Policy: **Office Facility Standards – Chiropractic Addendum**

Date of Implementation: **December 16, 2010**

Product: **Specialty**

The standards for a professional office facility have been established and approved by American Specialty Health – Specialty's (ASH) peer review committees. These committees are comprised of practicing clinicians who participate in ASH multidisciplinary practitioner networks. Each facility in which the practitioner intends to see members must meet the facility standards, including site appearance, office policies, emergency procedures, access to treatment/services, safety, privacy, confidentiality, medical record components and storage, and ability to meet expectations for the delivery of safe, professional, quality treatment/services and care.

The following facility criteria are **required** by ASH. Additional requirements for home or alternate facility locations are available online at;

- https://www.ashlink.com/ASH/public/Providers/CQM/PracticeResource.aspx.

The following facility and medical record standards are required of any facility in which a contracted practitioner intends to treat ASH members. If a facility is found to be non-compliant with any of these standards, ASH will work with the practitioner to come into compliance; however, those marked with an asterisk (*) are standards that can preclude a facility from being a part of the network.

Office Appearance Requirements

- The interior and exterior of the facility and surrounding area are clean, neat, well maintained, and of professional appearance.
- The facility location and the entrance to the facility are easy to locate, including either a visible sign noting the practitioner's name, clinic name, and/or specialty, or the address numbers on the building are clearly visible from the street and the appropriate entrance is easily located.
- The entrance and facility are handicapped accessible.
- *The waiting room/area is an appropriate size, well-lit and has adequate seating capacity based on one (1) seat per patient visit per hour for each treating practitioner within the office.

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Revised – July 18, 2024
To PRC for review and approval 06/27/2024
PRC reviewed and approved 06/27/2024
To QIC for review and approval 07/02/2024
QIC reviewed and approved 07/02/2024
To PCC KPT for review 07/03/2024
PCC KPT reviewed and recommended for approval 07/03/2024
To QOC for review and approval 07/18/2024
QOC reviewed and approved 07/18/2024

Required for Patient Privacy and Confidentiality

- *At least one room in the office must provide for complete physical and auditory patient privacy and confidentiality. At a minimum, this includes that the room has a door and is limited to interview/examination/treatment of one patient at a time. Confidential documents such as medical records or x-rays are secured and not accessible to anyone other than the practitioner/staff.
- *Telephone and fax lines are limited to use by the practitioners and staff only.
- Patient files (medical records, x-rays, etc.) filed in an organized manner, readily accessible to the practitioner/staff, and not accessible to the public.

Required Appointment Availability

- In addition to the following appointment requirements, an after-hours answering machine or service must provide instructions to the patient that is calling on what to do in case of an emergency or urgent situation.
- The average in-office waiting time is thirty (30) minutes or less from the time of the patient's appointment.
- An ASH member must be able to schedule an urgent appointment within twenty-four (24) hours of the patient's first contact with the office.
- An ASH member must be able to schedule a non-urgent appointment within seven (7) calendar days of a patient's first contact with the office.

Office Operations and Safety Procedure Requirements

- All exits from the office are clearly marked (e.g., exit sign over each exit door).
- There are smoke detectors or sprinklers in the office or fire alarms in the building.
- A fire extinguisher is readily available within the office space; visible; and depending on the type of fire extinguisher, either the gauge indicates it is adequately charged or the expiration date is in the future.
- There is a method for the practitioner/staff to disinfect their hands between patients (sink and/or hand sanitizer within the office space).
- There is a written evacuation plan in the form of a policy and/or a posted map showing available exit routes, and staff is trained in evacuation procedures.
- There is a written policy/procedure for medical emergencies (e.g., call 911).
- There is a written policy/procedure for patient non-compliance with health care advice.
- There is a written policy/procedure for confidentiality of medical records.
- There is a written policy/procedure regarding the safety of children (12 and under) in the office.
- If blood/lab studies are performed in the office, there is a current certification from the Clinical Laboratory Improvement Act (CLIA) or quality control checks are documented.

- *If blood/lab studies are performed in the office, there is at least one sharps disposal container in each treatment room and appropriate disposal of the container.
- Nutritional supplements are kept out of reach of patients and children. Acceptable options are:
  - In a locked cabinet; or
  - With a physical barrier separating the area where supplements are stored from areas of the clinic in which patients have access (e.g., behind the receptionist's counter, in a storage closet/cabinet, or the practitioner's private office); or
  - Empty "display" bottles may be placed in public areas as long as the actual bottles with supplements inside are stored in one of the above locations.
- *The physiotherapy equipment is safe, sanitary and in good working order.
- Clean gowns/towels are available for patient use, as appropriate during examinations and/or physiotherapy.
- If physiotherapy pads are used: re-usable sponge or carbon-based physiotherapy pads must be disinfected between each patient or if adhesive "gel" type physiotherapy pads are used, each patient must have his/her own separate set, used exclusively on that patient.

Child Safety

(Children within the context of this document are defined as aged 12 and under.)

- Mechanical tables (e.g., treatment tables with electrical or other moving parts) have safety/emergency stop features such as a "kill switch" or button.
- Children are supervised by an adult other than the patient when mechanical tables or similar devices are being utilized.
- Children are not left to wander unsupervised within the facility.
- Bio-hazardous sharps waste containers and small objects are removed from spaces easily reachable by a child.
- Unused electrical outlets are covered with a safety plug.
- Water dispensers that have both hot and cold features should have a safety feature.
- Wires and/or cords are not within reach of children.
- All equipment is routinely validated to ensure it is operating properly.
- Bookshelves and other large pieces of furniture are secured and protected against toppling over.
- Children are not left on a treatment table unattended.
- Warning signs are posted about the potential dangers to children of touching equipment.

X-Ray Equipment

- *If x-rays are performed in the office, the power level of the x-ray unit is capable of 100 kVp/200mA.

- If x-rays are performed in the office, a current x-ray operator's license is on display as required by state regulations.
- X-rays are filed in an organized manner, easily retrievable for practitioner and staff, and filed away from public access.

Medical Record Documentation

ASH requires that a medical record file is limited to one patient and, at a minimum, adheres to the following criteria:

- If the client benefit plan requires a referral, a copy of the referral must be kept within the medical record.
- Each entry clearly identifies the practitioner providing the evaluation or procedure by either initials, unique electronic identifier, or handwritten signature (even when they are the only practitioner in the office).
- Each page in the medical record contains the patient's name and/or identification number.
- The record must include the patient name, age or date of birth, address or telephone number, and employer and marital status.
- The date for each visit is documented.
- Past medical history must be documented.
- Documentation by the practitioner that is legible to another clinician reviewing the records.
- The chief complaint(s) or a problem list must be present. Significant illnesses and medical conditions are also indicated on the problem list.
- Medications, Allergies and Adverse Reactions are promptly noted in the record. If the patient has no known allergies, or history of adverse reactions, this is appropriately noted in the record.
- There must be documentation of history and physical examination pertinent to the chief complaint(s) and health history.
- Results/reports of diagnostic tests and imaging (when ordered or performed) are documented in the medical record and reflect review by the practitioner who ordered them, as evidenced by the date and the practitioner's initials, unique electronic identifier or handwritten signature
- Contraindications to care, if applicable, must be documented.
- There must be evidence of coordination of care with other health care practitioners, if applicable.
- If a consultation is requested, there is a note from the consultant in the record and documentation supporting the medical necessity of the consultation, as well as a review of the report.

- Any instructions provided to the patient related to the treatment plan must be documented.
- Documented treatment plan.

Daily treatment notes must also include the following in a manner that is clear to another clinician:

- Description of subjective and objective findings.
- Working diagnosis or symptom description.
- Treatment rendered (location and duration).
- Treatment response and/or adverse effects.
- Plan (e.g., discharge, follow-up plan, return in two to three [2-3] days).

Medical records must either be documented in English, or translated to English prior to providing ASH or any other requesting party (clinician, insurance carrier, state board, etc.) with a copy of the medical records.

ASH may request that a practitioner send a copy of member(s) medical records at any time. When medical records are requested, the medical records will be audited against the above criteria.

Please see the *Medical Record Maintenance and Documentation Practices (CPG 110 –S)* clinical practice guideline online at https://www.ashlink.com/ASH/public/Providers/CQM/techniqueprocedurecpgs.aspx for qualitative documentation criteria. These criteria were developed by clinical peers based upon the professional standards documented in the references noted at the end of the CPG.

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