
October 2015

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Recommended Citation

Gretchen Harper, *Trust Me I'm a Doctor: The Struggle over Scope of Practice and Its Effect on Health Care Fraud and Abuse*, 15 DePaul J. Health Care L. 237 (2013)

Available at: <https://via.library.depaul.edu/jhcl/vol15/iss2/6>

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TRUST ME I'M A DOCTOR: THE STRUGGLE OVER SCOPE OF PRACTICE AND ITS EFFECT ON HEALTH CARE FRAUD AND ABUSE

*Gretchen Harper**

INTRODUCTION

The state's power to regulate the medical profession in the form of licensing requirements is explicitly rooted in the constitution.¹ Implicit within this power is the determination of scope of practice for each respective profession.² Professional associations, as a means of strengthening their occupation, began limiting those that may enter the profession through state licensing statutes.³ By the early 1900s, most states had adopted medical practice acts, outlining the educational, training, and professional requirements that physicians must adhere to when entering the profession. Because allopathic (traditional) physicians first had domain over the "practice of medicine," an overwhelming proportion of discretion was afforded to the MD/DO (Doctor of Medicine/Doctor of Osteopathic Medicine) community.⁴ As a result, all other health care professional groups were relegated to a scope that was carved from the definition of "medicine." Here lies the crux of the current scope-of-practice debate that continues to intensify, as the effects of physician shortages require alternative methods of providing care to an aging population in the United States.⁵ Varying scopes of practice among state medical practice acts cause both patient and provider confusion, create unnecessary potential for fraud and abuse, and should be standardized further to promote patient safety and practitioner clarity.

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1. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), where the Court held that "states have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad powers to establish standard for licensing practitioners and regulating the practice of professions."

2. *Id.*

3. Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 306 (2002).

4. *Id.*

5. *Id.*

This article will discuss the ongoing struggle within the health care community over the abilities and responsibilities that should fall within each profession's domain, and how the scope of practice battle will affect health care fraud and abuse, both in its enforcement and application. This article will first explain scope of practice and the critical role it plays in health care, from the patient side at point of care, to the business side in coding and billing. The article will then explore the role that scope of practice plays in billing and coding determinations, and the prevalence of fraud as a result of the interplay between the two. Finally, the article proposes reform within the current regulatory scheme in order to ensure that patients are receiving care from qualified professionals, of which is documented and billed appropriately and accurately. For the purposes of this article, the term "physicians" refers to allopathic and osteopathic physicians. All other health care professionals beyond entry level will be referred to as "non-physician clinicians."

BACKGROUND AND SCOPE OF PRACTICE GENERALLY

Medical Practice Acts: Scope of Practice Precursors

Licensing statutes, developed and enforced at the state level, govern entry into licensed health care professions.⁶ Practice acts then establish codes of conduct within a given profession, as well as disciplinary measures, should licensees violate the regulations stipulated within the act.⁷ The practice act outlines the scope of practice for each health care profession.⁸ Most states enact separate practice acts by the type of health care profession, but oftentimes there will be overlap, as many of the acts grant the same broad right to "practice medicine" to both physicians and non-physician clinicians alike.⁹ In Illinois, for example, chiropractors, osteopathic physicians, and allopathic physicians are all governed by the Medical Practice Act¹⁰ and thus may "practice medicine," yet all three groups have varying levels of professional experience and enumerated

6. Deborah Haas-Wilson, *Regulation of Health Care Professionals Other Than Physicians*, CATO INSTITUTE, available at

<http://www.cato.org/sites/cato.org/files/serials/files/regulation/1992/10/reg15n4d.html>.

7. *Id.*

8. *Id.*

9. Barbara J. Safriet, *Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care*, in INSTITUTE OF MEDICINE, *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH*, (2011), available at <http://www.iom.edu/~media/Files/Activity%20Files/Workforce/Nursing/Federal%20Options%20for%20Maximizing%20the%20Value%20of%20Advanced%20Practice%20Nurses.pdf>.

10. Illinois Medical Practice Act of 1987, 225 ILCS 60, *et seq.*

abilities within their right to “practice medicine.”¹¹ Further, some states explicitly bar certain health care professionals from licensure, as is most often the case with alternative medical professionals, such as acupuncturists or naturopaths.¹² Though generally the scope of a profession’s practice contains similar standards across jurisdictions, state medical practice acts substantially vary in detail and operation. This is a key component in the confusion over which professionals should be performing what procedure and to what extent a third party payor, such as an insurer or the United States Government, should be reimbursing as such.

Medical practice acts are administered in two ways: some states define scope of practice in statutes enacted by the state legislature, while others delegate the Board of Medical Examiners as the authority to define the scope of practice through regulation.¹³ Though administered differently, each method of regulation carries with it equal force.¹⁴ The current statutory structure hinges on a “system of professional self-regulation.” While this system is inherently necessary to determine the functions best suited for that profession to perform, it is still subject to criticism for its restrictive entry barriers and its consequence of limiting competition.¹⁵

Scope of Practice: Defined and Development Process

Scope of practice is the roadmap that guides medical professionals in the care they provide to patients, and subsequently dictates the level of care they may bill to insurance companies, along with government programs and the like. Scope of practice is defined as “the activities that an individual health care practitioner is permitted to perform within a specific profession . . . based on appropriate education, training, and experience, and established by the practice act of the specific practitioner’s board.”¹⁶ In order to maintain professional competence and patient safety, states enact scope of practice statutes with the goal of ensuring that health

11. Illinois Medical Society, *Statement on Medical Practice Act*, available at <http://www.isms.org/govtaffairs/hub/Documents/Medical%20Practice%20Act%20summary-primer.pdf>.

12. James W. Hilliard & Marjorie E. Johnson, *State Practice Acts of Licensed Health Professions: Scope of Practice*, 8 DEPAUL J. HEALTH CARE L. 237, 251-2 (2004).

13. See Carolyn Buppert, *Nurse Practitioners Business Practice and Legal Guide*, 38, Jones & Bartlett, 4th ed., 2011.

14. *Id.*

15. Hilliard & Johnson, *supra* note 12, at 249.

16. *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards of the United States, Inc. (2005).

care professionals offer services according to and within their skill and training.¹⁷

State medical practice acts define what constitutes the practice of medicine in a particular state.¹⁸ A crucial component and source of debate amongst professionals when attempting to expand scope of practice is the definition of the “practice of medicine.”¹⁹ The statutory definition of “practice of medicine” carries weight because if viewed broadly, a professional’s clinical duties may arguably fall within its definition, and that profession can then make an argument as to why their scope of practice deserves revision. The Federation of State Medical Boards (“FSMB”), an organization of which all seventy medical and osteopathic boards within the United States belong to, and of which many model their practice acts after, defines the “practice of medicine” as involving the following acts: advertising to the public in a manner that represents one as authorized to practice medicine; prescribing, ordering, giving, or administering drugs; performing surgical operations; rendering a medical opinion concerning diagnosis or treatment; determining medical necessity of a decision affecting diagnosis or treatment; and using the designation “Doctor,” “Doctor of Medicine,” “M.D.,” “D.O.,” “Physician,” or any combination thereof.²⁰

Practice requirements within a professional’s scope of practice vary significantly by state, and remain the main source of contention with non-physician clinicians as their depth directly dictates the scope of practice. Some practitioners are authorized to practice independently within their scope of practice, whereas others must work under supervision of, or in collaboration with, a licensed physician.²¹ Supervision can be direct, where a physician must remain physically on the premises and readily available, or indirect, where the supervisor must generally be available in some capacity but oversight need not be as literal.²² For example, physician assistants are not trained or licensed to practice independently from physician supervision, while nurse practitioners have strived to design programs around independent practice.²³ When a professional provides patient care outside of the statutory practice rights granted, the

17. *Id.*

18. *Id.*

19. *Id.*

20. *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, *supra* note 16.

21. *Id.*

22. *Id.*

23. *Id.*

clinician is committing malpractice for practicing medicine without a license and is subject to penalties for practicing outside of her scope as defined by her state's act. Penalties are handed down both from the licensure board and from the state medical board.²⁴

A state's scope of practice can be defined in general or specific terms, and legislatures struggle to balance the need for outlining rights broadly, so as to allow for innovation inherent in the medical community, with the precision needed to ensure that a professional meets the governing standard of care.²⁵ A medical board may choose to shape the scope in one of three ways. First, the scope may be clearly defined by statute or regulation.²⁶ Professionals have used statutes framed in this way to advocate for scope-of-practice expansion when their enumerated rights explicitly mimic the rights granted to physicians.²⁷ Second, the scope may be vaguely defined by statute or regulation, where the language is susceptible to confusion as well as fraudulent practices.²⁸ Though the ambiguity is intended within the statute as built-in flexibility, it can lead to confusion and a great source of tension among professional turf battles.²⁹ Finally, the scope may not be defined at all, which is achieved by omitting the profession from the statutory language altogether, as is most often the case with alternative medical professionals.³⁰ Although this absence implicitly suggests that the state neither recognizes nor allows those professionals to practice within its jurisdiction, it may lead to rogue practicing and fraudulent reimbursement through use of recognized professional codes. As a result, there has been a surge of litigation to prevent the most active alternative medical providers from engaging in such practices.

24. Deanna L. Reising, & Patricia N. Allen, *Protecting Yourself from Malpractice Claims*, AM. NURSING TODAY, Feb. 2007, at 39.

25. Hilliard & Johnson, *supra* note 12, at 252.

26. Buppert, *supra* note 13, at 38.

27. See *An Explanation of the Scope of RN Practice Including Standardized Procedures*, NPR-B-03 06/1995, at <http://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf>.

28. Buppert, *supra* note 13 at 38.

29. See Hilliard & Johnson, *supra* note 12, at 252.

30. See Rebecca LeBehun & David Swankin, *Reforming Scopes of Practice: A White Paper*, NATIONAL COUNCIL OF STATE BOARDS OF NURSING, 19 (July 2010), available at <https://www.ncsbn.org/ReformingScopesofPractice-WhitePaper.pdf>.

SCOPE OF PRACTICE EXPANSION EFFORTS

Scope of Practice Expansion Drivers: More Patients, Less Physicians

Fueled by many driving factors, the battle over expanding the scope of practice is one of the most highly charged policy issues facing state legislators and regulators today. First, geographical medical disparities have led non-physician clinicians to serve as substitutes for the traditional physician episode of care in parts of rural America where physicians are unwilling or unable to serve less populated areas.³¹ Rural America is home to twenty percent of the nation's population, but these areas struggle to maintain physicians, hospitals, and other critical points of access to health care services.³² Second, the sheer volume of patients cannot be supported by the number of physicians presently in the workforce, and the lag will only continue as the baby boom generation continues to age and require further health care resources.³³ In addition, under the Affordable Care Act's increased access to health care coverage, an estimated thirty million more Americans will enter into the health care market, dramatically increasing the demand for high quality and cost efficient primary care.³⁴ The Association of American Medical Colleges ("AAMC") estimates that in 2015, the country will have 62,900 fewer doctors than needed. AAMC further estimated that with the expansion of insurance coverage driving up demand, those numbers will more than double by 2025.³⁵ The surge of new patients in the health care market is inevitable and a hike in costs will follow in an industry already consuming roughly eighteen percent of the gross domestic product of the nation's budget.³⁶ Non-physician clinicians are also seen as a cheaper alternative and an aid in combatting the exorbitant accumulating costs of care for the country.³⁷

31. *See id.*

32. *Id.* at 10.

33. *Id.* at 3.

34. *Id.*

35. Association of American Medical Colleges, *Physician Shortages to Worsen Without Increases in Residency Training* (Oct. 2004), available at <http://www.aacn.nche.edu/DNP/DNPPositionStatement.htm>; see also <https://www.aamc.org/download/150612/data>.

36. Health expenditure, total (% of GDP), THE WORLD BANK, World Health Organization National Health Account database (for the most recent updates, visit <http://apps.who.int/nha/database/DataExplorerRegime.aspx>).

37. Tine Hansen-Turton & Jamie Ware, Frank McClellan (FNaaal), *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235, 1245 (2010).

The following influences have been further bolstered by the Institute of Medicine's ("IOM") research reports analyzing the country's current health care environment in 2001 and 2003, which recognized the impending extreme physician shortages and urged the use of interdisciplinary teams.³⁸ The IOM advocated for innovative use of all types of clinicians to fill the void and to provide services.³⁹ In 2010, the IOM released "The Future of Nursing: Leading Change, Advancing Health," which reignited the debate over the role of nurses and their scope of practice in the delivery of health care.⁴⁰ The IOM's spotlight on the benefits of utilizing non-traditional care providers, coupled with the dire need for alternative methods of filling the physician gap, served as the catalyst for strong scope-of-practice expansion initiatives by non-physician clinicians. Subsequent backlash from MD/DO lobbyists ensued, in an effort to protect not only physician credibility, but also patient care.⁴¹

Scope of Practice Expansion Initiatives: Let the Turf Battle Begin

Non-physician clinicians have lobbied hard for more expansive rights, similar to their allopathic and osteopathic physician counterparts.⁴² Those that have traditionally been able to practice independently of physicians, such as physical therapists, have focused on expanding the types of treatments they can provide.⁴³ On the other hand, those that currently require oversight, such as nurse practitioners, have been pushing their legislature to remove the statutory barriers to independent practice.⁴⁴ Nurse practitioners have been among the strongest forces in their efforts to expand their scope of practice with nationwide initiatives, active and vocal lobbyists, and expansive campaigns advocating for rights very similar to those of physicians.⁴⁵

38. See *Federal Options for Maximizing the Value of Advanced Practice Nurses*, *supra* note 9, at 461.

39. *Id.*

40. *Id.*

41. *Id.*

42. Press Release, American Association of Nurse Practitioners, *Nurse Practitioners Unveil Federal Health Policy Team* (Feb. 27, 2013) available at <http://www.aanp.org/press-room/press-releases/28-press-room/2012-press-releases/1214-nurse-practitioners-unveil-health-policy-team>.

43. Hilliard & Johnson, *supra* note 12.

44. LeBehun & Swankin, *supra* note 30.

45. See Ashvok Selvam, *The Next Level: Annual Workforce Report Shows Nurse Practitioners Pushing for Increased Autonomy in Their Roles*, MODERN HEALTHCARE (Mar. 23, 2013), available at <http://www.modernhealthcare.com/article/20130323/MAGAZINE/303239953>. See also *AANP Launches National Public Awareness Campaign*, AMERICAN ASSOCIATION OF NURSE PRACTITIONERS (May 14, 2013) available at <http://www.aanp.org/component/content/article/28-press-room/2012-press-releases/945-aanp-launches-national-public-awareness-campaign>.

Expansion efforts generally fall within one of three categories: increased prescriptive or procedure rights, increased independence from oversight, or social recognition of further authority. One of the largest efforts has been the proliferation of numerous “Dr.” programs, with pharmacists, physical therapists, and chiropractors all now offering doctoral programs, in which those professionals may then represent and advertise themselves as a doctor.⁴⁶ The American Association of Colleges of Nursing has begun phasing out the masters Advanced Practice Nursing degree to a doctoral DNP, or Doctor of Nursing Practice, as the terminal degree for nursing professionals by 2015.⁴⁷ The rationale for such a phase-out is that a doctoral degree makes a stronger argument for nursing autonomy.⁴⁸ Movement from direct oversight in which the physician must be physically present, to general oversight with looser supervision requirements, has also been a common theme among non-physician clinicians’ attempts at expansion of their clinical scope of practice.⁴⁹ During the 2011 legislative session, several states pursued eliminating requirements that advanced practice registered nurses (“APRNs”) have collaborative agreements with physicians, and other states sought to grant APRNs prescriptive authority absent physician approval.⁵⁰ Other states proposed granting prescriptive authority to other non-physician clinicians, such as chiropractors, naturopaths, and optometrists.⁵¹ Further scope-of-practice expansion initiatives included allowing direct access to physical therapists without recommendation, allowing podiatrists to treat patients beyond the ankle, allowing optometrists to perform surgical procedures, and allowing pharmacists to administer vaccines.⁵²

In response, the American Medical Association (“AMA”) and the American Osteopathic Association (“AOA”) created the Scope of Practice Partnership (“SOPP”), a series of reports on physician and non-physician licensure requirements, highlighting the importance of physician oversight,

46. Veronica Feeg, Donna M. Nickitas, Editorial, *Doubling the Number of Nurses with a Doctorate by 2020: Predicting the Right Number or Getting it Right?*, NURSING ECON., May 2011, at 109.

47. American Association of Colleges and Nursing, *Fact Sheet: Advancing higher education in nursing: 2009 annual report* (Apr. 2013), available at <http://www.aacn.nche.edu/media-relations/fact-sheets/dnp>.

48. *Id.*

49. N.C. Aizenman, *Nurses can practice without physician supervision in many states*, WASH. POST (March 24, 2013), at http://articles.washingtonpost.com/2013-03-24/national/37989896_1_nurse-practitioner-physician-primary-care-practices.

50. See *Scope of Practice Legislative Database, 2011-2013*, NATIONAL CONFERENCE OF STATE LEGISLATURES, available at <http://www.ncsl.org/issues-research/health/scope-of-practice-legislation-tracking-database.aspx>.

51. *Id.*

52. See LeBehun & Swankin, *supra* note 30.

and the discrepancy between each profession's qualifications.⁵³ The platform for these initiatives centered on combatting the confusion that is likely to ensue if numerous health care professionals all represent themselves as doctors, despite not being physicians in a traditional sense.⁵⁴ SOPP was founded in 2003 to address concerns regarding training and education, state regulations, legislative licensure efforts by non-physicians, and general scope-of-practice issues. Fifty state medical societies and twenty-five national specialty societies now belong to the organization.⁵⁵

SOPP initiatives include: modules outlining the education and training requirements for each physician right-infringing profession, geographic mapping of non-physician versus physician practice patterns, and a public relations Truth in Advertising ("TIA") campaign, and advocating transparency in practitioner's credentials and scope of practice.⁵⁶ The TIA survey results revealed that the average patient was unsure of their clinician's qualifications, yet seventy percent of respondents said that they wished a physician be the only one performing major operations or prescribing medications.⁵⁷

SCOPE OF PRACTICE: IMPLICATIONS OF FRAUD

Acting in conflict with one's scope of practice under the respective state medical practice acts has state and federal implications. At the state level, clinicians are most prone to penalties for practicing outside their respective scopes of practice, which is enforced by the state medical board and punishable by loss of licensure.⁵⁸ At the federal level, fraud and abuse actions resulting from scope-of-practice violations arise under the False Claims Act.⁵⁹

The False Claims Act ("FCA") imposes liability upon "any person who makes (1) a false or fraudulent claim; (2) which was presented or caused to be presented by the defendant to the United States for payment or approval; (3) with the knowledge that the claim was false [no specific intent required], and is liable to the US government for a civil penalty, plus

53. AMA Leader Commentary, *Scope of practice: Need for continuing dialogue*, AM. MED. NEWS (June 2008), at <http://www.ama-assn.org/amednews/2008/06/02/edca0602.htm>.

54. *See id.*

55. *See id.*

56. *See* American Medical Association, *Truth in Advertising: 2008 and 2010 Survey Results*, (Dec. 17, 2012), at <http://www.ama-assn.org/resources/doc/arc/tiasurvey.pdf>.

57. *Id.*

58. *Federal Fraud and Abuse Laws*, AM. MED. ASS'N, at <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/regulatory-compliance-topics/health-care-fraud-abuse/federal-fraud-enforcement-physician-compliance/federal-fraud-abuse-laws.page?>

59. 31 U.S.C.A. § 3729 (West 2012).

treble the damages.”⁶⁰ Section 3729(a)(1)(a) places liability on anyone who “knowingly presents, or causes to present a false or fraudulent claim for payment or approval,” and most often pertains to billing and coding fraud.⁶¹ Recent federal case law appears to require practitioners to know what is legally required to withstand a valid submission for medical services.⁶² Practitioners who consciously choose to remain unaware of the law may be found to have acted in deliberate ignorance or with reckless disregard and therefore, liable under the False Claims Act.⁶³ Section 3729(a)(1)(B) places liability on anyone who “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.”⁶⁴ In the scope-of-practice context, this provision would be violated when a professional participates in misrepresenting himself as a physician.⁶⁵

False Claims Submission Liability

Statutes and regulations governing federal programs contain an implicit health care quality-of-care standard, and a provider’s failure to meet the professional standard may result in both exclusion from federally funded programs, i.e. Medicare and Medicaid, and substantial monetary penalties.⁶⁶ In addition, the submission of a Medicare claim by a provider is a certification that the provider has complied with the Medicare Act’s medical necessity definitions, as well as all relevant law regarding submission of claims to the federal government.⁶⁷ A provider may violate this certification, as well as the False Claims Act, by breaching the required standard of care, misrepresenting credentials, or erring in billing and coding of services.⁶⁸

60. *Id.*

61. 31 U.S.C.A. § 3729(a)(1)(a) (West 2012).

62. Norris, McLaughlin, & Marcus, *The Medical Profession Beware: The False Claims Act - A Danger You Can't Ignore*, Health Care Law Alert (July 2011), available at <http://www.nmmlaw.com/pdf/False%20Claims%20Act%20-%20FINAL.pdf>.

63. *Id.*

64. 31 U.S.C.A. § 3729(a)(1)(b) (West 2012).

65. See Jon A. Sale, & Benson Weintraub, *Emerging Trends in Criminal Healthcare Law Enforcement: The Patient Protection and Affordable Care Act of 2010 Reduces the Criminal Mens Rea Requirement for Healthcare Fraud and Increases Penalties Under the Federal Sent*, 23 HEALTH LAW 20, 24 (Feb. 2011).

66. Theodore Margolis, *Health Care Law Alert: The Medical Profession Beware: The False Claims Act - A Danger You Can't Ignore*, NORRIS, McLAUGHLIN, & MARCUS (July 2011), available at <http://www.nmmlaw.com/pdf/False%20Claims%20Act%20-%20FINAL.pdf>.

67. *Id.*

68. *Id.*

Standard of Care Claims

A quality standard of care is expected and implicit when a clinician comes into contact with a patient.⁶⁹ A provider may fall short of these standards when patients are subjected to unreasonable risks due to a provider acting outside the scope of their clinical competence. This is known as the “unauthorized practice of medicine,” and may also occur in instances where the scope is statutorily silent or when unlicensed assistants are delegated services meant for licensed practitioners.⁷⁰ There is little case law supporting the notion that medical malpractice issues often arise when non-physician clinicians act within the scope of physicians. Therefore, such a lack of evidence is used as an argument on the non-physician clinician side as to why their scope of practice should be extended further.⁷¹ In this regard, while acting outside their professional scope is considered fraudulent, the legal repercussions could also be seen as an unnecessary consequence to an effective means of providing care.

Misrepresentation of Credentials

A health care provider may also be liable for submitting a false claim under the FCA for misrepresenting the credentials of the professional who provided the services to the patient.⁷² For instance, a provider who is precluded from reimbursement performs a service and then codes the service as if an eligible provider performed it. The above scenario manifests itself in several ways, including billing for services rendered by an unlicensed physician, as well as falsely representing that a supervising physician is present when in actuality the service was performed independently, and thus outside of the professional’s scope of practice.⁷³

A real-life example of a particularly pervasive form of misrepresentation of credentials occurred in Washington State. In that state, naturopathic physicians are restricted by law from the use of chiropractic codes in rendering clinical services.⁷⁴ As a consequence, naturopathic physicians then began using either physical therapy codes or

69. *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, Federation of State Medical Boards of the United States, Inc., 2005.

70. Joy L. Delman, *The Use and Misuse of Physician Extenders Aiding and Abetting the Unauthorized Practice of Medicine*, 24 J. LEGAL MED. 249, 253 (2003).

71. *Id.*

72. CLEVERLY, ET. AL., *ESSENTIALS OF HEALTHCARE FINANCE* 90 (2010).

73. CLEVERLY, *supra* note 72, at 90.

74. W. Bruce Milliman, *Further Information on CPT Code Sets*, AMERICAN ASSOCIATION OF NATUROPATHIC PHYSICIANS, available at <http://www.naturopathic.org/content.asp?admin=Y&contentid=394>.

osteopathic physician codes to bill for procedures.⁷⁵ However, the Center for Medicare and Medicaid Services did not recognize naturopathy as a viable claim for care, thereby rendering the coding practice fraudulent, as the naturopathic physicians were representing themselves as physical therapists or osteopathic physicians to the Government through their billing slips.⁷⁶

Upcoding or Improper Coding Claims

When a claimant submits a Medicare reimbursement claim, documentation must be provided to support that claim.⁷⁷ Appropriate documentation requires enough information that the Government can determine correct coding has taken place in order to reimburse the health care provider at the proper rate.⁷⁸ Renaming a procedure as a means of receiving compensation for a service otherwise not reimbursable is a violation of the standard.⁷⁹ A nurse practitioner that performs a service outside of her scope may not be able to bill for procedure A, but could bill for procedure B and codes for B accordingly. When a provider instead chooses a higher reimbursement code without evidence in the record to support that code's use, the practitioner is participating in upcoding, in direct violation of the FCA.⁸⁰ Thus, when a nurse practitioner receives a lesser amount when unsupervised but a higher rate when supervised, and chooses the higher yielding code despite the absence of a physician, the nurse practitioner has fraudulently upcoded. This type of inter-office coding fraud is hard to detect, as there very well may be feasible coding scenarios. With the current state of patients' medical literacy, it is unlikely that they will catch the discrepancy on the explanation of benefits from their insurance provider.⁸¹

75. *Id.*

76. *Id.*

77. *Reducing Improper Payments in Medicare: Hearing on H.R. Before the Subcomm. on Government Organization, Efficiency, and Financial Management & the H. Comm. on Oversight & Government Reform*, 112th Cong. (2011) (statement of Michelle Snyder, Acting Deputy Administrator and Deputy Chief Operating Officer, Center for Medicare & Medicaid Services).

78. *Id.*

79. *Id.*

80. *Federal Fraud and Abuse Laws*, AMERICAN MEDICAL ASSOCIATION, available at <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/regulatory-compliance-topics/health-care-fraud-abuse/federal-fraud-enforcement-physician-compliance/federal-fraud-abuse-laws.page?>

81. See Jonathan Walters, *The Price of Medical Illiteracy*, GOVERNING THE STATES AND LOCALITIES (August 31, 2011), at

<http://www.governing.com/topics/health-human-services/price-medical-illiteracy.html>, stating:

Health literacy is defined by the U.S. Department of Health and Human Services (HHS) as "the degree to which individuals have the capacity to obtain, process, and understand basic

LEGISLATIVE/JUDICIAL EFFORTS

Truth in Advertising Laws

Recognizing the potential confusion regarding many clinicians' newfound ability to claim they are doctors, an influx of regulations promoting transparency in determining a health care provider's credentials have been enacted, known collectively as Truth in Advertising Laws.⁸² Case law is unsettled as to whether advertising as a doctor is equivalent to the "practice of medicine," but liability hinges on this distinction. Though not unanimous, most jurisdictions have held that if the individual holds himself out to be a doctor, he must have a license to practice medicine in order to escape liability.⁸³ In addition, twenty-five states have instituted legislation further requiring definitive categorization of professionals.⁸⁴ This has manifested itself most often in hospitals requiring proper identification of individuals on their I.D. badges. This would require "Dr." listed before the name, as well as the professional category below, such as "Physical Therapist."⁸⁵

Response by Center for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services ("CMS") has also made regulatory changes in response to non-physician clinicians' efforts for increased scope and subsequent billing changes that must result. Such changes, however, do not necessarily cut down on the fraudulent activity that may otherwise be attributed to the lack of practice rights within the coding system.

For much of Medicare's existence, nurse practitioners were reimbursed at eighty-five percent of the allowable physician rate, with no reimbursement distinction by provider type.⁸⁶ Instead, "they paid based on the CPT and ICD-9 codes billed, and nurse practitioners received the same reimbursement amounts as physicians doing the same work."⁸⁷ However,

health information and services needed to make appropriate decisions"... around 40 percent of the adults in the U.S. have only "basic" or "below basic" health literacy levels.

82. Carolyne Krupa, *Nonphysicians must be clearly ID'd, states say*, AMED NEWS (Oct. 15, 2012), at <http://www.amednews/article/20121015/profession/310159944/2/>.

83. *'Truth in Advertising' legislation for providers growing in popularity*, HEALTHCARE MANAGEMENT NEWS & INSIGHTS (Oct. 19, 2012), at <http://healthxecnews.com/truth-in-advertising-legislation>.

84. *Id.*

85. Krupa, *supra* note 82.

86. Lorraine Bock, *Changing Reimbursement Policies*, ADVANCE FOR NPS & PAS, at <http://nurse-practitioners-and-physician-assistants.advanceweb.com/Article/Changing-Reimbursement-Policies.aspx>.

87. *Id.*

in a preliminary phase, CMS no longer requires direct supervision over clinicians, but the institution will only receive eighty-five percent of the billing rate under general physician supervision.⁸⁸ For example, the estimated revenue for a medical practice billing nurse practitioner services at eighty-five percent of the code value and the physician at 100 percent of the code value, assuming four patients an hour, amounts to \$1,372,256 a year.⁸⁹ For the same practice, billing nurse practitioner services at 100 percent with physician supervision reduces the amount of patients to three an hour, and amounts to \$1,112,640 a year, a net difference of over \$250,000 a year.⁹⁰ This number is substantial, especially for family practices without larger hospital backing, and produces an unanticipated detriment to the acknowledgement of nurse practitioners as independent clinicians.

Some practices and institutions are now panicking at this fifteen percent reduction rate in reimbursement, and instituting policies in which a physician must “sign off “ on all episodes of care, seemingly meeting the conditions required to keep the 100 percent reimbursement levels.⁹¹ However, more than a mere sign off is required of the physician, for they must physically see and evaluate the patient.⁹² In this vein, the increased scope of practice rights, rather than clearing up confusion and cutting down on fraud as intended, produces negative monetary effects overall and trades one type of fraudulent activity for another.

In a separate preliminary release, CMS has stopped requiring nurse practitioners that provide Medicaid primary care to bill under a supervising physician in order to receive Medicare equivalent payments for primary care they provide under the Patient Protection and Affordable Care Act (“PPACA”).⁹³ However, they will need to be under a physician’s supervision in order to receive Medicare payments unrelated to PPACA.⁹⁴ In addition, fifteen Medicare outpatient services now may be performed by nurse practitioners and other eligible providers under general rather than

88. *Id.*

89. *Id.*

90. *Id.*

91. Bock, *supra* note 86.

92. *Id.*

93. CMS publishes preliminary Rules of Importance to Nurse Practitioners, AM. ASS’N OF NURSE PRACTITIONERS (Nov. 2, 2012), at <http://www.aanp.org/legislation-regulation/news/federal-news/68-articles/1118-cms-publishes-preliminary-rules-of-importance-to-nurse-practitioners>.

94. *Id.*

direct supervision; these services include vaccine administration, blood collection, and intravenous hydration.⁹⁵

It is important to note that CMS is a federal body adjusting medical scopes of practice for billing purposes, but its adjustment to scopes may or may not coincide with states' scopes enumerated within their practice acts.⁹⁶ This discrepancy creates a new layer of confusion and allows room for error and abuse.

SCOPE OF PRACTICE: PUSHING FOR BEST PRACTICE STANDARDIZATION

A legal and regulatory framework overhaul that supports scope standardization is crucial in order to remedy the current environment of clinicians who, instead of working amicably as part of a medical team, compete over who it is that may perform a service on a patient. The tension shifts the focus from the patient to the provider, and the solutions to these issues are not clearly addressed in the language of the relevant statutes or other government regulation. Congress, the Federal Trade Commission, and the Center for Medicare and Medicaid Services each retain responsibility for decisions that either could or must be made at the federal level to be consistent with state efforts to remove scope-of-practice barriers.⁹⁷ "While no single actor or agency can independently make a sweeping change to eliminate current barriers, the various state and federal entities can each make relevant decisions that together can lead to needed improvements."⁹⁸

In order to come to a stronger consensus as to scope of practice, standardization in some capacity would create a framework where performance abilities would be based on clinical ability, rather than state of employment. Because one of the greatest barriers to scope-of-practice discrepancy is the patchwork of state regulations in the form of medical practice acts, an outside agency would provide a valuable role in disseminating best practices and enacting reform toward the direction of those best practices, and obtaining state buy-in via tax incentives for their adoption. Internally, a stronger medical voice within the legislature would

95. CMS publishes preliminary Rules of Importance to Nurse Practitioners, AM. ASS'N OF NURSE PRACTITIONERS (Nov. 2, 2012), at <http://www.aanp.org/legislation-regulation/news/federal-news/68-articles/1118-cms-publishes-preliminary-rules-of-importance-to-nurse-practitioners>.

96. See Hilliard & Johnson, *supra* note 12.

97. Barbara J. Safriet, *Transforming Practice, in Care*, in INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 145 (2011).

98. *Id.*

be beneficial in applying and enacting legislation in compliance with and in furtherance of those best practices.

In addition, standard recognition of a clear subset of non-traditional clinicians would prove valuable in standardization efforts. In the United States, thirty-five percent to forty-two percent of adults seek various forms of alternative health care, and patients spend more than 27 billion dollars a year for non-physician health care.⁹⁹ The proportion of citizens utilizing alternative medicine is large enough to warrant acknowledgment and subsequent addendums for alternative medicine for patient safety and the efficiency of the health care system.¹⁰⁰ Scope of practice should be explicit, either in the positive, by listing acceptable services that may be billed for, or in the negative, by preventing practice within the state for those alternative services. Either way, explicit enumeration in one form or the other is needed for transparency.

Next, the driving force behind expansion efforts in the first place—the nation's high demand for care with the low supply of qualified professionals—is an integral piece and must be addressed. Ongoing research in finding the balance between patient safety and health care team collaboration should lead to a best practice adoption method which aids legislators in determining how broad of a scope to afford a particular profession. The Affordable Care Act mandates the creation of both a National Health Care Workforce Commission to help gauge the demand for health care workers and a National Center for Workforce Analysis to support workforce data collection and analysis.¹⁰¹ These programs should place a priority on systematic monitoring of the supply of health care workers across professions, review of the data and methods needed to develop accurate prediction of workforce needs, and coordination of the collection of data on the health care workforce at the state and regional levels.¹⁰²

99. *Complementary and Alternative Medicine (CAM) - An Introduction*, NURSING LINK, at <http://nursinglink.monster.com/training/articles/230-complementary-and-alternative-medicine-cam--an-introduction>.

100. Joseph A. Barrette, *The Alternative Medical Practice Act: Does It Adequately Protect the Right of Physicians to Use Complementary and Alternative Medicine?*, 77 ST. JOHN'S L. REV. 75 (2003). American interest in utilization of alternative medicine greatly increased beginning in the early 1990s. Research has estimated that consumer spending on alternative medicine will grow by as much as thirty percent annually.

101. American Association of Colleges of Nursing, *AACN position statement on the practice doctorate in nursing*, (Oct. 2004), at <http://www.aacn.nche.edu/DNP/DNPPositionStatement.htm>.

102. *Id.*

CONCLUSION

Scope of practice determinations and resulting regulations directly impact the composition and productivity of the health care workforce, and subsequently affect the quality and efficacy of patient care. Depending on the breadth of a clinician's practice rights, scope-of-practice law can promote access and decrease costs or limit access in a way that proves detrimental. Further, depending on how they are written and implemented, scope-of-practice laws can either limit or promote fraudulent activity. Implementing a best practice model of standardization takes the decisions regarding clinical abilities out of the hands of the legislators, and into the hands of professionals better suited to determine such competencies. In order to adequately address the scope-of-practice debate within the health care industry, an effective and systematic reform of state medical practice acts is needed. With further standardization in place, all health care practitioners, both physicians and non-physician clinicians, can again focus on the goal of all involved: providing safe, efficient, and cost-efficient patient care.

