Rehab by unlicensed providers, *a growing area of investigative concern*

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In working with health care providers throughout the country on compliance related matters I find that one of the more confusing areas, and potentially volatile practice activities for today's chiropractor, is the billing for ***Therapeutic Procedures*** rendered by unlicensed staff. The confusion may be caused by a general lack of understanding of the laws & rules governing health care, or by consultants and others instructing that the conduct is appropriate per delegation and "incident-to" standards. No matter the source of confusion, it is quite clear that the volatility of this practice activity rests with the ever-growing scrutiny of health care fraud investigators. Check out the headlines:

- *3/4/04, (TX) Local clinic operators convicted of Medicare fraud - fraudulently billed Medicare for claimed services that were performed by unlicensed technicians.*
- *12/18/03, (NJ) Allstate, Encompass Insurance lawsuit alleges central NJ medical practitioners bilked companies out of millions of dollars - permitted unlicensed assistants to administer physical therapy.*
- *9/18/03, (TX) Judge throws the book at Lone Star doc - issuing physical therapy bills to insurance companies even though in many cases therapy had not been performed or was performed by unlicensed aides.*
- *6/19/03, (LA) Health care clinic co-owner admits fraud - billing Medicare for reimbursement for the service of a physician when all services were done by unlicensed physical therapy technicians.*
- *5/29/03, (TX) Physician Faces Additional Charges for Defrauding Health Care Benefit Program - claimed services that were performed by unqualified persons…*

So what is the answer? Can a chiropractor train their unlicensed staff on "rehab", or the administration of therapeutic procedures? Can a chiropractor have their unlicensed staff provide therapeutic procedures to patients while the chiropractor is in the clinic treating other patients? Can the chiropractor then bill for the procedures rendered by their unlicensed staff as if he/she personally performed them? The best way to answer these questions, and others that may arise relevant to this practice activity, is to review some critical areas:

Coding standards. "Current Procedural Terminology" (CPT) codes, promulgated by the AMA, are the standards for health care providers, of all disciplines, to accurately report their services rendered and to collect proper compensation for those services. Providers using CPT are instructed to pick the code that most accurately identifies the service performed. Therapeutic procedure codes 97110 – 97546 are defined in the Physical Medicine & Rehabilitation section of CPT to include: *"Physician or therapist required to have direct (one-on-one) patient contact"* [during the reported procedure]. Some have argued that the codes permit a doctor to bill for the codes by an unlicensed therapist since CPT's definition does not say "licensed" therapist. But that argument is found to be invalid by contacting CPT for clarification, where CPT reports that the term therapist is referring to anyone who is licensed to perform the service. CPT reports that they are not a regulatory entity, nor do they become involved in third party payor issues, and, as such, appropriate state and institutional entities should be consulted regarding the requirements of services rendered by health care professionals – especially important when you are deviating from the definition of service/procedure codes in CPT. There is no CPT code for reporting therapeutic procedures administered by unlicensed providers, and to do so could be extremely problematic for the provider without appropriate notice and approval!

Delegation standards. State regulatory boards set administrative practice standards and promulgate laws and rules, *including those on delegation*, to protect the public and police their licensees. The standards on delegation vary from state to state, where many state boards indicate that it is inappropriate to delegate provider services (services that require clinical skill and licensure) to non-licensed individuals for administration. What does your state board say? If you are unclear on this issue, it would be advantageous to contact your state board or legal counsel to determine the appropriateness of delegating provider services to non-licensed staff. If your state board does not allow for the delegation of therapeutic procedures to non-licensed staff then you should make certain not to engage in this conduct. Moreover, licensing boards do not, for the most part, set reimbursement standards for third party payers - so even with administrative permission to

delegate, you still need to coordinate with all involved payers to determine their coverage and reimbursement standards to avoid potential misconduct and allegations of fraud.

Reimbursement standards. Third party payers determine what is covered, what is required and how much to pay – thus, they set the standards for reimbursement. *Are payers who refuse to reimburse for therapeutic procedures by unlicensed staff attempting to preempt state law when the law allows for delegation of these procedures - or are payers simply saying have the patient pay for those services directly?* Health care providers seeking payment for health care services rendered are usually required by payers to report these services via use of CPT codes on pre-designated forms. The payer, in their determination of whether to pay or deny a claim, has the absolute right to know what services were performed and who performed the services. Amounts to be paid for health care services are usually determined by reimbursement guides that establish relative values for the services in specific geographic areas. When looking further in this area one sees that services personally performed by a licensed provider are reimbursed at a higher rate than those that can be rendered by unlicensed staff under supervision. The billing for health care services is the biggest risk area for health care providers today, where a key in avoiding future costly and devastating problems is to contact each involved payor to determine their standards. If you do not do this you could face allegations of fraud – that you submitted billings that materially misrepresented the facts, i.e., *you billed for therapeutic procedures as if you personally rendered them when they were actually performed by an unlicensed person.*

"Incident-to" standards. The requirements for this billing practice are defined in Medicare law (Section 2050.1, Medicare Carriers Manual), and allows for services rendered by a nurse or assistant to a Medicare beneficiary to be reported as if the physician personally furnished them as an incident-to a physician's professional service, *e.g., blood pressure check by nurse*. I found nothing to support that "incident-to" allowed a provider to bill for therapeutic procedures as if they personally rendered them when actually rendered by a non-licensed person. In fact, it was noted that services by unlicensed [physical therapist] aides did not meet the *'licensing and other standards'* required in 1861(p). Further, HCFA reported that a chiropractor may provide "incident-to" services for physician (medical doctor), however, such services would be so limited in nature that the physician could only report CPT code 99211 for the service – *services not requiring the presence of a physician (services not requiring licensure).* In recent Work Plans, the Office of the Inspector General for Health and Human Services has identified inappropriate "incident-to" billings as targets for investigation. These standards have little implication on the activities of chiropractors in the Medicare program, as chiropractors are limited to reimbursement of chiropractic manipulative treatment for the correction of subluxations. Frequently, chiropractors report they are following "incident-to" practices when billing services to payers other than Medicare without recognizing that it is Medicare billing practice that may or may not be recognized by other payers. Providers must be sure of the requirements of all payers when submitting bills for reimbursement.

Health Insurance Portability & Accountability Act. HIPAA provides for a potential interesting wild card on the issue of billing for therapeutic procedures by unlicensed staff. The administrative simplification process of HIPAA set standards for the universal (electronic) reporting of health care services, where HIPAA identifies HCPCS and CPT-4 as the transaction sets to be used so that all are reporting the same codes, and that the codes mean the same thing. Could this mean that covered entities using CPT can not deviate from the definition of the services/procedures as defined by CPT? The provisions of HIPAA are very complex and it would be beneficial for providers to contact qualified legal resources for a legal opinion on this issue.

Malpractice Implications. Often the billing becomes an issue in malpractice when the doctor says one thing but the billing records say something else, making for the allegation of fraud on one hand or potential malpractice on the other. Additionally, there is the issue of having the challenge by a plaintiff attorney, on the allegation that the therapeutic approach caused the problem. If any of the treatment was provided by an unlicensed individual and it was against state statute the potential of vicarious liability could result or the doctor could be made to look not very credible or competent with this line of questioning. Remember it is about credibility and once that is tarnished by any method a malpractice case could sour before a jury.

When all is said and done, the provider must determine for themselves, via use of suitable legal and compliance resources, the appropriateness of billing for therapeutic procedures rendered by unlicensed staff. The answer here could be that if the board allows for the delegation of these procedures to non-licensed staff, and the involved third-party payer is aware of this activity and has approved it, then I suspect that the provider would have minimal problems, if any. However, providers who

do not take the necessary steps to ensure compliance may find themselves in the midst of a nightmare should this activity become the next big area of focus for health care fraud investigators and prosecutors.

Published: "Chiro-Code" March 2004 and "NCMIC Examiner" Fall 2004