

## Therapeutic Procedures, Explode Your Practice

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One of the more potentially volatile risk areas for health care practitioners today is the delegation of **therapeutic procedures** to unlicensed assistants, and billing for those procedures as though the practitioner personally provided the procedures. This practice activity is particularly prevalent and ever-growing in chiropractic!

Some practice consultants – *with promises of increased income*, coach chiropractors to integrate low-tech rehab and protocols into their practices. Chiropractors are **advised that it is legally permissible** for unlicensed assistants (e.g., chiropractic assistants) to perform the therapeutic procedures on patients that are billed (per “incident-to”) as if personally performed by the chiropractor, who at the same time, is providing services to other patients who are billed for the chiropractor’s services during the same time frames as the therapeutic procedures.

### ***Does the regulatory board allow for delegation of therapeutic procedures to unlicensed staff?***

Individual state health care regulatory boards establish their own state’s **administrative** practice standards for licensees for the purpose of protecting the public from conduct that does not conform to their state’s accepted standards of conduct. Such administrative regulations almost always include standards relating to the *delegation of services to persons other than the licensed provider*. In many states, chiropractic boards do not allow their licensees to delegate therapeutic procedures to unlicensed staff, and, as such it would be inappropriate in any and all circumstances for the licensees to engage in this conduct!

However, some boards opine that licensees (e.g., *chiropractors*) can delegate therapeutic procedures to qualified and properly trained unlicensed staff (e.g., *chiropractic assistants*) acting under a licensee’s supervision consistent with the health and welfare of a patient so as to encourage the more effective use of the skills of licensees. It would appear prudent for chiropractors to gain clarification from respective regulatory agencies regarding the following:

- *What are the standards that must be met by chiropractors to ensure their unlicensed staff are “qualified and properly trained”?*
- *What level of supervision (general, direct or personnel) is required of the chiropractor relative to unlicensed staff directing therapeutic procedures?*
- *What is meant by “consistent with the health and welfare of a patient so as to encourage the more effective use of the skills of licensees”?*
- *How should the therapeutic procedures (supervised) by unlicensed staff be documented in the patient’s clinical record?*
- *How should the therapeutic procedures be reported to payers – especially those following Medicare standards, to avoid potential allegations of misconduct?*

### ***Is reporting therapeutic procedure codes for supervised procedures consistent with CPT?***

Therapeutic procedure codes (**97110-97546**) identify the application of clinical skills and/or services that attempt to improve function that **requires** the physician or therapist to have direct (one-on-one) contact with the patient. These procedure codes do not indicate “**supervised**” services and to report them to payers in such a manner could result in allegations of misconduct. Consequently, it is imperative for the practitioner (e.g., chiropractor) to obtain prior approval for this billing practice from **ALL** involved payers notwithstanding the fact that this type of practice activity has previously been found to be consistent with state regulatory standards on delegation. The purpose of seeking the payer’s approval is not to enable the payer to make determinations on what practices are legal and what practices are not; rather, it is to protect the individual provider from a payer’s unilateral referral of the provider billing practices to law enforcement authorities who may have a differing interpretation of the acceptable standards of delegation that the provider’s state regulatory board.

Current Procedural Terminology (CPT) is a listing of (a) descriptive terms and (b) identifying codes. The foregoing is used to report medical services and procedures, as well as to provide a uniform language that accurately describes medical, surgical, and diagnostic services. The use of CPT provides an effective means of reliable nationwide communication among providers, patients, and payers.

- The listing of a service or procedure and its code number in a specific section is not restricted to any specific specialty group. Any procedure or service in any section may be used to designate services rendered by any qualified physician or other qualified health care professional. CPT indicates that the terms -"Physician or Therapist" and "Provider" as identified in CPT are interchangeable to refer to *someone licensed to perform health care services*.
- Select the name of the procedure or service that **accurately** identifies the service performed that is adequately documented in the medical record. Do not select a CPT code that merely approximates the service provided, and that if no such procedure or service exists then report the service using the appropriate unlisted procedure or service.
- Suggestions concerning introduction of new procedures, or the coding, deleting, or revising of procedures contained in CPT should be made by contacting the CPT Editorial Research & Development.
- The Final Rule for transactions and code sets as part of the Health Insurance Portability and Accountability Act (HIPAA) identifies CPT codes and modifiers as the national standard for health care plans and providers to electronically transmit: Physician services; physical and occupational therapy services; radiological procedures; clinical laboratory tests; other medical diagnostic procedures; hearing and vision services; and transportation services including ambulance.

#### ***Does the involved payer reimburse for supervised therapeutic procedures?***

Payers often set their own standards for reimbursement of health care services and determine what will be paid, who will be paid, and how much will be paid. Standards may vary from payer to payer, *and* may differ from those standards established by the provider's own regulatory licensing board. Accordingly, it is the responsibility of all practitioners (e.g., chiropractors) to be familiar with both the payer's billing/coding and their state board's standards and seek to abide by those standards that impose the stricter requirements when seeking reimbursement! By adopting a policy of compliance with the stricter standard the provider will always ensure that he/she is protected from claims of improper billing practices.

Medicare, and other payers following Medicare standards, indicates that therapeutic procedures supervised by (unqualified) unlicensed staff are not reimbursable! Payers with such standards do not pay for provider services, at provider rates, when such services are administered by non-providers. Further, these payers do not maintain that practitioners can not delegate therapeutic procedures to unlicensed assistants but are asserting that such services are not covered and, therefore, they are not reimbursable – **BILL THE PATIENT!** Medicare *Benefits Policy Manual, Chapter 15, Sections 220 and 230* specifies:

- *Therapeutic procedures are medically necessary only when they require the professional skills of a qualified practitioner, are designed to address specific needs of the patient, and are part of an active treatment plan intended to achieve a specific goal.*
- *Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists or appropriately supervised therapy assistants. Supervising patients who are exercising independently is not a skilled service.*
- *Providers can not bill and seek payment for one-on-one codes (e.g., therapeutic procedures) administered at the same time as other procedures were rendered to the patient, or to other patients.*
- *A physician may not delegate physical therapy services (e.g., therapeutic procedures) to unlicensed persons and report them as "incident-to" services unless that person has the education and clinical experience equivalent to a physical therapist.*

- *Incident-to a physician's professional services are defined (Benefits Policy Manual, Chapter 15, Section 60) as services or supplies furnished by auxiliary personnel as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness that are billed to Part B by the physician as if they personally provided them.*

Some within chiropractic have differing opinions as to the appropriateness of the delegation and billing of therapeutic procedures. Illustrative of this is the following written opinion of a chiropractor to whom a colleague was referred subsequent to requesting assistance from a State Chiropractic Association regarding the issue discussed herein:

*The auditor is confused, to say the least. As a doctor, you can delegate to whomever you wish to perform those [therapeutic procedure] services. You simply must be in the building at the time services are rendered to supervise [sic]. You do not have to perform the treatment yourself, nor do you have to stand over them and watch. This auditor may be confused with what some insurance companies are pushing for and have proposed, i.e., they require the doctor to do it. However, as far as I know, no insurance company has any policy in place to prohibit you from delegating to staff. As far as statute goes in Xx, if an insurance company did write that into their policy, we would have to go to the Xx with complaint. The P.T.'s would love to have those rules in place as well. Short answer is the auditor is wrong. Maybe some other state he/she is familiar with has that as a rule. Not here though. Checkout companion article: [Your License, Your Call & Your Exposure](#)*

The bottom-line is that due-care and good judgment must be exercised by chiropractors in this risk area, as missteps could result in administrative, civil and/or criminal exposure. A few years ago chiropractors, similarly instructed on use of "incident-to" to increase income, billed for their rendered services under the license of an associated medical doctor in MD/DC practices so as to avoid limited chiropractic (insurance) coverage. Several of these doctors, including a highly prominent chiropractic consultant who advised them on the use of "incident to" billing, are now serving federal prison sentences. Many chiropractors have learned the hard way that "incident-to" does not allow for the misrepresentation of the actual service provider to facilitate reimbursement for services that would otherwise be non-covered.

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