of the financial responsibility for the service.
3. ABN forms are maintained in the examination room to facilitate expedient completion of the form.
4. The service(s) is coded to reflect the fact that an ABN was obtained. The completed ABN is scanned or otherwise maintained on the patient's record.

3.5: BILLING INQUIRIES

PURPOSE:

It is the policy of NTCCC that incoming inquiries via letter, statement, telephone, fax, and e-mail regarding patients' financial accounts are directed to the billing office.

PROCEDURES:

1. A direct telephone number to the billing office is established for billing inquiries. The number will be staffed from 9:00 a.m. to 5:00 p.m. daily. In the event that patients call the main NTCCC number, the business office maintains a current list of account representatives and provides it to the telephone support staff to ensure the appropriate and expedient transfer of inquiring patients.
2. A separate and distinct e-mail account (future EHR patient portal), which is HIPAA secure, is established for billing inquiries. The account is published on patients' statements.
3. Every piece of written correspondence, whether a letter or a note on a statement, is forwarded on the day received to a NTCCC staff member who can review it and take action on the inquiry.
4. If a patient verbally communicates updated insurance or demographic information to a staff member who is appropriately trained in the registration process, the person accepting the communication registers the information.
5. All patient financial inquiries are recorded in the notes section of the patient's electronic account. All notes are marked with the NTCCC staff member's initials taking the message and/or the action, and currently dated.
6. Requests that cannot be achieved immediately (e.g., during the telephone call) are followed up within 48 hours.
 - a. All e-mail inquiries are followed up within 48 hours of receipt; however, the NTCCC's e-mail response does not contain any confidential medical information.
 - b. Instead, the NTCCC staff returns the patient's inquiry over the telephone if the response contains any such confidential information. (See related policy on E-mail Communication with Patients.)
7. Documentation of the resolution is recorded in the notes section of the patient's account. All notes are marked with the NTCCC staff's initials taking the message and/or the action, and currently dated.
8. If applicable, all source documents are scanned into the patients' accounts.
9. Requests that cannot be immediately resolved are placed in the electronic record on the Practice Management side, to ensure timely resolution.
10. Reports of inquiries are generated on a weekly basis and each account representative follows up on the status to ensure prompt resolution.

11. Consistent communication is maintained with the patient to convey steps being taken to resolve the issue.
12. Refer to collections policy.

3.6: FINANCIAL POLICY

PURPOSE:

It is the policy of NTCCC to provide a copy of NTCCC's financial policy to every patient, when requested.

PROCEDURES:

1. The financial policy includes information about NTCCC's policy as it relates to the following:
 - a. Insurance companies - participation and billing;
 - b. Time-of-service payment;
 - c. Patient's responsibility;
 - d. Workers' compensation; Fisherman's Fund
 - e. Auto accidents;
 - f. Collections; and
 - g. Contact information for the business office.
2. The financial policy will be posted on NTCCC's website and presented to patients when they register at the front desk.
 - a. After patients read the financial policy, a NTCCC staff member asks them if they have any questions.
 - b. The staff member answers any questions.
3. If the patient has no questions, the staff member verbally reinforces the patient's responsibility for paying his or her balance in full.

3.7: FINANCIAL HARDSHIP

PURPOSE:

It is the policy of NTCCC that patients experiencing financial hardship may apply for a discount or waiver of the patient's financial responsibility (e.g., copayment, coinsurance, and/or deductible). Whether or not such a discount or waiver is granted shall be based on an individual assessment of the patient's financial circumstances, and an assessment of NTCCC's legal and contractual obligations to the third-party payers.

PROCEDURE:

1. NTCCC does not advertise its financial hardship discount program, nor does it routinely offer discounts or waivers to patients.
2. NTCCC determines whether the patient is a beneficiary of a private third-party payer plan. If appropriate, NTCCC determines whether its agreement with the payer prohibits a financial hardship waiver or discount.
3. In order to be considered for a discretionary discount or waiver, individualized documentation of financial hardship must be included in the patient's medical record and a supporting note in the patient's financial account. The documentation needed to apply for a financial hardship discount or waiver is listed below:
 - a. A completed Patient Financial Assessment Form (see below).
 - b. One or more of the following:
 - i. Documented proof that a patient is at or below 150 percent of the current federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. Documented proof may include documents such as W-2 withholding statements, unemployment check stubs, pay check stubs, income tax return (1040), forms from Medicaid or other State-funded medical assistance, forms from employers, and/or welfare or community agencies; or
 - ii. Documentation that a patient has other circumstances that indicate financial hardship, which may include, but not be limited to, proof of bankruptcy settlement, catastrophic situations (for example, death or disability in family) or another documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses. NTCCC Tribal Health Director will be responsible for considering the grant or denial of hardship status under these circumstances on a case-by-case basis. Documentation must be submitted for the review.
 - c. Income shall be annualized from the date of request based on the documentation provided and upon verbal information provided by the patient. The annualization will also take into consideration seasonal employment and temporary increases and/or decreases to income.

4. Discounts or waivers for Medicare beneficiaries shall be applied only to the coinsurance or deductible amounts owed by the patient. Discounts for Medicaid beneficiaries shall be determined in accordance with applicable state law.
5. Any denial of the financial hardship discount or waiver request is documented and includes instructions for reconsideration. If additional documentation is received to support the financial hardship, the request will be reviewed and considered per the above guidelines. The decision of the Tribal Health Director is final.
6. All information relating to financial hardship requests will be kept confidential, except insofar as required by law.

PATIENT FINANCIAL ASSESSMENT FORM

Date: _____ Account #: _____

Social Security #: _____

Patient Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Alternate Phone: _____

Name of responsible party (if not patient, print name of Guarantor):

Patient Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ ZIP Code: _____

Length of Employment: _____ If unemployed, last date of employment: _____

Spouse Last Name: _____ First Name: _____

Spouse Employer: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ ZIP Code: _____

Length of Employment: _____ If unemployed, last date of employment: _____

Total in household (include yourself): Adults (18+) _____ Minors (under 18) _____

Guarantor (responsible party) Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ ZIP Code: _____

Length of Employment: _____ If unemployed, last date of employment: _____

Income (monthly)	Patient	Spouse	Responsible (Whom)	Children Working
Gross Monthly Salary	\$	\$	\$	\$
Public Assistance Benefits	\$	\$	\$	\$
Unemployment Benefits	\$	\$	\$	\$
Social Security Benefits	\$	\$	\$	\$
Workers' Compensation	\$	\$	\$	\$
Child Support	\$	\$	\$	\$
Other (Alimony, Pension, Life Insurance, VA Benefits, Disability)	\$	\$	\$	\$

Other Assistance:

Have you applied for Medicaid: Yes No (circle)

If 'yes,' provide current status or attach denial letter:

Have you tried to obtain financial assistance from other organizations? Yes No (circle)

List the organizations and current status:

List all outstanding hospital/physician bills:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Please provide any additional information/comments:
(attach additional sheet if more space is required, or use back of this form.)

Financial Documentation: (attach copies)

Previous year 1040 IRS: \$ _____ Year _____

W-2s: \$ _____ Year _____

If patient claims income is less than the previous calendar year tax form; attach most recent four pay stubs.

\$ _____ Date _____
 \$ _____ Date _____
 \$ _____ Date _____
 \$ _____ Date _____

Monthly Payment	Credit Type	Credit Limit	Balance	Monthly Payment
Mortgage/Rent \$	VISA	\$ _____	\$ _____	\$ _____
Gas & Electric \$	MC	\$ _____	\$ _____	\$ _____
Telephone \$	AMEX	\$ _____	\$ _____	\$ _____
Car Insurance \$	Discover	\$ _____	\$ _____	\$ _____
Car Payment		\$ _____		
Food \$	Other Expenses (Provide Explanation)			
Total Monthly Expenses This Column \$	_____			\$ _____
Total Monthly Expenses Other Column \$	_____			\$ _____
Monthly Expense Grand Total \$	_____			\$ _____
Yearly Household Income	Total		\$ _____	
Gross:		\$		
Net:		\$		

FOR OFFICE USE ONLY

Total wages for calendar year: \$ _____

Total Household: \$ _____

Eligible Discount: \$ _____

Date Completed: _____

By: _____

Notes: _____

Check when completed:

Discount Screen o

Patient Alert(s) o

Added to practice management system o

Name/Phone: _____

3.8: PAYMENT PLAN

PURPOSE:

It is the policy of NTCCC to offer payment plans to assist patients who have difficulty paying outstanding balances because of financial hardship.

PROCEDURE:

1. NTCCC encourages all patients to pay in full. However, NTCCC staff can create payment plans for patients unable to make full payments, so they can pay outstanding balances over time. Payment plans may be used for outstanding balances or pre-service deposits for procedures, or non-covered services.
2. The Tribal Health Director or designee trains and assigns responsibility to NTCCC staff to execute payment plans.
3. Payment plans may be established with patients in person or over the telephone.
 - a. If in person, NTCCC staff, ask patients to agree to a payment plan by acknowledging the agreement with a signature.
4. The minimum balance for a budget plan must be greater than \$100.
 - a. If the balance is less than \$250, it must be paid within six months.
 - b. If the balance is greater than \$250, it must be paid within 12 months.
 - c. Individual payments must be greater than \$25 per payment period.
 - d. The Tribal Health Director must approve any payment plan requested outside of these parameters.
5. When the NTCCC staff and the patient have agreed on a payment plan, the staff member keys the details into the practice management system.
6. When a payment plan is established, a confirmation letter stating the patient's commitment to follow the plan and the particulars of the plan is generated automatically or manually for the patient. The account is categorized as a payment plan for tracking and monitoring purposes.
7. NTCCC staff follow- up on every payment plan each month. A list of delinquent payment plan account (over 30 days since last payment) are printed each week.
8. A patient who has a delinquent account is allowed one month to make up the missed payment. If he or she fails to meet this schedule, the account is no longer eligible for a payment plan, and must be paid in full. If the account is more than 180 days past due, it is made eligible for collection agency turnover.
 - a. A standard letter is sent informing the patient of the change in the account status.

NTC Community Clinic Payment Plan

This payment arrangement is between

_____ and NTC Community Clinic.

This arrangement is contingent on receiving an initial 50% payment at time of service (TOS) and will be implemented for no more than 5 months. This will also be contingent on no prior balances.

Today's charges: _____

Payments begin (30 days from TOS) on: _____

Payments per month: _____

Payments end date: _____

NTC Community Clinic has offered this payment plan as a convenience to you. Please honor your arrangement and submit payments on time to avoid collections.

For patients in the process of Enrolling with Denali KidCare (DKC) or Medicaid, 30 days is given to bring in proof of eligibility with DKC or Medicaid to pay for services. If patient is not eligible with DKC or Medicaid, the bill is the signer's responsibility.

I, _____ understand that I am responsible for this entire account and that I will continue with this arrangement until my debt is paid in full and/or 5 months is over. At this time, I will make additional arrangements or will expect to be sent to collections.

I hereby acknowledge that I have read and I understand this agreement.

(Signature of financially responsible party)

(Date)

3.9: SELF-PAY/COLLECTIONS

PURPOSE:

It is the purpose of NTCCC to establish clear guidelines for collections for self-pay patients.

PROCEDURE:

1. Standard payment cycle:
 - a. Monthly statements will be sent for three months. The fourth month, a letter advising the patient that the balance is past due and a payment or budget plan needs to be set up to avoid collections, if the payment or budget plan is not received in 30 days, after the collection letter is sent.
 - b. If no payment is received by the fifth month, the debt will be forwarded to collections.
2. Budget Plans:
 - a. Patient can opt to break payment due into five increments (20% of original balance), having the payments completed by the end of the fifth month. If not paid within this timeframe, collection letter will be sent.
3. Special Circumstances:
 - a. Patients required to pay full balance at TOS (Time of Service), due to past account negligence will be eligible to pay 50% at the time of service after six months. If any balances are sent to collections, the patient will be permanently on the 100% paid at TOS listing.
 - b. Patients required to pay 50% at TOS are eligible for a special budget plan. Payments can be made over the next three months. If not paid, collection letter will be sent.
 - c. Patients will not be turned away if emergent, front desk personnel will have provider or Health Director make the determination.
4. Collections:
 - a. Once a collections letter is sent to the patient, they must pay in full, or set up a budget plan within 30 days. Any unpaid balances after 30 days from the mailing date of letter, will be sent to collections.

3.10: COLLECTIONS

PURPOSE:

The NTCCC mission is to provide access to quality and affordable health care to our service area, regardless of the ability to pay. Services are provided to both Native and non-Native beneficiaries.

PROCEDURES:

1. Adjustments on Accounts:

In general, there are not any courtesy adjustments available to patients unless they pay in full at the completion of their visit. A discount of 10% on total charges rendered on the same day of service is allowable. If a patient cannot pay their full portion of charges at the time of service, a partial payment of at least 50% will be accepted. Patients making partial payments at the time of service will be billed.

2. Aging of Accounts Receivable:

The computer system categorizes outstanding accounts incrementally by age, using the last date of zero balance entered in the accounts as the beginning date for determining account age. Accounts are aged in 30-day increments for current (less than 30 days), 30-60days, 60-90 days, 90-120 days and above 120 days.

3. Delinquent Accounts:

Patients should be asked to pay before they leave the clinic. The following procedures are appropriate:

- a. Patients with outstanding balances greater than \$25.00 will receive monthly statements until the balance is either collected or written off to bad debt. The statement includes an aging for the account and a statement prompting the patient to respond to any perceived errors in the account.
 - b. A message will be included in the monthly statements at 60 days and 90 days, urging the patient to make full or partial payment or to contact the front desk or billing office to work out a payment plan. At 120 days, a collection warning will be sent notifying that the bill will be turned over to collections. If no response, the bill is reported to collection no later than 150 days from the initial date due.
4. All final collection notices will be reviewed by the Tribal Health Director prior to being sent to a collection agency. The Tribal Health Director will evaluate accounts with balances over \$100.00 on which no payments have been made for four months and the responsible party has not made a good faith effort to either contact the clinic or to pay the bill. The Tribal Health Director signs off on the collection action and a notation is made in their third-party record.

3.11: BILLING PROCESS CHECKLIST

PURPOSE:

It is the purpose of NTCCC to ensure that proper procedures are followed for billing to ensure timely and accurate billing.

PROCEDURE

1. Front Desk staff will verify the insurance information is correct and current, prior to providing services (preferably at time of scheduling). **Patients are expected to pay deductibles and co-pays at the time of service. All Medicaid coverage must be verified prior to each visit and documented in patient registration. VA must be prior authorized by the biller before appointment in order to receive payment by VA.**
2. All patients must receive/be offered a receipt for payments made by cash or check, either by email or printed.
3. Medical coder will check charge reconciliation to ensure all visits have been appropriately billed. Medical biller will verify Behavioral Health charges to the daily excel schedule.
4. Send patient statements out monthly, on the 20th of each month (Or closest business day). Personalized statements containing past due balances should request that either, payment in full or a reasonable payment plan made.
5. After 6 months of non-payment, a letter will be sent to the patient alerting them that their account is set to be sent to collections if no payment is received within 10 days. If no response, a verification is made that account balances are correct and the balance is sent to collections. An alert will be placed in the system to alert scheduling that a payment is required before the patient can be seen. (With the exception of life or limb emergency.)
6. Charges will be submitted for billing within 72 hours of service when possible. (Coding issues should be sent to providers within the 72-hour period of receipt.)
7. Processed charges will be submitted to insurance daily. When submitting electronically, be sure to review claims acknowledgement and acceptance reports provided by the electronic claims clearinghouse. Any claims not found on the report should be immediately investigated for transmission errors. Claims errors on the report should be immediately corrected and set to re-bill in the next cycle.
8. Check the status of unpaid electronic claims if they are 20 days old or older and make account notes on the status. Follow up with sending any additional information needed or contact the patient if the payer needs information from them. Follow-up weekly until paid. **Work old claims first, most payers have timely filing limitations which could result in lost revenue!**
9. Check the status of unpaid paper claims if they are 30 days old or older and make account notes on the status. Follow-up weekly until paid. **Work old claims first, most payers have timely filing limitations which result in lost revenue!**

10. Follow-up on un-paid claims by payer (e.g., work all past due Medicare on one day). This saves time as you can check the status of several claims with one contact and allows for easy identification of patterns (e.g., all Medicare for a certain code remain unpaid).
11. Know the timely filing periods within the physician's payer contracts (don't agree to less than 90 days, this is one of the most negotiable items in the contract) and to make sure that the payer shows receipt of the claims within that time, even if the claim is delayed, for further development.
12. Work all claims denials promptly. There is a tendency to let this pile up and become lost revenue, over minor claims filing errors. Failure to work denials also leads to repeated mistakes and more denials.
13. Create cheat sheets which help you remember coding and billing rules from your most common payers.
14. Use the internet or electronic inquiries where possible to verify eligibility, claims status, payer policies, and to sign up for electronic newsletters from your common payers.
15. Attend local chapter meetings of billing or coding organizations and presentations provided by Medicare Contractors or other payers. These are a quick and inexpensive way to keep up-to-date and learn new information.
16. Use the most authoritative information sources that you can find (e.g., CMS or the local contractor for Medicare billing and coding information, the payer web site or provider representative for private payer information).
17. Get all billing instructions in writing and keep a file. If a customer service at payers claim office says to submit a claim with a different code, place of service or anything out of the ordinary, ask them to fax or email that instruction for your records. This could be important in the event of an audit.
18. Respond promptly when a payer requests records. Be sure to include all related records for the date of services (e.g., medication lists, test results and records from other sources which are referenced in the note, history forms completed by the patient). Review the information with the physician prior to sending it.
19. Don't ignore the problems. Some payers are notorious for slow claim payment and are difficult to contact regarding claims status. While it is tempting to focus on money more easily collected, these are the claims to work continuously, so that revenue is not lost and you can file grievances with supporting documentation. This is especially important when claims are processed by contracted vendors, whose contracts may be discontinued, if their service standards are too low.
20. Claims statuses, patient balances that require follow-up, or payment/billing related materials to read, need to be checked daily.

3.12: WORKER'S COMPENSATION

PURPOSE:

It is the policy of NTCCC to pursue claims resulting from work accidents and injuries by making a claim with the appropriate workers' compensation carrier.

PROCEDURES:

1. At registration, all patients are questioned about the nature of their complaint as it relates to their employment. NTCCC asks, "Is this injury or illness work related?"
2. If a patient states that his or her injury or illness is work related, a staff member gathers detailed information about the patient's employer and the corresponding workers compensation insurance company. The staff member then provides the patient with a yellow copy of the workers comp form to partially fill out and take into their visit for the provider to complete and submit to billing.
3. The claim for the services rendered to the patient is submitted to the appropriate workers' compensation carrier. NTCCC communicates with a case manager and submits any applicable paperwork and/or documentation necessary for payment on the claim.
4. NTCCC pursues payment from the workers' compensation carrier according to the protocols set forth for insurance follow-up activities (see related policy on Insurance Follow-Up).
5. If the patient was injured while working, NTCCC pursues payment from the employer and/or its workers' compensation carrier. The patient cannot be billed for the debt due.
6. If the claim is ruled non-work related, NTCCC bills the patient and/or his or her private insurance carrier.

3.13: LIABILITY ACCOUNTS

PURPOSE:

It is the policy of NTCCC to send claims for services resulting from an auto or other accident to the appropriate auto insurance (or other) carrier for reimbursement; however, the patient is held responsible for the payment.

PROCEDURES:

1. During the registration process the automobile and other insurance document information will be obtained and scanned into the chart for billing purposes.
2. The biller posts and submits the claims for these services.
3. The biller ensures that all required attachments are sent to the carrier at the time of claim submission.
4. Claims are submitted electronically to the appropriate payer when the carrier can accept such transmission and via paper claim when the carrier cannot.
5. The biller follows up on all liability accounts. Regular reports are generated to monitor the aging of these accounts.
6. After 90 days, if the balance is unpaid, the patient receives a letter explaining the status of his or her account and the balance is transferred to self-pay. Standard self-pay and collection policies will apply.

3.14: PRIMARY AND SECONDARY CLAIMS

PURPOSE:

It is the policy of NTCCC to submit clean claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered.

PROCEDURES:

1. Prior to submitting claims, charges are reviewed automatically or manually for accuracy.
 - a. Every effort is made to eliminate errors in registration, procedure, and diagnosis coding and charge entry to ensure timely reimbursement.
 - b. During the review process, any discrepancies are resolved immediately.
 - c. If necessary, the provider rendering the service for which the charge is being billed is contacted in person, or via communication directly in the EHR system regarding the charge.
 - d. *Providers have three business days to respond to questions about charges.
 - e. Charge edits are resolved in four business days.
2. Following the edit process, clean claims are sent electronically real-time or by the end of the business day.
3. Exception reports generated from the submission are worked on a same-day basis.
4. Claims are not suspended unless necessary.
5. An electronic log of suspended claims is maintained and monitored by the business office manager to ensure that suspended claims are resolved expediently.
6. NTCCC submits secondary claims if a patient maintains a secondary insurance policy and the primary insurance carrier, does not pay the full amount of the charge.
 - a. The secondary insurance carrier is billed for the remainder of the balance.
 - b. NTCCC makes best efforts to work with payers to crossover secondary claims automatically.
 - c. If not, the primary explanation of benefits (EOB) is flagged manually or electronically and submitted to a designated staff member to bill the secondary insurance carrier.
 - d. Within 24 hours of notification of responsibility of the secondary payer, the secondary claim(s) are submitted.
7. The full balance of primary and secondary claims submitted to third-party payers with whom NTCCC does not participate, are transferred to patient responsibility at 45 days, or another time period that the business office designates.
8. For IHS beneficiaries, charges are automatically adjusted by the biller, unless they have insurance, then the bill will be sent to that insurance and most services not covered will be written off, except for supplements.

**With the exception of Medicaid. Please see Medicaid policies.*

3.15: PAYMENT POSTING

PURPOSE:

It is the policy of NTCCC that payments received by NTCCC are handled in a timely manner with sensitivity to internal controls.

PROCEDURES:

1. NTCCC accepts payments remitted and transferred directly from third-party payers by all payers offering electronic payment remittance (EPR) and electronic funds transfer (EFT). Remittances are accepted when available from the payer but are not posted until designated staff confirms the remittance total to the funds transferred.
2. NTCCC accepts all non-electronic payments, including non-electronic third-party payer and patient checks.
 - a. Payments received via mail are given to the medical biller for posting.
 - b. Payments received at the front desk are posted and deposited by the front desk.
 - c. Copies of all checks and payments shall be made before sending to finance for deposit.
3. Correspondence, including rejections, with no payment attached is flagged manually or electronically.
4. A transaction code is posted to the charge level on the account to identify the type of rejection.
5. Rejections are worked by the medical biller at the time of receipt.
6. The Medical Biller is responsible for linking any “quick payment” postings to the individual invoices within the patient account.
7. The Medical Biller is responsible for the transfer of the account balance to the patient or to secondary or tertiary payers (and manually or electronically mark the primary explanation of benefits, unless, the claim is an automatic crossover by the primary payer).
8. Payment posting is monitored daily to ensure timeliness and accuracy, as well as to identify opportunities for improvement.
9. For payment posted at the time of service, see related policy on Time-of-Service Payment Controls.
10. For internal controls related to the payment-posting process, see related policies regarding financial management.

3.16: PAYMENT REFUNDS

PURPOSE:

It is the policy of NTCCC to return all monies that are not due to NTCCC. These may include overpayments from patients or third-party payers. NTCCC is committed to complying with state and federal laws, as well as to minimize the impact that refunds have on receivables (i.e., refunds negate receivables) and management reports regarding business office performance.

PROCEDURES:

1. Overpayments are flagged at the time the payment is posted.
 1. The poster, or another designated staff member, works these refunds by the close of the business day.
 2. The staff member completes a Refund Request Form (see below) to request the refund check be processed.
 3. A thorough review of the account is conducted to determine the cause of the credit balance.
 4. If a posting error caused the credit balance, a refund is not made.
 5. Thorough documentation of the refund is placed in the notes section of the patient's account.
 6. In addition to proactively refunding credits created during the posting process, the business office is responsible for refunding outstanding credits.
 - a. The accounts need to be reviewed thoroughly.
 - b. Credit invoices are identified and refunded to the patient, guarantor, or third-party payer within 60 days.
 - c. Any credits identified that can be transferred to another outstanding invoice are done within 60 days of creation date.
 - d. The oldest credits should be processed and refunded first.
 7. If a credit balance occurs for a guarantor with multiple patients on the account and a debit balance remains on the total account, the credit is posted as an open balance payment.
 8. Credit balances of less than \$5 are not refunded. Refunds are posted to the patient's account when the refund check is issued.
 9. Requests for refund checks are submitted to the Tribal Health Director or designee in writing or via internal e-mail on the Refund Request Form and require the Tribal Health Director's signature.
 10. Voluntary Refund Request Forms provided by the Centers for Medicare and Medicaid Services (CMS) accompany all Medicare refunds.

3.17: UNAPPLIED PAYMENTS

PURPOSE:

It is the policy of NTCCC to account for all payments and apply them to specific charges on corresponding dates of service. These payments are resolved and posted in a timely manner.

PROCEDURES:

1. Payment posters post all payments to the corresponding dates of service based upon the information provided from third-party payers on the explanation of benefits.
2. Payment postings are researched for any amounts that are not directly tied to a date of service and specific services. All open batches are posted before the end-of-day closing. Research may require calling the payer to clarify assignment of the payment.
3. A payment that is received prior to posting the charge is posted to the patient's account according to the protocol established by the billing system. The payment is linked to the charge when it is posted. Charges are posted within 72 hours of date of service, and therefore reconciliation and posting of these monies must occur in the same time frame.
4. If the patient is identified, but the date of service is not available, such as when a patient sends a check toward their account balance, the payment is posted to the patient's account proportionally, or to the oldest charges. If the account has insurance claims outstanding, the biller researches the account to ensure proper posting of the payment.
5. Documents that contain unidentified payments are held and the associated insurance or patient is contacted the same day to determine if the payment is an error or where it should be posted.
6. All open and unresolved, unapplied payments are resolved by the biller within 15 days. Any case unresolved is presented to the Tribal Health Director for resolution.
7. Upon resolution, the biller applies the payment to the correct patient and line item service and posts a reversal to the unapplied payment account. A notation in the unapplied account is noted to indicate where the payment was posted. This includes the patient and account number, as well as the staff member making the charge, the date, and any applicable notes.

3.18: WRITE-OFFS

PURPOSE:

It is the policy of NTCCC to track and monitor all monies that are written off from the original charge submitted to a third-party payer. Two distinct categories of write-offs are handled and monitored separately: contractual amounts, which are considered uncollectible as a result of a contractual agreement with a third-party payer and non-contractual amounts, which are considered uncollectible for reasons other than the contract.

NON-CONTRACTUAL SPECIFICATIONS:

1. Services required for employment such as immunizations and drug screens will be posted and adjusted as an NTC Admin write off with the specified service listed.
2. Any balance after insurance or self-pay balance for NTC staff members for acute services will be adjusted as an NTC staff write off at the discretion of the medical provider. Chronic care services are the responsibility of the patient, with the exception of the Weight Reduction Assistance Program (WRAP).
3. All adjustments that are specific to the Behavioral Health department will start with a BH referral to specify services.
4. IHS and NTC spouses primary and secondary claims will be adjusted in bulk weekly and will show up as IHS adjustments on the monthly adjustment summary.

PROCEDURES:

1. To track and monitor all write-offs, NTCCC maintains a dictionary of detailed adjustment codes for contractual and non-contractual write-offs. The non-contractual write-offs may also be attached with transaction message codes, if applicable.
2. NTCCC maintains current fee schedules, by procedure code, for each third-party payer health plan. As a third-party payment is posted, the assigned billing staff member is responsible for verifying that the payment allowance matches the expected reimbursement according to the procedure code and any applicable modifiers. To assist staff, the practice management system defaults to the contractual reimbursement for each procedure code posted, based on the agreement with each third-party payer, as applicable.
3. If the payment allowance matches the expected reimbursement, the residual money (NTCCC charge less payment allowance) is written off with the appropriate contractual adjustment code. If the payment does not match the expected reimbursement, the line item is flagged manually or electronically for follow up (see related policy on Claim Rejection).
4. From time to time, NTCCC billing staff may work on an account that has an outstanding balance with a health plan that cannot be collected. The reasons for NTCCC's inability to collect on the account may include, but are not limited to, a missed timely filing or appeal deadline, or failure to obtain an appropriate authorization or referral. If this type of write-off is identified, NTCCC billing staff

must receive approval to write off the account from a supervisor, by completing and/or submitting a Non-Contractual Write-off Request Form or email. The NTCCC biller processing the account in question also identifies their work on the account. The request is sent in a standard format via internal e-mail communication or a manual form.

5. The Tribal Health Director may decide that the biller may write off a specified maximum dollar amount without a supervisor's approval. The amount shall not exceed \$100 unless approved by the Executive Director or designee.

SECTION 4: PATIENT ADMINISTRATION

4.1: NEW PATIENT REGISTRATION

PURPOSE:

It is the policy of NTCCC that demographic and insurance information is collected from all new patients and is verified prior to or at the scheduled appointment.

PROCEDURE:

1. To ensure correct billing, contracting, and data analysis, every patient seen by a provider is registered in the system.
2. A new patient may preregister by:
 - a. Telephoning NTCCC
 - b. Scheduling an appointment in person at NTCCC; or
 - c. Completing and submitting all applicable forms electronically via NTCCC'S website (In the future).
3. A NTCCC staff member (or the future NTCCC's website) collects the following minimal demographic and insurance information, or that which is designated by the business office manager:
 - a. Patient name (first and last)
 - b. Status with practice (new or established)
 - c. Telephone number
 - d. Reason for visit
 - e. Date of birth
 - f. Insurance coverage, including guarantor, policy number, and group number. (The business office determines the minimum information required based on data necessary for insurance verification.)
4. A NTCCC staff member ensures all available information is collected before the patient/guarantor leaves the office or ends the telephone conversation. If applicable, registration forms are posted on the NTCCC's website (in the future) in order to capture this information.
5. All new patients are given (either in person or via e-mail) a new patient packet or are instructed to review it on the NTCCC's website (in the future). A new patient packet includes the following:
 - a. NTCCC brochure
 - b. The NTCCC no-show policy
 - c. The NTCCC financial policy
 - d. A new patient registration form

6. A new patient is fully registered prior to seeing the provider. When the patient arrives for his or her appointment, all insurance, identification cards and all remaining paperwork signatures are collected and scanned in to the Practice Management (PM). Paperwork signatures may include, but are not limited to, acknowledging receipt of NTCCC's privacy notice, the medical records release, and the assignment of benefits.
7. New IHS patients need to provide the following:
 - a. An ANMC number or:
 - b. Certificate of Indian Blood (CIB)or
 - c. Tribal Enrollment Card or
 - d. Tribal Letter
 - e. A National Patient Information Reporting System (NPIRS) should be filled out at the time of registration
 - f. All the above documents should then be scanned into the PM

4.2: INSURANCE VERIFICATION AND BENEFITS ELIGIBILITY FOR NON-BENEFICIARIES

PURPOSE:

NTCCC confirms that patients have active coverage for the insurance on record.

PROCEDURES:

1. For each account, the insurance company is contacted to verify coverage.
2. A Staff member will complete an insurance verification for each insured patient at time of appointment request whether in person or telephonically. All applicable information is electronically recorded for each patient verification.
3. If insurance or benefits for the services scheduled to be rendered cannot be verified, a staff member contacts the patient immediately.
 - a. If time permits, the patient is informed of the situation, and asked to provide coverage information.
 - b. If coverage is not available, the patient is informed of his or her responsibility to pay for the services to be rendered at the appointment.
 - c. If the patient chooses, the appointment may be rescheduled. If time does not permit, this information is provided when the patient registers.
 - d. Whether by phone or in person, each patient is asked for policy information he or she has for any alternative coverage.
 - e. If the patient has alternative coverage, a staff member confirms insurance coverage and benefits eligibility according to NTCCC protocols.
4. If the appointment scheduler knows the patient's health plan does not cover services to be rendered, the patient is informed at the time of scheduling. The scheduler also tells the patient that 50% of payment is expected when services are rendered.
5. A staff member informs each patient for whom no coverage is confirmed for insurance and/or benefits that 50% of payment is expected at the time of the appointment. Accordingly, collections are attempted upon arrival.
6. Consistent with time-of-service collections procedures, a NTCCC staff member gives a receipt to the patient that indicates the amount charged for non-covered services and the amount paid by the patient.
7. A patient who arrives for an appointment without insurance or benefits for the services to be rendered is requested to sign a waiver form to indicate expectation for payment. For Medicare patients, see related policy on Medicare Non-covered Services.
8. If a minor shows up for treatment for any of the following, which does not require consent: venereal disease, HIV testing, birth control/family planning or treatment for sexual assault. They must be informed that if they don't want their parents to

know about the reason for their visit and choose to use their parent's insurance, that the parent will find out. Otherwise, they will have to pay cash for the visit or depending on the problem, be referred to Family Planning.

4.3: PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to (PROVIDER OR GROUP NAME) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize (PROVIDER OR GROUP NAME) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (PROVIDER OR GROUP NAME). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Authorized Representative or Responsible Party

Date

Print Name of Patient, Authorized Representative or Responsible Party

Relationship to patient

4.4: IHS PATIENT RESPONSIBILITY FORM (BENEFICIARIES)

1. INDIVIDUAL’S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- I understand that NTC may cover a portion of the cost of urgent referrals to non-native medical facilities to assist in-house diagnoses if deemed necessary and approved by the medical provider.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to (PROVIDER OR GROUP NAME) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize (PROVIDER OR GROUP NAME) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (PROVIDER OR GROUP NAME). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Authorized Representative or Responsible Party Date

Print Name of Patient, Authorized Representative or Responsible Party Relationship to patient

4.5: TERMINATION OF DIFFICULT PATIENT

PURPOSE:

This policy is created to outline the process for the management and eventual discharge from service of difficult patients. This includes those who are perceived to be difficult with respect to recurrent hostile behavior, inappropriate use of NTCCC services, excessive non-compliance (including financial obligations), inappropriate use of controlled substances, or other patterns of behavior that represent excessive lack of respect or responsibility on the part of the patient.

POLICY:

NTCCC seeks to provide quality health services consistent with community standards, and to utilize its limited resources wisely in order to enhance its mission. Patients may be discharged from the practice immediately if they are deemed to be abusive or threatening to the staff. Patients who are perceived to be difficult, with respect to recurrent hostile behavior, inappropriate use of NTCCC services, excessive non-compliance, inappropriate use of controlled substances, or other patterns of behavior that represent excessive lack of respect or responsibility on the part of the patient, may be referred to the Tribal Health Director for review and discharge.

PROCEDURES:

Related to Patient Behavior

1. Providers who are considering discharging a patient are encouraged to discuss the behavior with the patient, explain the impact of the behavior on providers and staff, and request that the patient changes the previously described behavior. The behavior and the discussion should be documented in the patient's medical record.
2. When applicable, staff is encouraged to complete an Incident Report describing the behavior. Copies of this form should go to the provider seeing the patient and the Tribal Health Director. If there is a potential legal issue, the Executive Director shall be notified immediately.
3. Providers are encouraged to discuss incidents, reported by staff, with their patients as above. When a potential legal issue exists, the Executive Director will forward the report to NTC's legal counsel to keep on record in the event of future liability. The Tribal Health Director shall be notified of legal advice, when applicable.
4. The provider may refer the case to the Tribal Health Director for referral for recommendations regarding management of the patient, which may include discharge from NTCCC.
5. Staff and provider education/training will be provided on how to manage problem behaviors, how to discuss these with patients, how to prepare an effective behavioral contract, and how to recognize and manage common causes of "difficult" patients.

6. Patients may be discharged from NTCCC immediately if they are deemed to be abusive, threatening to the staff, or for other reasons at the discretion of the provider. If the threat or abuse is not directed at the provider, the staff shall make the primary care provider (PCP) aware of the situation. If the PCP is not available, another provider on-site should be contacted.
7. All patients being discharged shall be sent a letter informing them of their discharge from NTCCC, the effective date, and including the names of other outpatient providers. This letter shall be sent by certified mail and a copy kept in the medical record.
 - Print a letter on NTC letterhead and forward original letter, with one copy, and prepared envelope to Tribal Health Director.
 - **Tribal Health Director** will review and sign letter and forward to the Front Desk Clerk.
 - **Front Desk Clerk** will mail original letter via certified mail to the recipient, and notify the Biller. One copy of the letter will be retained in the “discharged patient” file in the EHR.
8. When applicable, documentation of discharge of patient from NTCCC should include the following:
 - a. Adequate verbal and written notice with a specific date for termination from the NTCCC. Verbal notice should be conducted with a witness present.
 - b. Discharge must allow for a reasonable time frame for the patient to find a new physician, generally 30 days is an acceptable time frame. Exception: If patient’s abusive behavior puts staff &/or other patients at risk, immediate discharge without 30 days notice will occur.
 - c. The provider in NTCCC must be available for all care in the interim period of time (30 days).
 - d. No cause of discharge from NTCCC need be identified in the discharge letter.
9. In the event of discharge, the discharge letter shall be routed to the Front Desk staff who will make notation of the discharge in the practice management system by adding the word “DISCHARGED” behind the patient’s first name in Patient Registration. The Health Information staff shall mark the front cover of the patient’s medical record with “DISCHARGED” in red marker and file the discharge letter and related documents, including the “Difficult Patient Chart Review Form” (if applicable) on top of the right side of the record.
10. In the event that the patient calls after discharge, the staff shall tell the patient that they have been discharged from NTCCC and may not be scheduled to see a provider. If the patient persists, staff shall transfer the call to the Tribal Health Director.

Related to Patient Financial Responsibility Behavior

Patients who fail to make a good faith effort to comply with their financial responsibilities, thus non-compliant with NTCCC Collections policy, may be referred to the Tribal Health Director for review and discharge. The above Steps 8 – 10 apply.

4.6: EMERGENCY ROOM VISITS COVERAGE

Emergency Care Defined: an acute medical condition, sudden in onset with severe symptoms posing an immediate threat to life, limb, or organ. An emergency requires immediate treatment by a physician. Medical conditions in which a delay in care would be hazardous to life or would result in serious complications are also considered emergencies.

The following requirements must be met in order for Ninilchik Traditional Council to pay for emergency care.

1. Must apply for and/or use alternate resources (Medicare, Medicaid, VA, Private Insurance, Denali Kid Care, Charity, etc.) and have a denial letter, before using NTC emergency funds
2. Must be a true 'life, limb or organ' emergency. For example: chest pain, acute respiratory distress, severe abdominal pain, loss of consciousness, stroke symptoms, severe wound, hemorrhage, sudden onset of weakness, numbness, severe injuries
3. Must be an eligible IHS beneficiary, non IHS spouses are not included
4. Must be an active clinic user within the last year and have lived in the Ninilchik Tribal boundaries for at least one year, does not include Homer
5. If you become ill during clinic hours, you must be seen at the clinic, if: your symptoms are not listed above, before a crisis develops, for the conditions listed below and for questions about whether your symptoms constitute an emergency
6. If you are experiencing illness symptoms during clinic business hours, you should be seen earlier in the day at the clinic and they can determine if an emergency
7. Must get payment authorization from NTC
8. Must notify NTC within 72 hours of occurrence

The following conditions do not warrant a trip to the Emergency Room:

- Recurrent migraine headaches
- Ear aches
- Sore throat
- Toothache
- Flu or cold symptoms
- Alcohol/drug intoxication
- Pain medication

Due to the limited funding, NTC providers will carefully determine eligibility and may or may not cover emergency care. Coverage will be based on the above criteria and after careful examination of emergency room medical records. There will be a cap of \$3,000.00 per year per eligible IHS beneficiary. This will include \$550.00 towards an ambulance ride. NTC will be payer of last resort. An appeal may be filed in writing and must be received within 30 days from the date your denial letter was received.

**Ninilchik Traditional Council
Community Health Clinic
Emergency Room Visits
Payment Denial**

Service for _____, rendered on _____
is being denied for the following reason(s):

- 1. _____ No proof of eligibility.
- 2. _____ The above named individual is not eligible for Alaska Native or American Indian Health Services.
- 3. _____ The above named individual has no active * chart with NTC Community Clinic or lives outside NTC Tribal Boundaries i.e., Kenai, Soldotna, Nikiski, north of the Kasilof River & Homer.
- 4. _____ Services rendered are considered not emergent.

Definition of "emergent" is derived from the Federal Register, Vol. 43, NO. 151, August 1978 and is as follows: "Emergency means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual."
- 5. _____ Services were rendered during normal NTC Community Clinic hours.
- 6. _____ Laboratory charges are not covered unless associated with approved Emergency Room Charge.
- 7. _____ Radiology (x-ray) charges are not covered unless associated with approved Emergency Room Charge.
- 8. _____ Outpatient surgery is a non-covered Contract Health Service
- 9. _____ Treatment in the Emergency Room for chronic alcoholism acute intoxication, drug and/or alcohol abuse are non-covered Contract Health Services.
- 10. _____ Failed to call clinic within 72 hours of being seen in the E.R. Or Other

Signature of Reviewer

Date

NOTE TO PATIENT: You may request reconsideration in writing within 30 days of receipt of this notice. Address your request in writing to the Tribal Health Director of the NTC Community Clinic.

* Active is defined as being seen at the NTC Medical Clinic within the last (1) year.

**Ninilchik Traditional Council
Community Health Clinic
Emergency Room Visits
Payment Approval**

_____ 'Life, limb or organ' emergency. For example: severe chest pain with associated symptoms, acute respiratory distress, severe abdominal pain, (not related to constipation), loss of consciousness, stroke symptoms, severe deep wound involving major arteries or hemorrhage, sudden onset of weakness, numbness, severe injuries. Severe fractures with noticeable breaks in the skin where bone is protruding.

_____ Notified Clinic within 72 hours of Medical Emergency

Reviewer signature

Date

4.7: DENTAL VISITS COVERAGE POLICY

Dental Coverage Defined: NTC will cover dental lab costs (root canals, dentures, partials & crowns) associated with work completed at NTC's contracted dentist, Southcentral Foundation or ANMC. These costs will be limited to no more than \$1,500.00 per year.

The following requirements must be met in order for Ninilchik Traditional Council to pay for dental care.

1. Must apply for and/or use alternate resources if eligible (Medicare, Medicaid, VA, and Private Insurance) and have a denial letter, before using NTC dental funds.
2. Must be an eligible IHS beneficiary, non IHS spouses are not included.
3. Must be an active clinic user within the last year and have lived in the Ninilchik Tribal boundaries for at least one year, does not include Homer.
4. Must get payment authorization from NTC at least 1 week prior to dental procedure.

Due to the limited funding, NTC providers will carefully determine eligibility and may or may not cover dental lab fees. Coverage will be based on the above criteria and NTC will be payer of last resort.

4.8: PATIENT ROAD TRAVEL REIMBURSEMENT

POLICY:

Road Travel Reimbursement Defined: Travel costs will only be covered for services that the NTCCC cannot provide at the clinic.

The following requirements must be met in order for Ninilchik Traditional Council (NTC) to pay Road Travel Reimbursement.

1. Must be an eligible IHS beneficiary, non IHS spouses are not included.
2. Must be an active clinic user within the past 6 months (does not include lab draws or blood pressure checks, must have been seen by a provider) and have lived in the Ninilchik Village Tribal boundaries for at least one year (does not include Homer).
3. If you become ill during clinic hours, you must be seen at the clinic. If you become ill when you are already in Anchorage for something else, you will not be eligible for road travel reimbursement.
4. Must get an approved road travel form directly from NTCCC prior to your trip to Anchorage. Road travel forms will only be issued when appointments are made directly by NTCCC staff for referrals to specialty clinics. This policy does not provide Road Travel Reimbursement when you set up your own appointments, or for Southcentral Foundation (SCF) Primary Care, as NTCCC can provide this service in-house. The only exception for setting up your own appointments and requesting Road Travel Reimbursement is for Optometry and Dental, wherein you are still required to get an approved Road Travel form from NTCCC staff prior to your appointment. In cases where NTCCC staff were not involved in the healthcare relating to a decision to be seen in Anchorage for Optometry or Dental, approval for Road Travel Reimbursement is as the sole discretion of NTCCC. Under no circumstances will a Road Travel Reimbursement be made where a form was not issued by NTCCC prior to the appointment.
5. Must get road travel form signed by the provider in Anchorage at the time of your visit and it must be returned to the NTCCC within 30 days, or payment will not be approved.
6. NTC will not be responsible for getting your form to Anchorage for signatures and verifications, patient will be responsible for these forms.
7. Patients shall only receive one (1) travel reimbursement for each actual road trip, and shall not be paid for separate days or by individual appointments where the patient remains in Anchorage for multiple visits.

The following conditions do not qualify for road travel reimbursement to SCF:

- Ear aches
- Sore throat
- Flu or cold symptoms
- PAP smears

- Physical exams
- Stomach aches

Due to the limited funding, NTC providers will carefully determine eligibility and may or may not cover Road Travel Reimbursement. Coverage will be based on the above criteria and after careful examination of road travel request.

SECTION 5: CLINICAL CARE

5.1: COMPETENCY

PURPOSE:

It is the policy of the NTCCC that every employee is assessed for competence in his or her assigned tasks and responsibilities.

PROCEDURE:

1. To evaluate an employee's knowledge of assigned tasks and responsibilities, he or she complete a competency assessment every two years, or as needed.
2. The employee's supervisor initially creates and then updates the competency assessment.
3. If the employee does not meet the competency requirement determined by the department, additional training is provided immediately. After training, a follow-up competency assessment is administered. If there is no change, the supervisor incorporates the issue into the employee's performance evaluation process.

5.2: MEDICAL EMERGENCIES

PURPOSE:

It is the policy of NTCCC to respond to all medical emergencies by performing the following:

- Call 911 immediately when the need for emergency care is identified.
- Maintain clinical staff qualified in basic cardiac life support (BCLS) because effective and efficient performance of BCLS depends on adequate training and practice. The clinical staff routinely reviews “code blue” procedures and conducts drills no less than every six months.
- Ensure all equipment used in a code is accessible and in good working order. The equipment is inventoried and tested according to the recommendation of the vendor.

PROCEDURES:

1. Any staff member who discovers a patient, visitor or employee needing emergent care is responsible for activating the emergency medical system. This involves:
 - a. Getting appropriate assistance, including notifying an employee who is currently trained in cardiopulmonary resuscitation (CPR).
 - b. Calling 911 to notify them of the emergency and exact location.
 - c. Notifying a provider in the immediate vicinity of the location and type of emergency.
2. The first staff member on the scene currently trained in emergency response initiates CPR or basic airway management. Following AHA protocol.
3. The first provider on the scene is responsible for managing the emergency situation until paramedics arrive. He or she should then assist as necessary. Until that time, the provider can delegate roles as he or she sees fit for the effective performance of resuscitation.
4. The first nurse/CHA on the scene ensures adequate staffing and assists the provider as directed until formally relieved by another nurse. The nurse/CHA recruits and dismisses personnel as necessary to ensure a coordinated and effective resuscitation. At a minimum, this includes at least three personnel:
 - a. One person responsible for airway management;
 - b. One person responsible for chest compressions; and
 - c. One person to record the events.
 - d. The emergency may also call for personnel to start an IV, administer medications, and other interventions. It is the provider’s decision to determine appropriate interventions, and the provider assigns the roles for the nurse to manage.
5. Monitor vital signs every five minutes.
6. If available, administer oxygen at the direction of the provider.

7. Assign a staff member to the entrance door to direct paramedics to the emergency location.
8. Patients in a “code blue” status are transported by ambulance to the nearest hospital emergency department.
9. A “code blue” may only be terminated by the provider on the scene.
10. Following a “code blue,” the responsible provider reviews the record for accuracy and completeness. He or she completes and submits an incident report to the Tribal Health Director. Other staff personnel should be prepared to document the incident upon request.
11. Every actual “code blue” event is followed within two working days by a meeting of all involved personnel at which time performance is reviewed and suggestions for improvement are noted.
12. Equipment needs are reviewed annually based on the needs of patients, new equipment available in the industry, and the operating condition of existing equipment. The review also includes an evaluation of protocols and staff minimum training and continuing education requirements.

5.3: REVIEW OF TEST RESULTS

PURPOSE:

It is the policy of NTCCC that all lab results, radiologic image results and other diagnostic studies, returning consults, and any patient reports are reviewed and initialed by a provider prior to being filed in the medical record. Under the direction of the provider(s) managing their care, patients are duly informed of the information provided in results and reports.

PROCEDURES:

1. Upon time of referral or lab test, the provider will inquire which process for results the patient prefer: appointment, call from provider, call from case manager or a letter (if normal results).
2. NTCCC staff stamp all results/reports on the day of receipt with a manual or electronic date stamp.
3. On the day of receipt, the report is forwarded to the staff member responsible for tracking receipt of the report and/or scanned into the patient's medical record with an electronic tickler to alert the provider to review. The tickler is removed when the result/report is read.
4. The provider (or a designated provider, in the case of a vacation or other absence) is responsible for reviewing inbound results/reports within 24 hours of receipt. If non-urgent primary care provider will follow-up with the patient. The provider manually or electronically marks the document or file to indicate that it was reviewed. The provider documents any contact with a patient based on the review of the result/report, and then notes the next action for the staff to take. As it is the policy of NTCCC to inform all patients regarding their test results.
5. The results may be mailed via certified mail, if all efforts to contact patient have failed.
6. A copy of the letter is scanned or placed in the patient's medical record;
7. After the provider reviews and documents action, the report is then scanned into the patient's record or returned to medical records for filing.

5.4: HIV TESTING

PROCEDURE:

It is the policy of NTCCC that a provider may only order a human immunodeficiency virus (HIV) test after personally obtaining written, informed consent from a patient and making the following information available to the patient:

1. Information about the meaning of the test results;
2. The availability of additional or confirmatory testing (if appropriate); and
3. The availability of referrals for further information or counseling.

Subject to applicable law, exceptions pertinent to the clinic setting are:

- a. Written informed consent, information, and counseling are not required when, in the judgment of the provider, such testing is medically indicated to provide the appropriate diagnosis and treatment to the subject of the test, provided the patient has otherwise consented to medical treatment by such provider, which otherwise encompasses the testing.
- b. To the extent permitted by applicable state law, written informed consent is not required when an employee NTCCC, another health care provider, a fire fighter, an emergency medical technician (EMT), or a police officer has been involved in the line of duty in an accidental direct skin or mucous membrane contact with the blood or bodily fluids of an individual who a provider determines, in his or her medical judgment, is of a nature that may transmit HIV. However, should the test result be positive, the affected individual is offered appropriate counseling or directed to other appropriate health care resources.

1. Testing process

- a. It is the provider's responsibility to ensure that the Informed Consent to Perform HIV Testing form (see below) is completed prior to testing a patient.
- b. The responsible NTCCC employee must receive the consent prior to drawing the blood; otherwise the patient is sent back to the ordering provider for compliance with this policy.
- c. The HIV consent form is filed in the patient's medical record.
- d. A request for an HIV test is placed on a separate requisition slip, regardless of which lab receives the specimen. This ensures that the report includes only the HIV results and no other test results.
- e. [Optional] For patients who desire anonymity, the requisition, log, and identifier are marked with a coded identifier. This coded identifier is the account number assigned at the date of service by NTCCC and the first initial of the first name and the first initial of the last name. Only the lab personnel and the provider are privy to the coded patient identifier.
- f. A separate charge ticket is issued for all HIV tests.

- g. NTCCC asks the patient if he or she wants this information to be kept undisclosed to his or her insurance company and document the patient's request in the medical chart.
 - h. The patient is advised that for test results to remain undisclosed to the payer, he or she must pay for the test at the time of service. If the test is to be billed to the insurance company, the patient must sign the charge ticket reflecting his or her consent to allow NTCCC to bill for the service.
2. Receipt and notification of results
- a. Upon receipt of the results, lab personnel notify the provider. If the results are positive, the provider attempts to contact the patient directly (during a follow-up visit whenever possible) to communicate the results and provide appropriate counseling or referral. The results are marked to indicate that they have been reviewed. When the patient is informed, the results are marked to indicate that the patient has been notified.
 - b. The identity of the individual tested and the results of any HIV test are confidential and cannot be disclosed except to:
 - i. The patient receiving the test or a legally authorized representative;
 - ii. Another organization providing health care and its authorized employees or agents who are involved in treating the patient and need to know such results for clinical purposes;
 - iii. The (state) department of public health in accordance with the rules of reporting and controlling the spread of disease as otherwise provided by state law;
 - iv. A patient's insurance company, if the patient has consented to submit data to receive third-party reimbursement as noted above;
 - v. A person allowed access to that information in accordance with a court order;
 - vi. Release protected health information as indicated in a written, signed HIPAA-compliant authorization that specifically allows the release of HIV information; and
 - vii. As otherwise required or permitted by law to protect the health and well-being of the patient and/or other third parties.

INFORMED CONSENT TO PERFORM HIV TESTING

My health care provider has answered any questions I have regarding human immunodeficiency virus (HIV) testing and has given me written information with the following details about HIV testing:

- HIV is the virus that causes AIDS (Autoimmune Deficiency Syndrome).
- The only way to know you have HIV is to be tested.
- HIV testing is important for your health, especially for pregnant women.
- HIV testing is voluntary. Consent can be withdrawn at any time.
- Several testing options are available, including anonymous and confidential.
- State law may protect (confirm the law in your state) the confidentiality of test results and also protects test subjects from discrimination based on HIV status.
- My health care provider will talk with me about notifying my sex or needle-sharing partners of possible exposure, if I test positive.

I agree to test for the diagnosis of HIV infection. If I am found to have HIV, I may agree to additional testing which may occur on the sample I provided today to determine the best treatment for me. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

Signature: _____ Date: _____
(Test subject or legally authorized representative)

If legal representative, indicate relationship to subject:

Printed Name: _____

Medical Record #: _____

CERTIFICATION

I certify that the named person above has been given an opportunity to read written information about HIV, ask questions and that he or she understands the issues presented, that his or her decision to undergo HIV testing is an informed and voluntary one, and that I have witnessed his or her signature.

Signature: _____ Date: _____
(Health care provider)

Printed Name: _____

5.5: CONSENT FOR TREATMENT

PROCEDURE:

Before a patient evaluation and treatment is provided, consent must be obtained from the appropriate person according to the laws governing the state.

PROCEDURE:

1. NTCCC must comply with the following guidelines:
 - a. All adults, ages 18 years and older, must sign an authorization-to-treat at time of registration;
 - b. All patients evaluated and treated for a work-related injury or illness must have a workman's comp authorization from the employer or the employer's designee; with a new injury, the provider must complete the initial Workman's Comp paperwork. This paperwork is provided to the billing department and a copy is given to the patient to submit to their employer
 - c. Consent to treat minors (younger than 18 years old) must be obtained.
2. The provider must document informed consent in the medical record and/or on the informed consent form for special procedures.
3. The patient is informed in the following ways:
 - a. Information about the diagnosis;
 - b. The nature and purpose of the proposed treatment;
 - c. The known risks and consequences of the proposed treatment;
 - d. The benefits to be expected from the proposed treatment, with an assessment of the likelihood that the benefits can be realized;
 - e. All alternative treatment modes that might reasonably be applied; and
 - f. The prognosis if no treatment is given.
 - g. The patient can either give informed consent or decline the procedure offered.
4. Providers must obtain informed consent for the following:
 - a. Procedures in which anesthesia is used, except in cases when local infiltration is used in repairing wounds incurred outside of NTCCC;
 - b. Nonsurgical procedures, including the administration of medicines and immunizations that involve more than a slight risk of harm to the patient or that may cause a change in the patient's body structure or scarring;
 - c. Repairs of facial wounds; and
 - d. Procedures, which have possible risk of infection or scarring.

5. Providers do not need to obtain consent or informed consent in the following situations:
 - a. Emergencies – when there is immediate risk of death or serious bodily harm;
 - b. Therapeutic privilege – when disclosure of the treatment would make the patient so ill, emotionally distraught, or psychologically damaged as to preclude rational decision or complicate or hinder the treatment;
6. Providers follow these guidelines in treating minors:
 - a. Minors may consent to or refuse any of the following tests regardless of parental decision:
 - i. Treatment for drug and alcohol abuse;
 - ii. Treatment for venereal disease: Treatment is confidential in the State of Alaska. The provider may not share this information without the minor's consent.
 - iii. HIV testing: If the minor is under the age of 16 or not emancipated, the provider may disclose the fact of consultation or treatment to the patient or legal guardian;
 - iv. Birth control or family planning;
 - v. Treatment for sexual assault: Prior to exam or treatment, the provider must make reasonable effort to notify the parent or legal guardian. If the person notified refuses to consent to treatment, the provider must report the refusal as medical neglect under the child abuse reporting laws.
 - vi. If there is a non-emergent minor medical issue that is not being addressed by the parent or guardian, the provider by law, may make a report to Office of Children's Services, if warranted.
 - vii. Treatment for mental health services: A minor 16 years of age or older may seek mental health services. An independent evaluation is required prior to hospitalization to determine whether admission is appropriate and is the least restrictive form of treatment.
 - b. Minors who can be treated as adults:
 - i. Emancipated minors: Emancipated minors are minors 16 years or older, living apart from parents or legal guardians, with or without consent, and who are managing their own financial affairs, regardless of source of income;
 - ii. Legally married minors;
 - iii. Minor parents of minor children may give consent for treatment of their children.

7. When faced with a parent who has refused appropriate medical care for his or her child, providers follow these guidelines:
 - a. If the condition from which the patient is suffering is not life threatening or likely to result in serious bodily harm, accept the parent's refusal of care;
 - b. If the child is likely to suffer death or serious bodily harm:
 - i. Contact the Office of Children's Services to request assistance in the matter; and
 - ii. Report the parent, regardless of the severity of the illness, if there is evidence of child abuse or neglect.
 - c. In both instances, complete documentation in the medical record of the parents' refusal to permit medical care and all the steps taken to secure care, then report the incident to the proper authorities.

SECTION 6: MEDICAL MANAGEMENT

6.1: MEDICATION REFILLS

Medication Refills: NTC will call in medication refills for patients who meet the following criteria:

1. Must be an NTC enrolled Tribal Member, non IHS spouses are not included.
2. Must be an **active** clinic user seen here within the last year.
3. Must have lived in the Ninilchik Tribal boundaries for at least one year.
4. Must be an Elder or individual with hearing or other cognitive challenge that inhibits the ability to call in refills to the Village Pharmacy.

We will no longer call in Village Pharmacy refills for those individuals who are not seen at the Ninilchik Community Clinic. This is a liability issue when our providers are not involved in your care and are asked to call in your refills, especially, if your outside provider has made changes to your medications. We are not notified of your current health status by your provider, therefore it is unsafe for us to continue this service.

If you would like to re-establish care with us then we would be more than happy to provide this service if you meet the above criteria.

6.2: PRESCRIPTION REFILLS

PURPOSE:

It is the policy of NTCCC to manage prescription requests and refills in a timely manner that is conducive to quality patient care and patient satisfaction.

NTCCC educates patients about its prescription policy. Prescriptions fall into two categories: (1) a request for an existing or new medication, for which there is no outstanding approval or refill, and (2) a refill, for which there is a standing approval already documented and available for dispensing by the pharmacy. Patients are encouraged to directly contact their pharmacy first to determine if a refill has been approved and to request dispensing accordingly. Patients are directed to NTCCC if no more refills are available and/or if the request is new.

PROCEDURES:

1. NTCCC schedules an appointment for a patient requesting a renewal of an existing medication if the patient has not been seen for a year. NTCCC schedules an appointment for a patient requesting a new medication. These requests for a new prescription or from a patient not seen for a year or longer are not honored over the telephone or by other means, unless approved by a provider.
2. The providers develop a list of written protocols for extending renewals. The written protocols include instructions regarding medical renewals, by name of medication and by patient condition. (A sample entry is shown below.) Each specialty is responsible for developing its protocols and reviewing the protocols annually, or sooner, in the case of a drug recall.
3. A trained clinical assistant manages the prescription renewal process. All patient requests are documented in the patient's medical record. The documentation includes detailed information about the medication, as well as the date and initials of the employee filling the request.
4. A provider reviews each request, whether it is filled by protocol or has to be reviewed, and signs his or her approval electronically or manually. When approved, pending prescriptions are transmitted to the pharmacy immediately. This process is consistent with the times outlined below.
5. NTCCC accepts renewal requests via its dedicated renewal telephone voicemail, fax, and secure web-based account. Morning requests are checked and processed by noon every day, and afternoon requests are checked by 5:00 p.m. every day.

Condition	Medication	Protocol
Acne	Tetracycline®, topicals, Differin®	May renew for 6 months
Allergy - nasal sprays	Flonase®, Nasacort®	May renew for 6 months
Allergy - antihistamines	Claritin®, Zyrtec®	Encourage nasal steroids check with provider

SECTION 7: MEDICAL RECORDS

7.1: CONFIDENTIALITY OF PATIENT INFORMATION

PURPOSE:

It is the policy of NTCCC to maintain the confidentiality of patient information and medical records and follow the rules set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All NTCCC employees are held accountable to this policy.

PROCEDURES:

All employees are fully informed about the following legal implications of maintaining patient confidentiality:

1. Unless sold to another entity, ownership of a physical record belongs to those (NTCCC) who make the record.
2. The patient owns the information.
3. The information recorded in medical records is legally required to be complete, accurate, and truthful in the eyes of the court.
4. Including copies of instructions given to the patient in his or her medical record is extremely important.
5. Some state statutes may exempt provider office notes as information to be shared with the patient. This information is released during a liability suit. Thus, it is best to record only objective observations and not subjective opinions.
6. The right of confidentiality belongs to the patient, not the provider. Violation can lead to civil rights and criminal prosecution.
7. Incident reports are not considered part of a medical record and are not subject to confidentiality.
8. The only time records are required to be released is when a court order is received or a patient requests records, unless the patient has signed a release. Again, only a summary of the physician notes, along with copies of lab results, X-rays, and other procedures or tests are necessary to fulfill this request for release of records.
9. The patient's right to confidentiality binds the provider.
10. Subpoenas for records require duty to resist the release of records, as only a court order can force release of records. However, search warrants can result in confiscation of records.
11. Patient consent for release of records carries as much power as a court order, and both carry more power than the subpoena.
12. Always be sure the patient realizes what he or she is releasing before signing a medical release form.

13. When a patient receives a medical excuse from work, the provider is able to give medical information regarding that excuse to the employer (i.e., the provider cannot be requested to tell only a portion of the diagnosis).
14. Duty to warn a third party of imminent danger allows breach of confidentiality (e.g., the State Department of Health may breach confidentiality in cases of AIDS).
15. Foster parents must have legal, not just physical, custody to consent to treatment or release of records.
16. Patient requests for information must be satisfied within 30 days of the request, or, if the records are not on site, within 60 days.
17. Records are provided in the format the patient requests, as a readable hard copy, for example, or another format agreed to by the patient.
18. If the patient is alert, ask him or her before releasing confidential information to his or her family. Otherwise, physicians can use professional judgment and decide to release information, but only whatever is relevant for the patient's care.

7.2: MEDICAL RECORDS DOCUMENTATION

PURPOSE:

It is the policy of NTCCC to use standards for documentation applicable to all providers entering data into a patient's health record.

1. Definition of documentation and why it is important
 - a. Documentation is the recording of pertinent facts and observations about an individual's health and medical history, including past and present illnesses, tests, treatments, and outcomes.
 - b. A medical record chronologically documents the care of the patient to:
 - i. Enable providers and other health care professionals to plan and evaluate the patient's treatment;
 - ii. Enhance communications and promote continuity of care among providers and other health care professionals involved in the patient's care;
 - iii. Facilitate claims review and payment;
 - iv. Assist in utilization review and quality of care evaluations;
 - v. Reduce hassles related to medical review;
 - vi. Provide clinical data for education; and
 - vii. Serve as a legal document to verify the care provided (e.g., in defense of an alleged professional liability claim).
2. When entering data into a medical record, providers follow these principles of documentation:
 - a. The medical record is complete and legible (when completing paper chart).
 - b. The documentation of each patient encounter includes:
 - i. Patient demographics
 - ii. The date;
 - iii. The reason for the encounter;
 - iv. Appropriate history and physical exam;
 - v. Review of lab, X-ray data, and other ancillary services, where appropriate;
 - vi. Assessment; and
 - vii. Plan for care (including discharge plan, if appropriate).
 - c. Past and present diagnoses are accessible to the treating and/or consulting provider.
 - d. The reasons for and results of X-rays, lab tests, and other ancillary services are documented and included.
 - e. Relevant health risk factors are identified.

- f. The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient noncompliance are documented.
 - g. The written plan for care includes, when appropriate:
 - i. Treatments and medications, specifying frequency and dosage;
 - ii. Any referrals and consultations;
 - iii. Patient/family education; and
 - iv. Specific instructions for follow-up.
 - v. Health Maintenance Record complete.
 - h. The documentation supports the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision-making.
 - i. All entries to the medical record are dated and authenticated.
 - j. The procedures and diagnosis codes reported on health insurance claim form or billing statement reflect the documentation in medical record.
3. Documentation in a patient's record must answer the following questions:
- a. Is the reason for the patient encounter documented in the medical record?
 - b. Are all services that were provided documented?
 - c. Does the medical record clearly explain why support services, procedures, and supplies were provided?
 - d. Is assessment of the patient's condition apparent in the medical record?
 - e. Does the medical record contain information on the patient's progress and on the results of treatment?
 - f. Does the medical record include the patient's plan for care?
 - g. Does the information in the medical record describing the patient's condition provide reasonable medical rationale for the services and the choice of setting that are to be billed?
 - h. Does the information in the medical record support the care given in the instance that another health care professional must assume care or perform medical review?
 - i. Does the electronic health record meet Meaningful Use Criteria, as specified according to the CMS guidelines.

7.3: COURT ORDERS/OFFICE OF CHILDREN'S SERVICES FOR RANDOM URINE ALCOHOL AND DRUG TESTS

PURPOSE:

It is the policy of NTCCC to comply with all court orders for ASAP (Alcohol Safety Action Program) and (OCS) Office of Children's Services urine and drug tests per orders.

PROCEDURE:

1. All court ordered and OCS ordered urine alcohol and drug screens will be performed by the clinical staff and recorded in the electronic medical record. A signed release of information will be obtained from the patient/client to record in the electronic health record and that the results will be shared with behavioral health and ordering entity.
2. All alcohol/drug test results will be given to the appropriate entity requesting, (this should include the court, the lawyer, probation officer and OCS case manager).

7.4: SUBPOENA COMPLIANCE

PURPOSE:

It is the policy of NTCCC to cooperate with civil authorities and to comply with state and federal laws regarding subpoenas for clinical or administrative records.

PROCEDURE:

1. NTCCC staff process all subpoenas served for medical records within the time constraints demanded.
2. A copy of the requested medical records and the subpoena is then forwarded to the Tribal Health Director or Executive Director for review and delivery to the designated place.
3. Any time there is a question about the subpoena and appropriate release of documents, the subpoena is faxed to the Tribal Health Director or Executive Director for review prior to processing.
4. All subpoenas for any other type of records or for personal testimony of individuals are forwarded to the Tribal Health Director or Executive Director, who determines the parties responsible for follow up.
5. All NTCCC providers involved in the care of a patient whose records have been subpoenaed are notified of the subpoena request.
6. As deemed necessary, the Tribal Health Director or Executive Director notifies all other personnel.

SECTION 8: COMPLIANCE RISK

8.1: COMPLIANCE

PURPOSE:

It is the policy of NTCCC to strive to fully comply with all rules and regulations governing the health care industry. NTCCC is committed to complying with all federal, state, and local laws and regulations, including compliance with all licensure laws and regulations. In its pursuit of this compliance, NTCCC is guided by applicable standards of legal and ethical conduct.

NTCCC does not knowingly engage in any illegal business practices. Contractual and financial arrangements with providers, vendors, or referral sources are structured to enhance compliance with applicable federal and state laws and regulations. This reinforces the standards of ethical behavior by the NTCCC, and serves the best interests of our patients.

NTCCC makes best efforts to ensure that all drugs or other controlled substances used in the treatment of patients are maintained, dispensed, and transported in conformity with all applicable laws and regulations.

NTCCC does not knowingly take any action that is in violation of any statute, rule, or regulation.

PROCEDURES:

1. NTCCC maintains an open line of communication for every employee and encourages every employee to communicate with a member of NTCCC management regarding any legal or ethical concerns.
2. No employee is penalized or receives retribution as a result of identifying any action or issue that raises compliance concerns about NTCCC.
3. Every employee may communicate compliance concerns either to his or her supervisor or to NTCCC'S designated compliance representative.

8.2: QUALITY ASSURANCE

PURPOSE:

It is the policy of NTCCC to provide quality patient care. NTCCC establishes and implements a monitoring system that identifies opportunities to improve quality throughout the organization. This is accomplished through a quality assurance work plan that addresses the following tasks:

- Identifying quality issues;
- Assessing the cause, scope, and impact of each quality issue;
- Evaluating each quality issue;
- Determining alternative solutions;
- Implementing the best solution; and
- Monitoring progress.

The objectives of the policy are to promote and improve the quality of care by:

- Coordinating patient care;
- Establishing criteria and standards to assess quality;
- Maintaining timely, regular evaluation of providers;
- Monitoring the progress of the quality initiatives; and
- Reporting activities to the board of directors and the Administrator or designee at least annually to demonstrate that quality management objectives are being met.

Effective quality assurance is accomplished through the creation of a quality assurance (QA) committee. This body creates, evaluates, implements, and monitors the quality assurance policy of NTCCC.

PROCEDURES:

1. **The quality assurance committee** applies to all NTCCC employees who provide patient services and care.
2. **Quality assurance committee**
 - a. The quality management committee is authorized by the board of directors to assess and improve quality. Quality assurance committee members are:
 - i. One provider;
 - ii. One Board member;
 - iii. The Tribal Health Director
 - iv. The Executive Director
 - v. Clinic Special Projects Coordinator
 - vi. Other individuals invited by any committee member to attend (nonvoting).
 - b. The Tribal Health Director is responsible for overseeing the implementation of all policies.

- c. The quality assurance committee has the following responsibilities:
 - i. Determines medical necessity and ensures delivery of the appropriate level of care;
 - ii. In conjunction with the provider, monitors and evaluates patient services and care;
 - iii. Identifies and addresses problems;
 - iv. Provides appropriate feedback to providers;
 - v. Serves a two-year term; and
 - vi. Meets quarterly and as deemed necessary by the chair.
 - d. Minutes and reports
 - i. Prepares and maintains complete and accurate minutes from each meeting, including date and duration, attendance, problems encountered, follow-ups initiated, and any decisions/recommendations with reports and data that substantiate decisions.
 - ii. Regular reports include:
 - 1) Monitoring and quality control initiatives;
 - 2) Problem identification;
 - 3) Studies in progress;
 - 4) Problems resolved informally; and
 - 5) Complaint and grievance resolution.
- 3. Statement of confidentiality**
- a. All individuals and guests of the quality assurance committee must maintain confidentiality of all related information.
 - b. Although the procedures and minutes of the committee are open to state and federal regulatory review as required by law, they are closed to those persons not residing on the committee.
- 4. Conflict of interest**
- a. No provider may participate in the evaluation or review of anything in which he or she has been professionally involved or in which his or her judgment may be compromised.
 - b. In the case of an extenuating circumstance, such as a mortality that is likely to result in a malpractice case against the provider, the provider's malpractice carrier is consulted.
- 5. Organizational communication**
- a. Committee conclusions, rationales, decisions, and policies are appropriately summarized and distributed to NTCCC's employees, during clinic staff meeting and to the Board of Directors during Council meetings.
 - b. Communicating that the providers create utilization review policy reduces resistance to change and imparts a positive corporate culture.

8.3: RISK MANAGEMENT

PURPOSE:

It is the policy of NTCCC to minimize its business risk by consistently applying ethical decisions and actions to NTCCC operations. The risk management program adopted by NTCCC QA Committee, applies to all departments within NTCCC.

PROCEDURES:

1. Every patient has the right to refuse care. If a patient refuses the care recommended by the attending provider, the following is documented in the patient's clinical record:
 - a. Patient's condition and medical necessity;
 - b. The treatment plan recommended;
 - c. The patient's refusal to accept and follow the recommended treatment plan and possible consequences of refusal; and
 - d. Measures to secure alternative treatment, if applicable.
2. Patient, visitor, and employee safety are monitored closely, with efforts to eliminate any potential for harm.
 - a. All incident reports of patient, visitor, and employee injuries are reported and reviewed by the Tribal Health Director and forwarded to the Chief Financial Officer (CFO).
3. A periodic review of all litigation proceedings that may affect and/or involve NTCCC, its staff, and/or health care providers is conducted through the quarterly QA committee meetings.
4. A review of all deaths, trauma, or adverse events occurring on site is conducted through a NTCCC-designated quality assurance committee.
5. Patient satisfaction and complaints are addressed through the patient satisfaction survey information, patient advocacy program and referred to NTCCC'S quality assurance committee.
6. Any information requested in writing from governmental agencies, attorneys, consumer advocate groups, reporters, and other media are provided after review and advisement of the Executive Director.
7. All communications and relationships entered into with organizations, such as third-party payers, competing health care organizations, hospitals, and other entities outside of NTCCC are handled in a professional and courteous manner in compliance with all local, state, and federal regulations.

8.4: PATIENT ADVOCACY PROGRAM

PURPOSE:

It is the policy of NTCCC that all patients are provided a process by which they can present questions, concerns, and grievances about NTCCC. All patient concerns receive a timely and professional response.

PROCEDURES:

1. The Tribal Health Director is the designated patient advocate.
 - a. The patient advocate records and tracks each complaint on the Patient Advocate Report form (see below) to ensure resolution and patient satisfaction.
 - b. Patient advocate report forms should be reviewed on a weekly basis.
2. Any patient who has a specific question, complaint, or need that cannot be met by the department handling that patient, is referred to the patient advocate.
3. Nature of complaints
 - a. Staff members should respond to any patients' questions they can answer that are not complaints.
 - b. Complaints can be related to:
 - i. Quality and accessibility of medical care in the NTCCC office;
 - ii. Service within the office, which may include billing; and
 - iii. Questions or concerns regarding the patient's medical office visit.
4. Questions or concerns strictly relating to the quality of the medical care of any provider or clinical assistant are immediately referred to the Tribal Health director.
5. Concerns strictly related to billing are referred to the billing office.
6. Complaints about staff members are handled and reviewed by the Tribal Health Director and that particular staff member's direct supervisor.
7. Every attempt is made to respond to patients with complaints within 48 hours, and, if applicable, a follow-up letter is sent within one week.
8. Patient advocate quarterly report
 - a. A monthly report of all complaints is recorded using the Patient Advocate Quarterly Report (see below).
 - b. A copy of each complaint accompanies this form.
 - c. NTCCC'S Board of Directors reviews the report on a quarterly basis.

PATIENT ADVOCATE REPORT

Date: _____

Patient/Person Involved: _____

Location: _____

Address: _____

Phone Number: (Home) _____ (Work) _____

City/State/ZIP: _____

Source: Patient Visit Call-In Mail E-mail

Date Patient Seen: _____ Account No.: _____

Please check all that apply by marking an "X" in the left column:

X	SUBJECT:	SPECIFICS:
	Provider	
	Clerical Staff	
	Clinical Staff	
	Referral network	
	Access –office hours	
	Access-Appointments	
	Access-Follow-ups	
	Access Phone Responses	
	Waiting Time to next available appointment	
	Waiting Time in Office	
	Billing	
	Other	

Response: _____

Resolution? Yes No Date: _____

Patient Satisfied: Yes No

Forwarded to : _____ Date: _____

Patient Advocate: Janet Mullen

PATIENT ADVOCATE QUARTERLY REPORT

Date: _____

NTCCC _____ NTC Annex _____ Behavioral Health _____

SUBJECT	J	F	M	A	M	J	J	A	S	O	N	D	TOTAL
Provider	0	0	0	0	0								0
Clerical Staff	0	0	0	0	0								0
Clinical Staff	0	0	0	0	0								0
Referral Network	0	0	0	0	0								0
Access – office hours	0	0	0	0	0								0
Access - appointments	0	0	0	0	0								0
Access – follow-ups	0	0	0	0	0								0
Access – phone response	0	0	0	0	0								0
Waiting time to next available appointment	0	0	0	0	0								0
Waiting time in office	0	0	0	0	0								0
Billing	0	0	0	0	0								0
Other	0	0	0	0	0								0
OVERALL TOTAL	0	0	0	0	0								0

Comments:

8.5: PATIENT SATISFACTION SURVEY

PURPOSE:

It is the policy of NTCCC to conduct annual patient satisfaction surveys at least twice a year to maintain a commitment to excellence.

PROCEDURES:

1. A designated Patient Service Satisfaction Questionnaire will be used to monitor the quality and efficacy of patient services.
2. The Tribal Health Director collates the results of the survey and provides a summary to the Board of Directors.
3. The Tribal Health Director produces a corrective action report or commendation strategy for any deficiencies/positive results noted on the report.
4. The Tribal Health Director summarizes all commendation communications and distributes a list of strategies which increase patient satisfaction to all sites.

8.6: PRACTICE REVIEW FOR (CLIA & CARF) ACCREDITATION

PURPOSE:

It is the policy of NTCCC to maintain current status with applicable accrediting bodies for the Clinical Laboratories Improvement Amendments (CLIA) and Commission on Accreditation of Rehabilitation Facilities (CARF).

PROCEDURES:

1. NTCCC conducts an operational review of the Strategic Plan (for CARF) and quarterly reviews for (CLIA) and (CARF) in accordance with the requirements of each of the accrediting bodies.
2. The requirements of the accrediting body are used as the standards during each site operational review.
3. The CARF committee is the governing body for the operation review, and is responsible for ensuring compliance and that appropriate standards are being met per requirements, based on site reviews, and that related policies and procedures follow the accrediting body's requirements.
4. The Tribal Health Director, with the assistance of the Laboratory staff (this includes medical oversight through South Peninsula Hospital) and the Behavioral Health staff, performs the operational assessment of NTCCC site in accordance with the requirements of the accrediting body.
5. The Tribal Health Director may request an additional annual operational effectiveness assessment that includes evaluations of office safety, patient satisfaction, Incident report and follow-up, medical chart review and documentation, compliance with CARF/CLIA standards, and internal control compliance.

SECTION 9: EXPOSURE CONTROL

9.1: HANDWASHING

PURPOSE:

It is the policy of NTCCC to use proper handwashing technique, as the single most important means of controlling the spread of infection and minimizing any effects of chemical contact with skin.

PROCEDURES:

1. Hands are washed properly at the beginning and end of each shift.
2. Hands are washed before and after any patient and specimen contact, whether or not gloves are used.
3. Hands are washed before and after eating or using the lavatory.
4. Hands are washed after nose blowing, sneezing, coughing, or any other activity that could cause infection in others.
5. Hands are washed immediately after skin contact with a chemical.
6. Proper handwashing techniques are:
 - a. Using a paper towel to turn on the faucet;
 - b. Disposing of the paper towel in a proper container;
 - c. Wetting hands under warm running water;
 - d. Soaping hands vigorously for at least ten seconds;
 - e. Rinsing hands well under warm running water and making sure fingertips are pointed down into the sink so that the water runs from the wrists toward the fingertips;
 - f. Drying hands well with a paper towel; and
 - g. Turning off the faucet with a paper towel before discarding the paper towel in a designated container
7. OSHA approved hand sanitizers may be used between patients and when hands are not visibly soiled.

9.2: UNIVERSAL PRECAUTIONS

PURPOSE:

It is the policy of NTCCC that all blood and body fluids from every person are considered potentially infectious. NTCCC takes all precautions to ensure that infections do not occur.

PROCEDURES:

1. Blood and body fluid precautions are used with every patient and specimen. In addition, disease-specific precautions are used as indicated. (see related policy on exposure control plan for further instructions.)
2. Gloves are worn when touching blood, body fluids, mucous membranes, and non-intact skin of all patients. Gloves are also worn for handling items on surfaces soiled with blood or body fluids and performing venipuncture or other vascular access procedures.
3. Hands are washed before and after each patient contact. If gloves are used, they are changed between each patient contact. Hand sanitizers may be used when hands are not visibly soiled.
4. Masks, protective goggles, and gowns are worn during procedures likely to generate droplets of blood or airborne particles.
5. Hands or other skin surfaces are washed with soap and warm water immediately if contaminated with blood or body fluids. All blood or body fluid spills are cleaned up immediately. An appropriate disinfectant as well as gloves are used. Clean-up material is handled as hazardous waste and disposed of accordingly.
6. Sharps are handled with great care to avoid contamination. Needles are disposed of in labeled, puncture-resistant biohazardous containers (see related policy on needlesticks and sharps.)
7. Mouthpieces, resuscitation bags, or other ventilation devices are available for use for emergency mouth-to-mouth resuscitation.
8. Employees do not eat, drink, or handle contact lenses or make-up in laboratories and other work areas where blood or other potentially infectious materials are present. Food and drinks are not stored in refrigerators, freezers, cabinets, or other areas where blood or other potentially infectious material may be located.
9. Employees with oxidative lesions or weeping dermatitis refrain from all direct patient care and equipment handling until the condition resolves.

9.3: CLEANING AND DECONTAMINATION

PURPOSE:

To ensure appropriate levels of cleanliness and infection control, it is the policy of NTCCC to prevent contamination. In the event that a contamination occurs, the NTCCC maintains a consistent protocol to avoid or control the negative impact of a contamination.

PROCEDURES:

1. Surfaces in all exam rooms are washed with disinfectant after every patient. A provider or a clinical assistant washes surfaces after any procedures where contamination is possible. Clinical assistants clean blood spills promptly with a disinfectant solution. Household bleach is an effective disinfectant and can be used in a 10-percent solution to clean up spills. Other germicides within NTCCC can also be used.
2. Worksites at NTCCC are maintained in a clean and sanitary condition. A written schedule for cleaning is available, outlining the method of cleaning or decontamination to be used for each situation.
3. Contaminated equipment is cleaned and decontaminated as necessary.
 - a. If such equipment must be shipped for service and cannot be completely decontaminated, appropriate parts are biohazard-labeled, and the equipment is sealed in a red color-coded or biohazard-labeled wrap before shipping.
 - b. Outer packaging is biohazard-labeled as well.
4. Contaminated instruments are cleaned and decontaminated or sterilized as necessary for use.
5. Contaminated employee's personal clothing is red bagged as soon as it is necessary for use.
 - a. It is then disinfected and washed in accordance with NTCCC's policy on contaminated laundry.
 - b. Extra clothes are provided to the employee by NTCCC at no cost to the employee.
6. Contaminated laundry is bagged as soon as it is removed.
 - a. Gloves or other protective equipment are worn when handling visibly contaminated laundry.
 - b. The contaminated once removed from the room can be taken directly to the washing machine.
 - c. Contaminated laundry is washed in-house, using a washer and dryer located in a designated area.

7. Contaminated surfaces are decontaminated with an appropriate disinfectant upon completion of procedures and at the end of every work shift.
8. Equipment that might become contaminated is inspected at the following interval(s) and is cleaned and decontaminated as necessary. Surfaces and equipment protected with plastic wrap, foil, or other non-absorbent materials are inspected frequently for contamination, and protective coverings are changed when they are found to be contaminated. The cleaning inspection schedule is:
 - a. Every day at start of day
9. Infectious or biohazardous (regulated) waste consists of liquid or semi-liquid blood or other potentially infectious materials; items contaminated with materials which could release them if compressed; items caked with dried blood or potentially infectious materials capable of releasing them if handled; contaminated sharps; and pathological and microbial waste containing blood or other potentially infectious materials. This waste is removed NTCCC according to local and state law:
 - a. Contaminated sharps are disposed of in closable, puncture-resistant, leak-resistant red or biohazard-labeled containers. These containers are disposed of when the manufacturer-placed indicator on the container is reached.
 - b. Other regulated waste, including disposable laundry and other personal protective equipment, is disposed of in closable, leak-resistant red or biohazard-labeled bags or containers. If outside contamination of this container occurs, it is placed in a second container that is closable, leak-resistant, and appropriately labeled.
10. Laundry equipment used to wash contaminated laundry is cleaned by running a load cycle with appropriate disinfectant on the following schedule:
 - a. When contamination is suspected
11. Waste cans and pails are inspected and decontaminated on a regular basis.

9.4: PERSONAL PROTECTIVE EQUIPMENT

PURPOSE:

It is the policy of NTCCC to provide personal protective equipment (PPE) for use by all employees with occupational exposure to potentially infectious materials.

PROCEDURES:

1. Employees are required to use this equipment when performing tasks that involve risk of exposure.
2. The following personal protective equipment is available at the Practice and provided free of charge. The use of PPE is mandatory.
 - a. Disposable gloves are available in appropriate sizes, and their use is mandatory for all employees in at-risk occupations or who perform tasks that may bring them in contact with potentially infectious materials. Hypoallergenic and powderless, non-latex types of gloves are included for all individuals.
 - b. If face or eye protection is necessary, the following types are provided:
 - i. Chin-length face shields
 - ii. Face masks and glasses with side shields
 - iii. Face masks and goggles, which must be worn together. When mouth must be covered, nose and eyes must also be covered.
 - c. If footwear or headwear is necessary, the following types are provided:
 - i. Shoe covers
 - ii. Surgical caps
 - d. The use of these PPE is mandatory. If protective clothing is necessary, the following types are provided:
 - i. Aprons
 - ii. Clinic jackets
 - iii. Gowns
 - iv. Laboratory coats
 - e. If respiratory equipment is necessary, the following types are provided:
 - i. Mouthpieces
 - ii. Resuscitation bags
 - iii. Other ventilation devices
 - f. Non-latex gloves are available for housekeeping staff and for all individuals involved in cleanup activities. Utility gloves are checked for cracks before each use, and are replaced as necessary.
3. Employees must remove all PPE as soon as possible after leaving their work area and place them in designated areas for storage, washing, decontamination, or

disposal. On rare occasions, employees may briefly decline to use personal protective equipment because, in their professional judgment, its use in that specific instance would prevent the delivery of health care or public safety services, or would pose an increased hazard to the safety of the employee or co-worker. When the employee makes this judgment, the circumstances are investigated to determine whether changes can be instituted to prevent such occurrences in the future.

4. A record is maintained regarding any failure to use PPE, using the Failure To Use Personal Protective Equipment Form (see below).

FAILURE TO USE PERSONAL PROTECTIVE EQUIPMENT

This form is used to document instances during which an employee declines to use personal protective equipment while performing a task that involves risk of exposure to potentially infectious materials.

On rare occasions, an employee may briefly decline to use personal protective equipment because, in his or her professional judgment, its use in that specific instance would prevent the delivery of health care or public safety services, or would pose an increased hazard to the safety of the employee or a co-worker.

Name: _____

Title: _____

Task Being Performed: _____

Reason Personal Protective Equipment Was Not Used:

Action Taken:

Recommendations for Future Policy:

Signature: _____

Date: _____

9.5: SHARPS AND NEEDLESTICKS

PURPOSE:

It is the policy of NTCCC to provide safe disposal by employees and nonemployees of used needles, syringes, and other “sharps” (scalpel blades, blood vials, used slides, glass vials and pipettes) in a container clearly identified for the purpose of storing hazardous waste until such time that it can safely be disposed. Safe disposal of sharps protects employees and others from injury and transmission of disease from contaminated materials.

Under the Bloodborne Pathogen Standard, an occupational exposure incident is defined as “a specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee’s duties.”

When such an incident occurs, certain follow-up activities are performed. These follow-up activities are provided by the employer at no cost to the employee and are conducted in a confidential manner.

PROCEDURES:

1. A sharps container that is puncture resistant, leak proof, and labeled and color-coded as bio-hazardous waste is located within easy access to any work area where procedures are performed (such as exam rooms, lab area, cast room, and treatment rooms).
2. All contaminated uncapped needles, syringes, and other sharps are discarded into a designated sharps bio-hazardous container immediately after use without recapping, bending, or cutting. Contaminated needles are not recapped unless medically necessary. In the rare event that recapping a contaminated needle is medically necessary, a one-handed technique or a mechanical device is used. In addition, no one is permitted to bend, shear, or break a contaminated needle or scalpel. Scalpel blades are removed using hemostats or needle holders. Bare or gloved hands do not touch the scalpel blade.
3. Bio-hazardous sharps containers are kept upright at all times. The lid is tightly sealed prior to removal of the container and removed when three-quarters full. The containers are closed prior to removal to prevent spillage or protrusion of contents during the disposal process. If there is any chance of leakage, the sharps container is placed in a second secure, closable, and leak-proof container that is labeled with a bio-hazardous sticker.
4. The sealed containers are placed in the designated bio-hazardous waste pick-up area. Bio-hazardous waste containers are removed from each site by a licensed biohazard disposal service and disposed of in a manner that complies with local and state regulations.
5. The old container is replaced with a new sharps disposal container at the time the old (full) one is removed.

6. Reusable containers are not opened, emptied, or cleaned manually in any manner that could expose employees, providers, or patients to sharps injury.
7. To the extent possible, needleless systems are provided and used as an alternative to needles for specified procedures, thereby reducing the risk of percutaneous injury involving contaminated sharps.
8. A formal exposure control plan is developed, implemented, and monitored by a designated safety officer. (See related policy on Exposure Control Plan.)
9. Input is solicited from employees responsible for direct patient care in the identification, evaluation, and selection of engineering and work practice controls.
10. An OSHA Sharps log is maintained of percutaneous injuries from contaminated sharps. All sharps injuries are documented in the OSHA sharps injury log that is maintained for five years from the date of exposure. Incidents requiring more than first aid are also documented in the OSHA Sharps log. All exposed employees are offered post-exposure and follow-up treatment according to the procedure prescribed by the U.S. Public Health Service.
11. An employee exposed to bloodborne pathogens via a needle stick incident immediately informs the safety officer. If that person is unavailable, the employee informs the highest-ranking employee present. Following a report of an exposure incident, NTCCC immediately makes available, at no cost to the employee, a confidential medical evaluation and follow-up.
12. After an incident, the safety officer uses the checklist for needle stick incident provided in the policy. In addition, the safety control officer uses the Safety Device Evaluation Form, the sharps injury log, and the Procedure for the Evaluation of Circumstances Surrounding Exposure Incidents Form (see below). He or she also offers a follow-up medical evaluation, which an employee may refuse by completing the Informed Refusal of Post-Exposure Medical Evaluation Form (see below).
13. The designated safety control officer conducts regular inspections using the Safety Device Evaluation Form provided in this policy to ensure the consistent use of effective safer medical devices and reduce the potential of exposure incidence involving a contaminated sharp.
14. The use of safer sharps is an integral part of the exposure control plan. These devices must conform with OSHA's criteria. NTCCC uses automatically retracting capillary puncture devices, plastic or coated capillary tubes, and selected safer needle devices.

CHECKLIST FOR NEEDLESTICK INCIDENT

- _____ Document all details of the incident (see Exposure Incident Report), including routes of exposure and circumstances under which the incident occurred.
- _____ Require that the employee sign a declination form if no follow-up is desired. If this is the case, stop here. Otherwise, continue with the rest of the checklist.
- _____ Identify the source individual unless the identification is not feasible or prohibited by law.
- _____ Obtain consent for an HIV blood test from the source individual, unless consent is not required by law and blood is already available
- _____ Collect a blood specimen if not already available from the source patient.
- _____ Obtain permission from the employee for baseline blood collection and storage or immediate testing.
- _____ Collect a blood specimen from the employee for immediate or future testing. (Blood may be stored up to 90 days if the employee does not want immediate testing. The employee may request testing within that 90 days.)
- _____ Choose—or let the employee choose—a licensed health care provider to perform the follow-up.
- _____ Send specimens to a licensed laboratory for testing for HBC and HIV with instructions to send reports only to that health care provider chosen to do the follow-up. If the source is known to be infected with HIV and HBV, that test does not need to be repeated.
- _____ Forward a copy of the detailed information concerning the incident to the selected health care provider. This information includes:
 - _____ A copy of the Bloodborne Pathogen Standard;
 - _____ A description of the employee’s duties as they relate to the incident;
 - _____ Documentation of the routes of exposure and the circumstances under which the exposure occurred;
 - _____ Results of the source individual’s blood testing, if available; and
 - _____ All medical records relevant to the appropriate treatment of the employee, including documentation of his or her vaccination status.
- _____ Offer a hepatitis B vaccination to the employee if this has not already been done. The health care provider is then responsible for informing the employee of the results, providing necessary prophylaxis and counseling, and for informing the Practice that this has been done.
- _____ Obtain the health care provider’s written opinion to the employee within 15 days of the incident.
- _____ Document summarized information.
- _____ Maintain all relative documentation for 30 years after the end of the employee’s employment.

EXPOSURE INCIDENT REPORT FORM

CONFIDENTIAL

Exposed Employee: _____ Date of Exposure: _____

Job Position: _____ Time of Exposure: _____

Department: _____ Date of Report: _____

Source Patient: _____

Procedure being performed: _____

Instrument being used: _____ Brand _____

Size: _____ Incident as described by exposed employee: _____

Was a safety device used? ____ Yes ____ No

If "yes," was the safety feature activated? ____ Yes ____ No

If a safety device was not used, could a safety device have prevented the injury? ____ Yes ____ No

Did the injury occur before or after activation of protective mechanism? ____ Before ____ After

If so, how?

Could any of the following controls have prevented the injury? If so, describe how.

Engineering Control _____

Administrative Control _____

Work Practice Control _____

Signed: _____ Date: _____
Exposed Employee

Safety Officer: _____ Date: _____

PROCEDURE FOR THE EVALUATION OF CIRCUMSTANCES SURROUNDING EXPOSURE INCIDENTS

Employee: _____

Injury: _____

What workplace condition, practice, or personal protective equipment contributed to the incident?

Describe corrective action required to prevent repeat of incident: _____

Have corrective measures been taken? Yes No

If no, why not?

If no, when will corrective measures be taken? _____

Was a company safety policy violated? Yes No

If yes, which policy? _____

Was employee aware of this policy? Yes No

Will a new safety policy have to be adopted? Yes No

If yes, describe the new policy and how it differs from existing policy.

INFORMED REFUSAL OF POST-EXPOSURE MEDICAL EVALUATION CONFIDENTIAL

I, _____, am employed by NTCCC. My employer has provided to me training regarding infection control and the risk of disease transmission in the medical office.

On _____, I was involved in an exposure incident when I (describe incident):

My employer has offered to provide follow-up medical evaluation for me in order to ensure that I have full knowledge of whether I have been exposed to or contracted an infectious disease from this incident.

However, I, of my own free will and volition, and despite my employer's offer, have elected not to have a medical evaluation. I have personal reasons for making this decision.

Signature of Exposed Employee:
Name (printed):

Address:

City/State/Zip:

Date:

Witnessed by: _____

Date: _____

Note: Maintain this record for duration of employment plus 30 years.

9.6: EXPOSURE CONTROL

PURPOSE:

It is the policy of NTCCC to adopt an exposure control plan to assist in complying with the Occupational Safety and Health Administration (OSHA) Regulations on bloodborne pathogens. It is used in conjunction with the complete standard, Title 29 Code of Federal Regulations, 1910.1030.

The intent of this policy is to provide guidance to NTCCC in meeting two goals:

- To protect health care workers from occupational exposure to bloodborne pathogens and other potentially infectious materials; and
- To protect patients from accidental exposure to blood and other potentially infectious materials in acute care facilities.

PROCEDURE:

NTCCC protects its workers through performing the following procedures:

1. Identifying which office procedures involve risk of exposure to biohazardous materials. The primary material is human blood, but the full list of fluids regulated by OSHA also includes semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between fluids.
2. Determining which job classifications and employees are responsible for performing the at-risk procedures identified.
3. Providing appropriate labels and signs identifying biohazardous materials, storage areas, shipping containers, etc.
4. Training employees initially and offering an annual refresher for all employees involved in at-risk activities, including providers and part-time or contract employees. The training includes the entire subject of protection against bloodborne pathogens, work practice controls, use of universal precautions, handling of biohazardous materials, proper disposal of sharps, decontamination procedures, and how to handle a post-exposure incident. NTCCC conducts and documents training annually.
5. Creating a safe working environment. Observing universal precautions to prevent contact with blood or other potentially infectious materials, always treating them as if they were all infectious for human immunodeficiency virus (HIV) and hepatitis B virus (HBV).
6. Providing engineering controls and work practices, such as handwashing facilities, sharps, disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered injury protections, and needleless systems in a form to establish and monitor Engineering Controls (see below).

7. Identifying and supplying staff with appropriate personal protective equipment, such as gloves, masks, gowns, and face protection.
8. Developing written cleaning procedures and schedules for cleaning and decontaminating work areas. Properly collect, handle, and dispose of all biohazardous waste in accordance with existing OSHA, Environmental Protection Agency (EPA), and local laws. Use biohazard warning labels and signs.
9. Offering free vaccination for hepatitis B to all current and new employees who perform at-risk tasks. Those who decline vaccination are required to sign a waiver. Use the Hepatitis B Vaccination Form and the Hepatitis B Declination Form (see below) for documentation.
10. Providing post-exposure evaluation and follow-up to all workers exposed to potentially biohazardous materials. See the Blood/Body Fluid Exposure Evaluation Form and the Source Patient information form.
11. Keeping confidential medical records on all employees having occupational exposure, both during employment and for at least 30 years after the end of employment.
12. Establishing a medical record for each employee having occupational exposure. Maintain this record for 30 years past the last date of employment. Keep the record confidential and separate from other personnel records. Keep the record on site and retained by the health care professional who provides services to employees concerning occupational exposure. The record contains:
 - a. Employee name.
 - b. Social security number.
 - c. Hepatitis B vaccination status, including dates of vaccination and the written opinion of the health care professional regarding the vaccination.
 - d. Reports documenting any occupational exposure incident, including results of any testing following the incident.
 - e. Post-evaluation opinion of the health care professional concerning an occupational exposure incident.
 - f. Documentation of any information provided to the health care provider regarding an occupational exposure incident.
13. Keeping complete written records of all compliance activities.
14. Developing a written plan for specific evaluation and follow-up procedures to be used when an exposure incident involving bloodborne pathogens has occurred with an employee.
15. Documenting all individuals receiving the training program on the Validating the Training Program Per OSHA Regulation Form provided in this policy.
16. Establishing a training record to document each training session conducted at NTCCC.

17. Providing employees with potential exposure training on blood borne pathogens (1) upon hire; (2) whenever a change of procedure or assignments results in a new potential for exposure to infectious body fluids; and (3) annually thereafter.
18. Maintaining this record for three years, which includes:
 - a. Trainer's name and qualifications;
 - b. Date(s) of training;
 - c. Content outline training; and
 - d. Names and job titles of all persons attending the training sessions.

ENGINEERING CONTROLS

The following engineering controls are present at the sites noted at NTCCC and are in use as of the recorded date. These controls are inspected and maintained on a

weekly bi-weekly monthly other _____ basis.

As new safer medical devices become available, they are evaluated by NTCCC.

Handwashing facilities are available at the following locations:

Where handwashing facilities are not available, antiseptic hand cleanser and clean towels or towelettes are available at the following locations:

Date: _____

Mechanical pipettes are available and in use at NTCCC, where necessary. Mouth pipetting or suctioning is prohibited.

Date: _____

Safer medical devices are continually evaluated at NTCCC, with records of such evaluations maintained at NTCCC at the following location:

Date: _____

Regulated (biohazardous) waste of the following types is generated by the activities at NTCCC:

- Any item containing blood or potentially infectious materials
- Any item soiled with blood or potentially infectious materials
- Bandages, gauze
- Paper towelettes
- Patient specimens
- Swabs
- Thermometers/covers
- Tongue depressors
- Used gloves
- Used sharps
- Other:

This waste is kept in red color-coded or biohazard-labeled closed containers that can contain all contents during handling, storage, and transport without leaking. Disposal is as follows:

Types of container(s) in use:

Date: _____

Sharp containers that are leak-resistant, puncture-resistant, red color-coded, or marked with appropriate labels are available at the following locations:

Types of container(s) in use:

All containers for reusable sharps in use at this location are designed to be emptied without risk to the person emptying them.

Date: _____

Specimens of blood or other potentially infectious materials are kept in leak-resistant containers during collection, handling, and storage. Types of container(s) in use:

When packages that contain specimens of blood or other potentially infectious materials are shipped, a biohazard label is attached to the outside of the package.

If a secondary outer container is necessary to protect against leakage, such a container is also appropriately biohazard-labeled.

Date: _____

Other engineering controls listed below are in use at NTCCC (e.g., hoods for specimen preparation, needle guards, etc.):

HEPATITIS B VACCINATION

Instructions:

Write the names of appropriate employees and the date they were offered vaccination. In the space provided, note employees who are exempt or who declined vaccination. All at-risk employees must be offered vaccination within 10 days of employment or assignment to non-risk activities. If you need more space, attach additional pages.

The following employees are employed in jobs that may involve contact with blood or other potentially infectious materials when not using personal protective equipment. These individuals have been offered an opportunity to receive hepatitis B vaccination, including necessary booster doses, at no charge. Their hepatitis B vaccination status is part of their confidential medical record.

Name Date

At-risk employees who have declined vaccination have signed an appropriate declination statement that is kept in the employee's confidential medical record.

HEPATITIS B VACCINATION DECLINATION FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Name:

Employee Signature:

Witness Signature:

Date :

SOURCE PATIENT INFORMATION FORM

Source patient known: _____ Yes _____ No

Medical Record #: _____ Date of birth: _____ Practice: _____

Attending Provider: _____

Diagnosis:

Source Risk Factors (as documented in medical records or patient interview)

Known HIV positive _____ Yes _____ No _____ Unknown

Known homosexual, bisexual, prostitute or sexual contact with same
_____ Yes _____ No _____ Unknown

Known IV drug user _____ Yes _____ No _____ Unknown

Received blood transfusion between 1977 and 1985
_____ Yes _____ No _____ Unknown

Received recent multiple transfusions
_____ Yes _____ No _____ Unknown

Currently taking Zidovudine (AZT), Lamiduvine (3TC) and/or Indinavir (IDV)
_____ Yes _____ No _____ Unknown

History of hepatitis B, past, present, or carrier _____ Yes _____ No _____ Unknown

History of hepatitis C, past, present, or carrier _____ Yes _____ No _____ Unknown

History of hemophilia, kidney dialysis, transplant _____ Yes _____ No _____ Unknown

Currently elevated liver enzymes _____ Yes _____ No _____ Unknown

Current fever, lymphadenopathy, rash, malaise, GI or neuro symptoms
_____ Yes _____ No _____ Unknown

Traveled outside the United States _____ Yes _____ No _____ Unknown

If yes, which countries _____

Signature of individual preparing form: _____

Date: _____

BLOOD/BODY FLUID EXPOSURE EVALUATION FORM

Name: _____ Date of Birth: _____
Employee #: _____ Department: _____
Job Title: _____ Work Phone _____ Home Phone: _____

INCIDENT

Date and time of exposure: _____ Location: _____
Date and time reported: _____

Description of incident:

Was exposure site washed or flushed? Yes: _____ No: _____

BODY SUBSTANCE INVOLVED

Check which of the following substances were involved in the incident:

- _____ Blood _____ Pericardial fluid _____ Synovial fluid _____ Amniotic fluid
- _____ Cerebrospinal fluid _____ Pleural fluid _____ Vaginal secretions
- _____ Peritoneal fluid _____ Body tissue _____ Semen
- _____ Other fluids containing visible blood

If any of the above substances are checked, provide information on the type of exposure below.

If none of the above substances are checked, no further follow-up is needed. In this case, please give this form to NTC's Tribal Health Director and instruct the employee to submit a Report of Employee Injury or Exposure form as soon as possible.

TYPE OF EXPOSURE

Check which of the following conditions were involved in the exposure:

- _____ Hollow bore needle _____ Solid (suture) needle _____ Splash to mucous membrane
- _____ Bite with obvious blood in saliva _____ Exposure to nonintact skin _____ Large or prolonged exposure to intact skin
- _____ Other sharp object containing visible blood or body fluids. Please describe: _____

Specific type and brand of device involved in the accident:

If any of the above conditions are checked, please provide this form to the employee and have them seek corresponding appropriate medical attention.

VALIDATING THE TRAINING PROGRAM PER OSHA REGULATION

The following individuals attended a training session based on bloodborne diseases; engineering controls; work practice controls; personal protective equipment; cleaning, decontamination, and disposal of biohazardous waste; the OSHA regulation; and NTCCC's Exposure Control Plan.

Name: _____
Job Description: _____

Trainer: _____

Title: _____

Date: _____

9.7: HAZARD COMMUNICATION

PURPOSE:

It is the policy of NTCCC to adopt a hazard communication program to inform employees of the hazards present in the workplace.

The written program addresses the four elements of the hazard communication standard: (1) identification of hazardous materials; (2) labeling; (3) material safety data sheets (MSDS); and (4) employee training.

A copy of the written program is available to all employees.

PROCEDURES:

NTCCC maintains an inventory of materials used. The site list of hazardous materials is organized by each work area: clinical areas, business office, laboratory, radiology, and housekeeping. The site uses information in material safety data sheets (MSDS) from manufacturers to determine which materials are hazardous and updates the inventory list of hazardous materials each year.

Manufacturers of hazardous materials must develop and distribute an MSDS for every hazardous product they sell. MSDS are designed to give employers and employees all the information necessary to use the material safely. Although MSDS may vary in structure from one manufacturer to another, they must contain the following sections:

Section I. Identification includes product name; manufacturer's name, address, phone number, and emergency phone number; the date of the MSDS; and the preparer's name.

Section II. Ingredients include name, permissible exposure limits, and percentage of ingredient for all hazardous ingredients in the product.

Section III. Physical characteristics: physical and chemical characteristics of the chemical, such as boiling point; vapor pressure; vapor density; melting point; evaporation rate; water solubility; appearance; and odor.

Section IV. Fire and explosion hazards include: flashpoint, flammable limits, extinguishing information, and special firefighting procedures.

Section V. Reactivity hazards include: stability; conditions to avoid; incompatibilities; and hazardous decomposition that can occur.

Section VI. Health hazard data includes: routes of entry, health hazards (acute and chronic), signs and symptoms of over exposure, carcinogenicity (cancer causing), medical conditions aggravated by exposure, and emergency first aid procedures.

Section VII. Precautions for safe handling and use include: spill procedures, waste disposal methods, and precautions for handling and storage.

Section VIII. Control measures include: personal protective wear, engineering controls, and hygienic work practices.

MSDS are available to all employees 24 hours per day.

All employees that use hazardous materials ensure proper labeling of containers of hazardous materials. All labels of hazardous materials contain the following information:

1. Product name;
2. Name and address of the manufacturer or supplier; and
3. Appropriate hazard warning.

A written, pictorial, or symbolic hazard warning is present to convey the hazards of the product in the container. Employee training includes information on how to interpret hazard warnings posted in NTCCC.

The manufacturer's label is used whenever possible to satisfy hazard communication labeling. The manufacturer's label must have at least the above information to serve as a proper label.

Generic adhesive labels serve as hazard communication labels if:

1. The manufacturer's label becomes illegible;
2. The manufacturer's label falls off;
3. The manufacturer's label is not adequate; or
4. The product is transferred to a container without a label.

NTCCC uses adhesive labels that adhere to the National Fire Protection Agency (NFPA) rating system to warn employees of product hazards. The MSDS provides information necessary to complete a label.

1. Labeling hazardous areas
 - a. NTCCC maintains hazardous material in an area ensure proper labeling of the area. Hazard warnings appear on doors of restricted areas. Restricted areas contain one of the following hazards:
 - i. Radiation;
 - ii. Chemical;
 - iii. Infectious agents; or
 - b. Some chemical storeroom doors and tanks display the NFPA hazard warning diamond.
 - c. Some areas of NTCCC are restricted due to the presence of a hazardous material or agent. Warning signs, such as "Biohazard," and "Radiation

- Hazard,” are posted on doors. Only authorized personnel should enter these areas.
- d. Written hazard warnings must contain a signal word to alert the employee of the seriousness of the hazard. Signal words ranking from most to least severe are:
 - i. DANGER
 - ii. WARNING
 - iii. CAUTION
 - e. Written hazard warnings also contain a brief description of the physical and health hazards of the product.
2. Employee training includes information on how to identify restricted areas.
 3. Notification of private contractors
 - a. NTCCC is responsible for disclosing all of the NTCCC-based chemical hazards that contractors may be exposed to during their normal work activities.
 - b. Private contractors are responsible for protecting themselves, their employees, and their subcontractors from disclosed hazards.
 4. Employee training
 - a. NTCCC employees receive hazard communication training:
 - i. Upon hire;
 - ii. When an employee receives a new assignment;
 - iii. When a new hazard is brought into the work area; and
 - iv. Before performing a non-routine task with hazardous materials.
 5. Orientation training follows NTCCC’s training guide. New hazard and non-routine task training is hazard specific.

9.8: HAZARD COMMUNICATION TRAINING

PURPOSE:

It is the policy of NTCCC to adhere to the Occupational Safety and Health Administration (OSHA) Hazard Communication Standard. This standard is also called the “Right to Know Standard,” stating that employees have the right to know the chemical hazards they encounter in the workplace and measures they can take to protect themselves from chemical hazards.

- OSHA requires employers to develop a Hazard Communication Program that includes:
 - Employee training
 - Product labels
 - Material safety data sheets (MSDS)

Employers must have a Written Hazard Communication Plan that describes how each of these is to be addressed. The Written Hazard Communication Plan is kept in the OSHA manual and is available for employee review.

NTCCC develops and uses a Hazard Communication Program. The material included in this training guide is covered during new employee orientation.

The components of the Hazard Communication Program follow:

PROCEDURES:

1. Categories of hazardous materials
 - a. According to the OSHA regulation, a chemical or material is hazardous if it exhibits at least one of the following three characteristics. Many hazardous materials exhibit more than one hazardous characteristic.
 - i. Flammable materials. These materials burn when ignited. The flammability of a liquid is determined by its flash point. The flash point is the temperature at which flammable liquids produce enough vapor to burn.
 - ii. The lower the flash point, the more flammable the liquid. Combustible materials are also included in this category. Combustibles must be heated before they will burn. Alcohol, nail polish remover, tincture of benzoin, collodion, and aurozoin are examples of flammable materials.
 - iii. Corrosive materials. These materials cause burns or tissue damage upon contact. They also cause damage to metal. Corrosives come in a variety of strengths and concentrations. Diluted or weak corrosives are called irritants, and are less dangerous than pure corrosive materials. Sodium hydroxide, hydrogen peroxide, acetic acid, formaldehyde, and glutaraldehyde are examples of corrosive materials.

- iv. Toxic materials. These materials cause clinical symptoms or disease when over-exposure occurs. Toxicity may be: 1) acute, meaning that the symptoms or disease occur immediately upon over-exposure; or 2) chronic, meaning that the symptoms or disease occur after long-term over-exposure. A symptom or chemical disease can only occur if there is:
 - (1) An exposure route such as ingestion, inhalation, skin absorption, or skin contact;
 - (2) A target organ such as the liver, nervous system, respiratory system, or skin; or
 - (3) An over-exposure that is above the permissible exposure limit. Permissible exposure limits are determined by OSHA based on the amount of a hazardous material to which a person can be safely exposed. Every hazardous material has an established exposure limit. Permissible exposure limits are given in units of parts per million (ppm). An exposure limit may be a time weighted average (TWA) of 8 hours, a short term limit (STEL) of 15 minutes, or a ceiling limit (highest allowable exposure).
 - b. The following guidelines can be used to interpret an exposure limit of chemicals:
 - i. Mildly toxic chemicals have exposure limits of 500 to 1,000 ppm;
 - ii. Moderately toxic chemicals have exposure limits of 50 to 500 ppm;
 - iii. Toxic chemicals have an exposure limit of 1 to 50 ppm; and
 - iv. Highly toxic chemicals have an exposure limit of less than 1 ppm. Phenol, methyl alcohol, formaldehyde, mercury, and chemotherapeutic agents are examples of toxic materials.
 - c. Reactive materials. These materials may explode or release toxic gases if heated or mixed with incompatible materials. One large group of reactive materials are oxidizers. Oxidizers act as if oxygen were being added to a fire and makes a fire more intense and difficult to extinguish. Silver nitrate, nitrous oxide, iodine, and chlorine are examples of reactives.
2. Procedures for safe handling
- a. The procedures for safe handling are as follows:
 - i. Flammable materials. When using flammable materials, limit the release of vapor and ignition sources. Safe work practices for flammable materials include:
 - (1) Eliminating ignition sources;
 - (2) Cleaning up spill quickly;
 - (3) Covering containers when not in use;
 - (4) Using flammables in well-ventilated areas;
 - (5) Storing materials in tightly sealed containers;

- (6) Storing flammables separate from oxidizers and corrosives; and
 - (7) Wearing gloves to protect hands. Prolonged skin contact with flammable liquids can cause drying and irritation. Wear goggles if splashing is likely. Some flammables are also toxic. Respiratory protection may be necessary if using a large volume of flammable liquid.
- ii. Corrosive materials. Many corrosives react violently when mixed with incompatible materials and also are destructive to metal. Safe handling procedures include:
- (1) Not mixing strong acids and bases, which react violently;
 - (2) Adding acid to water when diluting the acid, rather than adding water to acid;
 - (3) Storing corrosives in tight-fitting plastic containers;
 - (4) Storing containers of corrosives on the highest shelves possible;
 - (5) Flushing with water during drain disposal; and
 - (6) Cleaning up spills on metal surfaces quickly.
 - (7) Avoiding skin and eye contact, which may result in tissue damage or irritation. Wearing protective gloves and goggles or a face shield if splashing is likely. When using large volumes, boots and aprons may also be necessary to prevent skin exposure.
- iii. Toxic materials. Toxic materials are the largest group of hazardous materials. Overexposure is prevented by knowing the route of exposure of a toxic material and using appropriate engineering controls and personal protective wear. Safe handling procedures include:
- (1) Washing hands after handling toxic materials and before eating or smoking;
 - (2) Not eating in areas where toxic materials are used;
 - (3) Not storing food items in areas where toxic materials are used;
 - (4) Using adequate ventilation or a fume hood to avoid inhalation;
 - (5) Wearing a respirator to avoid inhalation of toxic materials;
 - (6) Wearing gloves, goggles, a face shield, boots, and an apron to avoid skin contact and skin absorption; and
 - (7) Checking the material safety data sheet for routes of exposure, target organs, exposure limits and appropriate protective devices for a specific toxic material.
- iv. Reactive materials. Exposure to incompatible substances, heat, or shock may produce a violent reaction. Safe handling procedures include:

- (1) Checking for incompatibilities on the MSDS before mixing products;
 - (2) Storing incompatible materials separately;
 - (3) Storing containers in a cool dry place in sealed containers;
 - (4) Preventing contact between oxidizers and combustible materials;
 - (5) Separating flammables/oxidizers during storage; and
 - (6) Securing pressurized gas cylinders to prevent tipping.
- v. Many reactive materials may also be toxic or corrosive. Read the MSDS and take the appropriate precautions.
3. First-aid procedures
 - a. Administer first-aid procedures immediately upon exposure to hazardous materials. Specific first-aid procedures are available in the MSDS for each product. General first-aid procedures are as follows:
 4. Skin and eye contact. Following exposure to the eye, hold eyelids open while flushing the eyes with water. Flush the affected area with large amounts of water for at least 15 minutes. Seek medical treatment if irritation or pain develops.
 5. Inhalation. Move to fresh air if experiencing symptoms. Move the exposed employee to fresh air and give artificial respiration if s/he is not breathing. Seek medical attention.
 6. Ingestion. Check MSDS before inducing vomiting. Dilute the ingestion by taking one or two glasses of water. Seek medical treatment.
 7. Spill. Upon discovering a spill of a hazardous material, perform the following:
 - a. Remove patients, visitors, and employees from the immediate spill site;
 - b. Report the spills of mercury, chemotherapeutic agents, or small volumes (less than one gallon) of moderately hazardous materials (such as alcohol, acetone, and hydrogen peroxide) to the Safety Officer, Tribal Health Director, and the Executive Director.
 - c. Report all spills of highly hazardous materials and large spills (over one gallon) of moderately hazardous materials to the Safety Officer, Tribal Health Director, and the Executive Director.

9.9: TUBERCULOSIS TESTING

PURPOSE:

It is the policy of NTCCC that each employee has an appropriate screening test for tuberculosis. This is accomplished by a chest X-ray or a purified protein derivative (PPD) skin test within the first seven days of employment.

PROCEDURES:

1. NTCCC makes PPD tests available to every employee (new and current) at no cost to the employee.
2. Each employee should be aware that if he or she has a positive reaction, since the last PPD, he or she is required to go see a medical provider for a chest X-ray (if completed at NTC, no cost). If the x-ray shows active TB then a sputum sample should be provided and if this too shows active TB, the staff person will be referred to Public Health for follow-up and treatment.
3. An annual test is required.
4. The employee must sign a tuberculosis (TB) test form.
5. Each employee must make arrangements to have an X-ray or PPD test. If one has been done in the past nine months, the employee must supply written evidence that it has been done and provide documented results.
6. Anyone who tests positive on their (TST) Tuberculin skin test but who has a negative x-ray will then be required to have a chest x-ray every 5 years and continue to have a TST yearly.

TUBERCULOSIS TEST FORM

I hereby request that I be given a PPD test through NTCCC in order to meet the state public health requirements of a screening test for tuberculosis. I understand that NTCCC assumes no liability for this test and that if I have a positive reaction, I will consult my primary care physician.

Date: _____

(Employee's Signature)

(Employee's Printed Name)

Date of Birth: _____

Department: _____

Date Test Given: _____ Date Test Read: _____

Read by: _____

Results: _____ Negative _____ Positive Arm: _____ Left _____ Right

Lot No.: _____

SECTION 10: FACILITIES

10.1: FIRE CONTROL AND EVACUATION

PURPOSE:

It is the policy of NTCCC to conduct a fire drill or handle a fire in a manner that saves lives, prevents undue panic, and prevents the spread of fire. Each employee is aware of fire exits, fire extinguishers, fire zones, and the proper procedures for ensuring fire safety. All staff members are aware of the proper steps to be taken in the event of a fire. No employee should take any chance or action that may endanger his or her life; rather, the intent of this policy is to ensure the safety of both patients and staff.

PROCEDURES:

1. Training procedures and responsibilities

- a. Employees are thoroughly trained in the responsibilities and duties that could be required of them.
 - i. The Tribal Health Director or designee is responsible for ensuring that proper training of staff members takes place and is documented properly.
 - ii. Fire drills take place to simulate possible conditions and to evaluate the response of the staff.
 - iii. Fire drills take place at least quarterly each year.
 - iv. Appropriate in-services are held pertaining to fire safety.
- b. Employees are also trained to operate all fire-fighting equipment present in the office.
 - i. This training occurs during each employee's initial orientation and at least annually thereafter.
 - ii. Alarm and notification systems present in NTCCC are also part of this training process, with instruction occurring at initial orientation and each annual reorientation.

2. General procedures and responsibilities

- a. A fire is considered an uncontrolled flame and/or smoke.
 - i. In the event that a fire is discovered, employees shall be instructed to not shout "fire!"
 - ii. Employees stay calm and act quickly, following these "R-A-C-E" steps as simultaneously as possible:
 - (1) R – RESCUE:
 - Remove any patients or visitors from the immediate area.
 - (2) A – ALERT:
 - Activate the appropriate fire alarm.

- Notify the supervisor and/or Tribal Health Director or designee immediately.
 - Be prepared to name the location of the fire.
 - If unable to leave the vicinity of the fire, designate someone to make appropriate notifications.
 - The person who finds the fire, or the designee, calls 911 outlining:
 - (i) Location;
 - (ii) Extent of fire; and
 - (iii) Type of fire
 - The Tribal Health Director or designee is notified immediately.
 - (i) The Tribal Health Director or designee determines the need to evacuate the entire office and to notify the medical staff.
 - (ii) If the need to evacuate exists:
 - Announces a designated code (e.g., RED) for a fire three times consecutively over the public address system (if available), giving the location of the fire: “Code red, code red, code red.”
- (3) C – CONFINE
- If possible, close all doors and windows in the area of the fire and in successive areas leading out of the office, and shut off electricity to the area.
 - Confine the area.
 - Personnel not involved directly with fighting the fire evacuate patients and visitors from the immediate vicinity according to the fire escape plan map, which shows locations of fire extinguishers and clinic fire evacuation exits and is located throughout the facility.
- (4) E – EXTINGUISH
- If possible, and if it is safe to do so, attempt to extinguish or contain the fire using the appropriate equipment until the fire department arrives.

3. Specific procedures and responsibilities

- a. The Tribal Health Director or designee does the following:
 - i. Acts as the coordinator for fire procedures, evaluates evacuation needs, and supervises evacuation if necessary;
 - ii. Coordinates the closing of doors and windows;
 - iii. Disconnects utilities to the fire;
 - iv. Assists the fire department if needed;
 - v. Checks mechanical equipment;

- vi. Secures elevators if applicable;
 - vii. Assumes responsibility for:
 - (1) Safety of patients in the area;
 - (2) Sending personnel to area of need; and
 - (3) Keeping corridors and doorways clear.
 - viii. Secures the office;
 - ix. Designates the individual to report to alarm zone until the fire department arrives;
 - x. Notifies appropriate supervisory personnel;
 - xi. Secures business, personnel, and medical records, if possible; and
 - xii. After the fire is extinguished, completes an incident report, and forwards it to the Tribal Health Director or designee.
- b. Other personnel perform the following:
- i. Report to the designated area for instruction;
 - ii. Close doors and windows;
 - iii. Designate one employee to monitor the front entrance and ask visitors to remain in waiting areas;
 - iv. Reassure patients and family members;
 - v. Evacuate as directed;
 - vi. Remain calm;
 - vii. Secure business, personnel, and medical records, if possible; and
 - viii. A designated employee announces three times, after receiving notification from the Tribal Health Director or designee that the fire is under control: "All clear, code red, all clear, code red, all clear, code red."

4. Evacuation procedures, responsibilities, and duties

- a. The following list sets forth responsibilities and duties for the evacuation of personnel from the office in the event of fire or similar disaster:
 - i. The Tribal Health Director or designee:
 - (1) Orders the evacuation of the office;
 - (2) Personally directs or appoints an individual to direct the evacuation process;
 - (3) Conducts an accurate head count of all staff and patients in the designated assembly area;
 - (4) Ensures that at all times the safety of the staff and patients comes first in any decision-making process;
 - (5) Organizes available staff and volunteers not already involved with other duties;

- (6) Ensures that ambulatory patients are assisted to the degree warranted by a staff member to the designated assembly area; and
 - (7) Ensures that staff members transport non-ambulatory patients using the appropriate transportation equipment to the designated assembly area.
- ii. Other personnel:
- (1) Perform transportation or give assistance to patients or visitors as instructed;
 - (2) Keep patients and visitors being assisted moving quickly, but calmly;
 - (3) Stay with evacuated individuals in the designated assembly area unless instructed to assist with other responsibilities or procedures of containment;
 - (4) When outside, everyone congregates in the designated assembly area in order to take account of all persons;
 - (5) Sign-in and checkout sheets are compared at this time to track patient numbers; and
 - (6) No person is allowed to re-enter the facility until the fire officials have deemed it safe.

10.2: NATURAL DISASTER WARNING

PURPOSE:

It is the policy of NTCCC to be prepared for a natural disaster. When the National Weather Service posts a warning about an impending natural disaster, providers and staff secure and close the Clinic.

PROCEDURES:

1. When a natural disaster warning is posted for Ninilchik or Kenai Peninsula, NTCCC completes storm preparations within a minimum of 12 hours. Closely monitor weather and television for updates.
2. Prepare a list of emergency contacts for maintenance, telephone repair, computer, water, electric, and emergency services. Provide copies of this list to the Executive Director, the Tribal Health Director, supervisors, and providers.
3. Unplug and cover computers and other medical equipment. Raise them off the floor.
4. Set refrigerators and freezers to their coldest settings, clinic refrigerator on back-up generator.
5. Put medications and injectables in cold storage or watertight containers.
6. In the event that NTCCC does not maintain web-based back up, backup to jump drive or external hard drive any vital information and store in a secure location. Make extra backup jump/external hard drives and copy or scan important documents if time permits. Give jump/external hard drives to the Tribal Health Director and, at minimum, one provider to secure in their personal residences in the case of a loss of data at NTCCC.
7. Cancel patient appointments for the working days anticipated to be impacted by the natural disaster.
8. Lock cash in the fireproof locked cabinet. Raise the cabinet off the floor.
9. The Tribal Health Director or designee and providers keep call schedules and patient schedules, to include contact information, with them until such time NTCCC is fully operational.
10. Inventory medications and injectables in coolers for security purposes. The Tribal Health Director/designee and nurse case manager maintain the inventory.
11. Complete preparations for the storm (see policy on Natural Disaster Watch). Perform a visual walk-through to complete the checklist.
12. Put vital office documents in the safe, including:
 - a. Appointment lists;
 - b. Staff documents (name, addresses, and emergency contacts);
 - c. Accounts receivable not yet posted.

NATURAL DISASTER WARNING CHECKLIST

- _____ Computers and other medical equipment are unplugged, raised, and covered.
- _____ Refrigerators and freezers are set to the coldest setting.
- _____ Medications and injectables are inventoried and secured.
- _____ Backup and vital information are secured. Checklist put in container.
- _____ Final deposit is made to the bank.
- _____ Visual walkthrough and lockup is completed.
- _____ Medical staff services are notified of providers on call through natural disaster.
- _____ Meeting place and time are set depending on the disaster's arrival and end.
- _____ A list of emergency contacts is completed for maintenance, telephone repair, computer, water, electric, and emergency services.
- _____ Generator
- _____ Locked fireproof cabinets
- _____ Other. _____

CHECKLIST FOR VITAL INFORMATION STORAGE

- _____ Telephone lists and emergency contacts.
- _____ Accounts receivable.
- _____ Appointment lists.
- _____ Staff documents.
- _____ Petty cash.
- _____ Other _____

10.3: NATURAL DISASTER

PURPOSE:

It is the policy of NTCCC to be prepared for a natural disaster. Providers and staff are issued assignments to prepare NTCCC for the disaster. (See related policies on Disaster Planning.) All persons are briefed on their responsibilities prior to the earthquake, volcano, flood, and storm or at such time any natural disaster is anticipated.

PROCEDURES:

When a natural disaster watch is posted for the NTCCC vicinity, the Tribal Health Director assigns the following preparations to various staff members:

1. Contact maintenance to complete preparations on the building.
2. Prepare the inside of the building for flooding and storm damage.
3. Run lists of patients with scheduled appointments.
4. Contact patients to reschedule and/or give instructions on shelters and hospital procedures.
5. Provide a copy to the staff and providers.
6. Make preparations to move all medications and injectables to a secure location and maintain proper temperature.
7. Stock up on flashlights and batteries and put them in designated areas.
8. Clean out refrigerators and remove any and all foods that will spoil
9. Stock up on ice and ice packs.
10. Check first aid supplies and fire extinguishers for readiness.
11. Make sure there are adequate supplies of water, nonperishables, and waterless hand cleansers.
12. Stock up on clean scrubs for on-call providers.
13. Run month-end reports, and secure them in a secure watertight, fire safe place.
14. Ensure backup procedures are followed immediately.
 - a. Back up all systems.
 - b. In the event that the back- up is not Internet based, place back-up tapes or files in a secure, watertight, fire safe place.
 - i. Make two additional electronic copies of the backup.
 - ii. Give the backups to the Executive Director or designee and provider(s) to take to their personal residences to secure.
 - iii. Secure all important papers including insurance policy numbers and banking documents in watertight, fire safe containers.
 - iv. Secure server room and phone room.
15. Review status of telephones and cell phones.

- a. Update telephone lists for staff and providers to include cell phones.
 - b. Remind all employees to charge their cell phones.
 - c. Provide extra batteries for the Tribal Health Director and providers.
16. Organize a notification tree by addresses not telephone numbers based on where employees live.
- a. Arrange a meeting location for after the storm/disaster.
17. Get alternate numbers and/or make arrangements with the NTC Executive Director
18. Complete Natural Disaster Watch Checklist to ensure NTCCC is ready (see below)

NATURAL DISASTER WATCH CHECKLIST

- _____ Phone list is updated and distributed.
- _____ Arrangements for the after-hours coverage set.
- _____ Contact the scheduled patients. Reschedule and/or provide information about shelters and patient instructions.
- _____ Batteries and flashlights are ready.
- _____ Exterior is prepped and ready.
- _____ Ice and cold packs are on site. Empty spaces are in freezers.
- _____ Perishables and medications are contained.
- _____ Water, canned goods, and waterless hand cleaner supplies are obtained.
- _____ Fire extinguishers and first aid supplies are ready.
- _____ Providers' scrubs are on site for those who might be unable to get home.
- _____ Vital information is collected and put in waterproof, fire safe containers.
- _____ All information systems are backed up.
- _____ The server room and phone room are secured and protected.
- _____ Other preparations as required by anticipated natural disaster.

10.4: FOLLOWING A NATURAL DISASTER

PURPOSE:

It is the policy of NTCCC to access the facility and determine the safety and security of the building before allowing staff to return to work. When the safety and security is determined, NTCCC takes measures to resume normal office hours for patient care.

PROCEDURES:

1. After the natural disaster passes and emergency management has deemed it safe to travel on local roads, the Executive Director/Tribal Health Director evaluates the office to determine the extent of damage and if the building is safe to enter.
2. If power has been restored and the building is deemed safe, use the Post-natural Disaster Checklist (see below) to determine if NTCCC can return to normal office hours.
3. Execute the telephone contact policy to inform staff when to report for work.
4. If the building has no power or water, management evaluates whether emergency patients can be treated on site.
5. If the office has sustained damage and cannot open, follow the proper procedures to document damage based on insurance company policy and protocols.
 - a. Determine if alternate office space can be obtained and whether patients can be treated there.
 - b. Staff documents (name, addresses, and emergency contacts);
 - c. Timesheets; and
 - d. Accounts receivable not yet posted.

POST-NATURAL DISASTER CHECKLIST

- Inspect the building exterior for downed power lines and tree limbs, roof damage, and broken windows.
- Enter the building from the rear and check for power. If the power is off, use flashlights for safety until panels can be removed.
- Inspect the office for interior damage, such as water, broken ceiling tiles, and broken glass.
- If the building has power, turn the lights on and check that the telephones are working properly.
- Contact the information systems vendor to bring the server back up.
- When the server is restored, slowly bring up the computers and run diagnostic tests.
- Contact the water company to determine whether a “boil water” order is in effect.
- Contact supervisors and other management team members to update them on the building status. Inform staff when to report to work and how to dress.
- Notify scheduled patients of operating conditions, including whether the office is open or closed and where they should go for care.
- If damage has been sustained, document the damage with photos. Contact the insurance company and obtain the claim number and instructions for becoming operational.
- Begin an inventory log of damaged equipment and furnishings. Contact suppliers to check availability of items to be replaced.
- Check medications and injectables to ensure that proper temperatures are maintained.
- Take the bank deposit to the bank as soon as possible.
- Reactivate the alarm system as soon as possible.
- Call the hospital to determine if patient care areas are open and back to normal. If not, determine where to care for patients.

SECTION 11: PROGRAMS

11.1: WRAP

PURPOSE:

It is a policy of NTCCC to offer a medically supervised program to help promote health and wellness within the Kenai Peninsula, specifically for overweight and obese patients. The Weight Reduction Assistance Program (WRAP) is a specific weight loss program that was created and designed solely by Ninilchik Community Clinic. This program promotes team support and encouragement with motivational teaching to change eating habits, promote lifestyle changes, encourage increased activities, support behavior modification and assist with appetite control if needed.

PROCEDURES:

1. If a patient is interested in learning more about WRAP they are encouraged to make a Consultation Appointment with the Provider. At this appointment the Provider will discuss what the program is, will provide an intake packet and review all documents in such packet, and take a brief medical history from the patient. The Intake Packet includes: Consent form for WRAP and Photo, Standard Plan Time and Financial Agreement, Price breakdown and cost sheet with what is billed to insurance and what is not covered, Health Coach Survey, and a Diet Readiness Questionnaire. If there does not seem to be any contraindications, then the provider will recommend a second visit for a complete physical exam.
2. A complete physical exam visit is to include an EKG and labs. If a complete physical, EKG and labs have been completed elsewhere, within the last 6 months, the patient will be asked to provide these medical records for review. The Standard WRAP Plan lays out the expectations of the visit schedule and highlights any potential financial obligation that is required. The provider and patient will review and sign all the documents in the Intake packet. A copy will be made and scanned into the patient electronic health record.
3. A WRAP binder is provided to the patient. This binder includes: WRAP team contact information, visit log check list, SMART goals, weekly food journal, nutrition information, fitness and measurement log, reference documents for MyPlate and clean eating shopping list, and a blank calendar for 6 months.
4. A photo is taken of the patient with their consent and a copy of the photo is placed in their WRAP binder.
5. A meal management plan is decided on with the patient. Teaching is performed with the patient regarding how to stick with this meal plan, information and teaching materials are provided to the patient to help them learn about the plan they have chosen. The provider may suggest to the patient that they should consider purchasing prescription protein shakes or bars to help them reach their weight loss

goals. This is optional to the patient. The WRAP program offers several Meal Management Options: MyPlate 1500 calorie per day healthy clean eating, Ketogenic diet, Reduced calorie diet of 1200-1500 calorie per day, and VLCD (very low-calorie diet) of 800-1000 calories a day. Some of the diet plans require more frequent healthcare visits and monitoring which is explained to the patient.

6. The patient is then encouraged to visit the Ninilchik Health Club and make their introduction as a new WRAP patient. The Health Club staff should sign them up for their free membership, give them a tour, and take their initial body measurements.
7. If the patients want to meet with the Personal Trainer, they are to contact her directly to make an appointment.
8. The new patient information will be added to the WRAP tracking sheet. This tracking sheet is updated by the Health Coach every time they are seen.
9. The patient returns to the clinic as directed, typically every three weeks to see the Health Coach and every 2-4 weeks to see the Provider.
10. If a patient's appointment is missed, the Health Coach will call and check on the patient. If there are barriers with the patient to make their appointment, the Health Coach will consult with the WRAP Provider. A plan will be established to try and meet the patients needs to keep them active in the program.
11. The patient will remain in the program until they reach their goal and then will be kept in a maintenance program up to two years to monitor for relapse.

SECTION 12: OTHER

12.1: NO PET POLICY

PURPOSE:

For the Health and Safety of our patients, Ninilchik Traditional Council has a No-Pets policy for the Ninilchik Community Clinic/Outreach.

PROCEDURES:

1. The No-Pets policy applies to:
Pets
Emotional Support Animals
Comfort Animals
Therapy Animals
2. The Ninilchik Clinic complies with the American with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, we do allow working service dogs to accompany our patients. Service animals are individually trained to perform work or tasks for people with disabilities. Service Animals are required to be leashed or harnessed and have their official Service Dog paperwork in their pack, except when performing work or tasks where such tethering would interfere with the dog's ability to perform the work or tasks.
3. Pets whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA. Under ADA regulations that became effective on March 15, 2011, there are no protections for emotional support animals in terms of access to public accommodations and public entities. The Department of Justice has stated that emotional support animals are not protected as service animals under these regulations.
4. Providers and any NTC staff will not sign, write a letter or fill out any documents for their patients, that supports the need for an emotional support, Comfort or Therapy animal.
5. Should a patient arrive to an appointment with a pet that is not a service animal, they will be asked to remove the animal from the clinic/outreach facilities.