**UC Riverside, School of Medicine Policies and Procedures**
**Policy Title:** Termination of Physician/Patient Relationship for Cause
**Policy Number:** 950-03-016

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|---|---|
| **Responsible Officer:** | Chief Medical Officer |
| **Responsible Office:** | Clinical Affairs |
| **Origination Date:** | 03/01/2016 |
| **Date of Revision:** | 02/16/2023 |
| **Scope:** | UCR Health Clinics |

## I. Policy Summary

This policy outlines the process for terminating the physician/patient relationship when a patient is non-compliant with treatment recommendations or otherwise violates patients' responsibilities. (Attachment A)

## II. Definitions

NA

## III. Policy

**A.** It is the policy of UCR Health to maintain cooperative and trusting physician/patient relationships. When a physician/patient relationship is no longer proceeding in a mutually productive manner, it is the policy of UCR Health to terminate the physician/patient relationship within the bounds of applicable state and federal laws, rules, and regulations.

**B.** UCR Health may not discharge a patient from care due to an adverse change in the patient's health status, or because of the patient's utilization of medical services, a patient's diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs unless this behavior seriously impairs the provider's ability to furnish services to either this or other patients.

**C.** Patient discharge is a measure of last resort. Patient discharge from UCR Health may occur when, in a care provider's professional judgment:

1. The patient/provider therapeutic relationship can no longer effectively exist.
2. The patient's behavior is a safety concern.
3. The patient is non-compliant with:
   a. UCR Health "Patient Rights and Responsibilities,"
   b. Recommended medical treatment,
   c. Payment or
   d. Medication Management Agreement (Attachment B)

**D.** Patients' Rights and Responsibilities shall be publicly posted at each UCR Health clinic location. Physicians may terminate a doctor-patient relationship for any objective, non-discriminatory reason, which should be based on a patient's conduct. Examples of patient conduct which may lead to discharge from service may include, but are not limited to the following:

1. Habitual non-compliance with UCR Health practice guidelines and/or a treatment plan.
2. Abusive, threatening, hostile or destructive behavior in person, on the phone, via email, social media, or other contacts that may impact the delivery of care to this or other patients, including bringing a weapon onto University property.
3. Reasonable suspicion based on objective information that a patient altered or forged prescriptions.
4. For Pain Management practice patients, violation of the Medication Management Agreement, or drug seeking behavior.
5. Theft or fraud.
6. Other behavior which has caused or creates a breakdown in the provider/patient relationship.
7. Failure to pay for UCR Health services.

## IV. Responsibilities

Attending Faculty Physicians.

## V. Procedures

**A.** The termination process must be initiated by an attending/faculty provider. Staff or residents may give input into the process, but it remains up to the discretion of an attending/faculty provider to make the final decision. If a provider declines to treat an established patient with the intent to permanently terminate the relationship, a termination letter must be sent.

**B.** The Chief Compliance and Privacy Officer should be notified prior to the termination notice being sent to the patient.

**C.** The termination letter shall provide a reasonable notice to the patient that the doctor-patient relationship is being terminated, (except in extreme circumstances involving threats of violence), affording the patient an opportunity to find other medical care:

1. A minimum of 30 days from receipt of the notice.
2. Forty five (45) day notice period for patients with MediCal beneficiaries, as required by state law.

**D.** Each Termination Letter should be signed by the attending/faculty provider. Refer to Termination for Non-Payment (Attachment C) Termination for Non-Compliance (Attachment D)

**E.** The medical record documentation supports the decision for termination and the letter to the patient must include documented reason for the dismissal.

**F.** The Termination Letter should explain to the patient in simple and understandable terms the reason for the termination of the doctor-patient relationship.

**G.** Discharged patients may submit a written appeal to the Compliance and Privacy Officer if they feel that their rights were violated, or if there are facts or conditions that were not known at the time the discharge decision was made. Compliance staff will review the patient's appeal and shall make a recommendation to the attending physician as to whether to reconsider the termination. The patient will be notified, in writing, of the attending physician's decision, which is final.

## VI. Forms/Instructions

Attachment B – Medication Management Agreement
Attachment C – Termination for Non-Payment Letter
Attachment D – Termination for Non-Compliance

## VII. Related Information

CFR 438.56 Disenrollment: Requirements and limitations.

## VIII. Revision History

Revised 03/30/2023

Approvals:

COMPLIANCE COMMITTEE (04/28/2023)

DocuSigned by:
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4/28/2023 | 12:38 PM PDT

PAUL HACKMAN, J.D., L.LM.
CHIEF COMPLIANCE AND PRIVACY OFFICER,
SCHOOL OF MEDICINE

DATE

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5/1/2023 | 9:40 AM PDT

DEBORAH DEAS, M.D., M.P.H
VICE CHANCELLOR, HEALTH SCIENCES
DEAN, SCHOOL OF MEDICINE

DATE

**Attachment A**

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# Patients' Rights and Responsibilities

You have the right to be treated with respect, consideration, and dignity. You have a right to nondiscriminatory care from your doctors, other healthcare providers, and the UCR Health staff regardless of your race, ethnicity, national origin, gender, sexual orientation, disability, genetic information, or source of payment.

You have a right to privacy. Examinations, consultations, and treatment will be conducted in private.
**You have the right to communicate with healthcare providers in confidence and to have any individually identifiable healthcare information about you protected. You must authorize any release of personal health information, except when required by law. You also have the right to review and to obtain a copy of your own medical record and to request amendments to your record.**

- With very few exceptions, individually identifiable healthcare information can be used without written consent only for health purposes, including the provision of healthcare, payment for services, health promotion, disease management, and quality assurance.
- In addition, examples of legally permitted disclosures without written consent include: medical or healthcare research for which an institutional review board has determined anonymous records will not suffice, investigation of healthcare fraud, and public health reporting.
- When disclosure occurs, no greater amount of information will be disclosed than is necessary to achieve the specific purpose of the disclosure.

**You have the right to receive accurate, easily understood information to make informed decisions about your healthcare, health plan, care professionals, and facilities. This information will include:**

- Healthcare: To the degree known, complete information concerning the diagnosis, evaluation, treatment and prognosis.
- Health plan: Covered benefits, cost-sharing, procedures for resolving complaints, and provider network composition.
- Health professionals: Education, board certification, recertification, and years of practice.
- Healthcare facilities: Services provided, patient satisfaction, procedures for resolving complaints.

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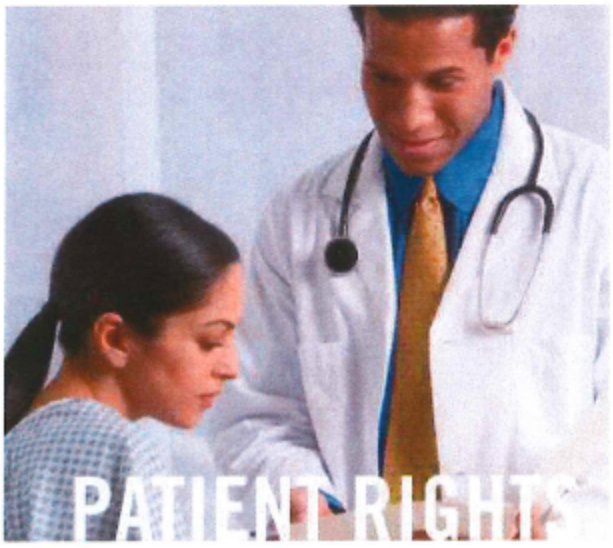
# Patients' Rights and Responsibilities

**You have the right and responsibility to fully participate in all decisions related to your healthcare, except when contraindicated for health reasons. If you are unable to fully participate in treatment decisions, you have the right to be represented by family members, guardian, durable power of attorney for healthcare, or other conservators.**

- Consistent with the informed consent process, you have the right to easily understood information and the opportunity to decide among treatment options, including the option of no treatment at all.
- You have the right to discuss all risks, benefits, and consequences of treatment or no treatment.
- You have the right to a discussion of the use of advance directives—both living wills and durable powers of attorney for healthcare– with your healthcare provider and your designated family members.
- You can expect that your healthcare provider will abide by the decisions made by you and/or your designated representatives consistent with the informed consent process.

**You have the right to access easily-understood information concerning your rights and responsibilities, the services available to you, after-hours and emergency care, fees, payment policies, and the credentials of the healthcare professionals.**




**You have the right to choose your healthcare providers.**

- You have the right to request the same practitioner for continuity of care.
- You have the right to change healthcare practitioners.
- You have the right to a second medical opinion before making a decision.

You have the right to accurate and clearly presented marketing and advertising information about your health plan, healthcare professionals, and healthcare services.

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# Patients' Rights and Responsibilities

**You have the right to communicate your thoughts about your healthcare to UCR Health. You have the right to a fair, fast, and objective review of any complaint you may have against the health plan, doctors, other healthcare personnel, or the facility.**

- You have the right to communicate your thoughts about your healthcare to the Compliance/Privacy Office.
- Send written concerns to: University of California, Riverside, School of Medicine Compliance Office, 900 University Avenue, Riverside, CA 92521 or fax to (951) 263-7271.
- Call the Compliance/Privacy Officer Directly at (951) 827-3257.
- Discuss your concern with the Ethics Point Whistleblower Hotline at 1-800-403-4744.

PATIENT RESPONSIBILITIES

**With patient rights come patient responsibilities. Active participation in your healthcare will assure the best outcome.**

- Maximize healthy habits—exercise, do not smoke or use illegal drugs, eat a healthy diet, and do not abuse alcohol.
- Become involved in care decisions.
- Work collaboratively with providers in developing and carrying out agreed-upon treatment plans.
- Provide accurate and complete information to your provider about your health, any medications, including over-the-counter products, dietary supplements, and any allergies or sensitivities. Clearly communicate your wants and needs; if you are uncomfortable with disclosure, let your provider know.
- Become knowledgeable about your health plan coverage and options, including limitations, exclusions, rules regarding referrals and use of network providers, and processes to secure additional information.
- Arrange for a responsible adult to transport you home and stay with you if need be, if required by your provider.
- Inform your provider about any advance healthcare directives, durable power of attorney for healthcare, or other directive that could affect your care.

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# Patients' Rights and Responsibilities

- Show respect for other patients and the healthcare workers.
- Accept personal responsibility to meet your financial obligations for your healthcare.

## Attachment B

UCR Health

Patient Label

### MEDICATION MANAGEMENT AGREEMENT

This Agreement between _____ (patient) and the UCR Health Pain Management Physicians is for the purpose of establishing an understanding between the doctors and patient on clear conditions for their pain management program, which may include the prescriptions and use of pain controlling medications prescribed by the doctors for the patient. The doctor and patient understand that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

As Consultants in Pain Management, we will recommend and/or initiate therapy for your chronic pain condition. This may include performing procedures and formulating an optimal medication regimen. A reduction in the intensity of your pain and an improvement in your quality of life are the goals of this program. An agreement between the UCR Pain Management Physicians and your primary care physician may be necessary prior to initiating opioid medications.

I agree to and accept the following condition for my pain management program, which may include pain medications prescribed by my UCR Health Pain Management doctor:

_____ 1. Opioids may cause drowsiness. I understand that they are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them. Overdose of this medication may cause death by stopping of my breathing. This can be reversed by emergency personnel if they know I have taken opioid pain-killers. It is suggested that I wear medical alert bracelet or necklace that contains this information.

_____ 2. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving or the operation of machinery. If there are any questions of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side-effects to resolve.

_____ 3. I realize that all medications have potential side-effects. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances and that my physician will advise me as knowledge and training advances and will make appropriate treatment changes.

_____ 4. I understand if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life-threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and I will use appropriate contraceptive measures during the course of treatment with opioids.

_____ 5. I understand I must contact my pain physician before taking Benzodizepines (drugs like Valium or Ativan), sedatives or muscle relaxants (drugs like Soma, Xanax or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. I will not use recreational drugs while on opioids. If consumed the consequence will be termination from the program.

_____ 6. In particular, I understand that opioids analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I agree that continued refill of opioid medications may be contingent upon compliance with the program in general as well as other chronic pain treatment modalities recommended by my doctor.

_____ 7. I will keep all scheduled appointments in the pain clinic. I will bring in medication bottles to each visit. Noncompliance such as frequent cancellation of appointments may result in termination of my doctor.

_____ 8. I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain. In consideration of that goal and the fact that I may receive potent medication to help me reach that goal I agree to help myself by the following better health habits: exercise, weight control, and avoiding the use of tobacco. I must also comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

_____ 9. I agree to comply fully with all aspects of my treatment program which may include behavioral medicine and physical therapy. Failure to do so may lead to discontinuation of your medication and referral to an outside physician.

_____ 10. Refills of controlled substance medication: 1) will be made only during the office hours of 9 am to 3 pm, Monday through Friday. Refills will not be made at night on holidays or weekends. 2) will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. 3) will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 48 hours ahead if I need assistance with a controlled substance medication prescription. 4) If your medications are stolen and you complete a police report regarding the theft, an exception may be made. A copy of the report will be required to be filed in the chart and upon immediate notice to the office at least the police report number needs to be provided in order to consider a second script. **Repeat offenders will not have exceptions.

*All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.*

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_____ 11. **I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with my UCR Health Pain Physician.**

_____ 12. I will not use any illegal controlled substance (cocaine, heroin, etc)

_____ 13. I will not share, sell, or trade my medication for money, goods or services.

_____ 14. I will discontinue all previously used pain medication, unless told to continue them.

_____ 15. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the UCR Health Pain Management Physicians.

_____ 16. I understand that once my pain management is optimized, refill of my medication will be transferred to my primary care physician. If I do not have a primary care physician at the time, I will have 1-3 months to find a doctor that will take over my care and prescribe my medications.

_____ 17. I understand that this medication regimen will be continued for a definitive time period as determined by my doctor. My case will be reviewed at the end of that period. If there is no evidence that I am improving or that progress is being made to improve my function or quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.

_____ 18. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the doctor to provide a copy of this Agreement to my pharmacy, other healthcare providers, and any Emergency Department upon request.

_____ 19. I understand that random urine testing may be employed to monitor effectiveness and compliance of my medication regimen.

_____ 20. I understand that if a random urine test is ordered, and I do not complete the test, my medication **MAY NOT** be refilled at my next appointment.

My UCR Health Pain Management physician and I agree that this contract is essential to my doctors' ability to treat my pain effectively and that my failure to comply with the agreement may result in the withdrawal of all prescribed medication by my doctor and termination of the doctor/patient relationship.

I have read the above agreement and understand the rules regarding prescribing and use of opioid medication. I also agree to testing and detoxification if necessary.

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

If at any time you are concerned about your medication or side effect of your medication, you may call the UCR Health Pain Management number 951.827.7962. A physician or nurse will return your message.

I agree to use _____Pharmacy, located at _____, telephone number _____, for all my pain medication. If I change pharmacy for any reason, I agree to notify the doctor at the time I received a prescription, and advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on this _____day of _____20____.

| Patient Signature | Doctor's Signature | Witness' Signature |
|---|---|---|

**Attachment C**

Date_____

Dear Patient,

While it has been our pleasure treating you, it has come to our attention that your account with UCR Health is in arrears, and though you have been previously notified of this issue, there has been no resolution. As a result, we must terminate the patient/physician relationship due to your lack of compliance with UCR Health's financial protocols.
We will be available to continue treatment for the next 30 days but encourage to seek the regular care of another physician as soon as possible. We will be happy for forward your medical records with your written authorization.
We regret the need to terminate this relationship over this matter and wish you success in the treatment of your future healthcare needs.

Sincerely,

cc: Compliance

## Attachment D

Date_____

Dear Patient,

Over the course of treatment with UCR Health there have been frequent incidents where you have not followed the recommend course of care. Although it is your right to reject your physician's recommendations, we believe the effects of your non-compliance do not meet accepted medical practice standards.
We will be available to continue treatment for the next 30 days but encourage to seek the regular care of another physician as soon as possible. We will be happy for forward your medical records with your written authorization.
We regret the need to terminate this relationship over this matter and wish you success in the treatment of your future healthcare needs.

Sincerely,

cc: Compliance Department