

“Light at the End of the Tunnel”

By Cheryl G. Murer, JD, CRA

Legal developments over the last few years may understandably have given rehabilitation service providers reason to wonder about the viability of providing physical, occupational, and speech therapy in traditional open environments, such as group therapy. The HIPAA¹ Privacy Rule² as originally promulgated by the Department of Health and Human Services (DHHS),³ with its emphasis on protecting personal health information against all but the most necessary disclosures, seemed completely at odds with the entire concept of group therapy. Earlier this year the news that the rehabilitation giant, HealthSouth Corp., had been devastated by a CMS directive on physical therapy billing only seemed to make matters worse.

A close examination of the facts, however, reveals a much brighter picture. Although HealthSouth's troubles result directly from the CMS directive, the company had previously been relying on an ambiguous interpretation of therapy billing rules. Most physical therapy providers should have little trouble complying with the CMS directive. DHHS delivered even better news to rehabilitation service providers in August, when its amendments to the Privacy Rule were published in final form.⁴ These amendments make clear that traditional, open therapy environments not only do not conflict with the Privacy Rule, they fit comfortably within its regulatory scheme.

Physical Therapy Billing and HealthSouth

HealthSouth's difficulties seemingly began on May 17, 2002, when CMS published a directive adding a new section to the Medicare Carriers Manual, which read in full:

“Pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required.”⁵

¹ Health Insurance Portability and Accountability Act, Public Law 104-191.

² 45 C.F.R. Parts 160 and 164.

³ 65 Fed. Reg. 82462 (Dec. 28, 2000).

⁴ 67 Fed. Reg. 53182 (Aug. 14, 2002).

⁵ CMS Medicare Carriers Manual § 15302 (effective July 1, 2002).

This directive was financially devastating to HealthSouth because, as reported by Vince Galloro in the September 2nd, 2002 issue of *Modern Healthcare*, “Under HealthSouth’s previous interpretation, a therapist could bill for two or more patients at the ‘individual therapy’ rate if the patients were engaged in separate therapy activities.”

Given the financial challenges that rehabilitation providers face in relying on Medicare reimbursement, HealthSouth’s reported previous interpretation of individual therapy is tempting, but the CMS directive nevertheless is based on simple logic. The therapist cannot be in two places at once, and he or she cannot be giving full, undivided attention to more than one patient at a time. A therapist providing services to two or more patients at the same time is engaging in group therapy whether the services are formally designated as such or not. It should be noted, however, that HealthSouth remains a large, viable organization that can be expected to press through all available avenues for a change in CMS’ policy.

Indeed, while HealthSouth’s troubles only seem to be multiplying,⁶ the CMS directive seems to have presented relatively few problems for other outpatient therapy providers. The key to compliance with the directive is both careful scheduling and careful, accurate, and thorough documentation of the therapist’s time. If group therapy is, in fact, contemplated, it should be scheduled as such. On the other hand, if a single therapist is expected to treat different patients individually and bill for that service accordingly, the patients should not be scheduled to begin their treatment at the same time. Equally importantly, the therapist should keep accurate, by the minute, logs of time spent with each patient. Rounding up the time to intervals of even as little as 15 minutes can make the records appear to an auditor as if the therapist was treating multiple patients simultaneously, when, in fact, that was not the case, resulting in charges for over-billing that could easily have been avoided by accurate recordkeeping.

Privacy Rule Relief

In promulgating the HIPAA Privacy Rule, DHHS has continuously sought to balance the individual’s privacy concerns with the need to carry out both treatment and health care payment operations efficiently. In the version of the Privacy Rule published in December 2000, DHHS believed that the best balance could be struck by requiring only those health care providers who had “direct treatment relationships” with patients, to obtain the patient’s written consent prior to using or disclosing protected health information for treatment or payment purposes. Providers were permitted to condition the delivery of treatment on the patient’s signing of the consent form, but this did little to alleviate the enormous problems the prior written consent rule presented for many providers, including most rehabilitation service providers. As DHHS itself stated: “The most troubling, pervasive problem was that health care providers would not have been able to use or disclose protected health information for treatment, payment, or health

⁶ Three shareholders’ class action law suits reportedly were filed against HealthSouth during the last week of August, 2002.

care operations purposes prior to their initial face-to-face contact with the patient, something which is routinely done today to provide patients with timely access to quality health care.”⁷ For rehabilitation providers who rely almost exclusively on referrals, this rule would have meant that they could not schedule therapy appointments with patients until the patient had made a separate visit to the rehabilitation facility for the express purpose of signing the consent form.

Fortunately, DHHS realized how unworkable the prior consent requirement would make the delivery of many types of health care,⁸ and the amendments to the Privacy Rule, published in final form on August 14, 2002,⁹ do away with the prior written consent requirement entirely. Instead health care providers must furnish their patients with a notice of privacy practices no later than the date of first service delivery or, in an emergency treatment situation, as soon as practicable after the emergency situation, and “make a good faith effort” to obtain from the patient a written acknowledgment of the receipt of the notice.¹⁰ A provider may choose to obtain written consent from the patient (and such may be required by state law), but there is no longer a need to obtain the consent or acknowledgment before scheduling treatment.¹¹

Furthermore, the amendments explicitly permit one health care provider to disclose a patient’s individual health information to another health care provider for the treatment and payment activities of the provider that receives the information.¹² Thus the amendments permit, for example, an orthopedic surgeon’s office to transmit a patient’s records to the rehabilitation provider so that the therapist can plan and schedule the patient’s therapy program prior the patient’s first visit.

Beyond alleviating the referral and scheduling problems created by the prior Privacy Rule, the amendments also make it clear that open, interactive treatment methodologies, such as group therapy do not conflict with the Rule’s requirements. The original Rule’s general stricture requiring that “reasonable safeguards” be implemented to protect the privacy of individual health information had caused many providers to wonder if not only explicitly interactive practices like group therapy would be disallowed, but also if the entire, open treatment setting, like the PT gym and OT kitchen, would have to be scrapped in favor of private treatment rooms.

In July, 2001, DHHS provided the first hint that such drastic measures would not be required. In a Q & A published on the department’s web site,¹³ the

⁷ 67 Fed. Reg. 53209 (Aug. 14, 2002).

⁸ In addition to the scheduling problems the rule would have presented for specialists like rehabilitation providers, pharmacists would have been unable to fill prescriptions without obtaining prior written consent and DME suppliers would have faced similar difficulties.

⁹ 67 Fed. Reg. 53182 (Aug. 14, 2002).

¹⁰ 45 C.F.R. § 164.520.

¹¹ 45 C.F.R. § 164.506(b).

¹² 45 C.F.R. § 164.506(c).

¹³ <http://www.hhs.gov/ocr/hipaa/>.

department's Office of Civil Rights stated that the Privacy Rule was not intended to do away with traditional health care practices such as sign-in sheets, x-ray light boards, and bedside charts. Instead, the Rule required only that reasonable measures be implemented to safeguard the information on such devices from unnecessary disclosure. Thus, the sign-in sheet should not state the reason for the patient's visit, and the x-ray light board should be positioned so that it is not visible to everybody in the facility. The Q &A, however, did not directly address group therapy.

Fortunately, in the commentary accompanying the new amendments to the Privacy Rule, DHHS does explicitly address the problem of group therapy. First, DHHS again emphasizes that "the Privacy Rule is not intended to impede common health care communications and practices that are essential in providing health care to the individual."¹⁴ Moreover the amendments contain a new provision permitting incidental uses and disclosures of private health information as long as reasonable precautions are taken to safeguard and limit the protected health information disclosed.¹⁵

Most importantly, the commentary states explicitly that a disclosure in "a group therapy setting would be a treatment disclosure, and thus permissible without individual authorization." In other words, disclosures of health information made during a group therapy session are being made for treatment purposes and, therefore, by definition, are permitted under the Privacy Rule. The commentary also notes that the Privacy Rule generally permits when the patient is present during a disclosure, the disclosure of protected health information if it is reasonable to infer from the circumstances that the individual does not object to the disclosure.¹⁶ According to DHHS, "Absent countervailing circumstances, the individual's agreement to participate in group therapy or family discussions is a good basis for such a reasonable inference. As such disclosures are permissible disclosures in and of themselves, they would not be incidental disclosures."¹⁷

Thus, in today's regulatory environment, group therapy remains a viable vehicle for the delivery of rehabilitation services. Careful attention must be paid to scheduling and the maintenance of time logs, and reasonable precautions against patients' health information being broadcast beyond the therapy room should be taken. Such measures, however, should be part of any diligent compliance program.

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¹⁴ 67 Fed. Reg. 53194 (Aug. 14, 2002).

¹⁵ 45 C.F.R. § 164.502(a)(1).

¹⁶ 45 C.F.R. § 164.510(b).

¹⁷ 67 Fed. Reg. 53195 (Aug. 14, 2002).