Author: Attorney Dan A. Riegleman
N63 W23965 Main Street
Sussex, Wisconsin 53089
Prepared: 09/22/15

WHITE PAPER: DR2507

Establishing Pre-Paid Treatment Plans

At this time of increasingly restricted insurance reimbursement for treatment, many chiropractors are developing "pre-payment plans" or "wellness" plans which offer general maintenance type treatment for non-acute injuries or conditions. Under these types of plans, (hereinafter, the "Plan") the patients do not have any specific acute injury or trauma and are receiving long term treatment for their general health or wellness. Many patients who accept this type of program do not have insurance coverage and agree to pay a pre-determined amount for a defined course of chiropractic treatment. While the duration and nature of the long term care varies with each plan, the patient receives the benefit of spinal wellness care while the doctor can promote the long term benefits of chiropractic treatment and avoid the inconveniences and expenses associated with an insurance based practice.

There are a number of significant legal issues which must be considered by the doctor before establishing a pre-pay plan. This document summarizes the nature of several such significant concerns and references relevant portions of Wisconsin Statutes and Administrative Code which impact these issues.

A. Insurance

These types of plans are often established in situations where neither the office nor the patient are anticipated to submit any claims through insurance. In general, a chiropractor can establish an individualized payment plan with a patient which functions independently from reimbursement through health insurance. Plan documents can indicate that the "Plan" will be "terminated" or "frozen" if the patient elects to utilize existing insurance coverage.

There are several important insurance matters which must be considered should the patient ever seek to submit a claim for the treatment provided under a wellness plan. First, it should be noted that the patient ultimately has the right to file a claim on their own initiative. If claims are submitted by the patient, the health insurer has the right to scrutinize all aspects of your manner of treatment to determine whether that

treatment is reasonable and necessary. In such a situation, you may need to provide an explanation or basis for the charges under the Plan; as compared to typical charges for similar treatment provided to patients with health insurance coverage.

Second, the doctor is obligated to avoid interfering with any contractual obligations a patient may have with their insurance company should a claim be submitted for insurance coverage. Consequently, the chiropractor cannot ignore or otherwise disregard any of the deductible, co-payment, or coinsurance provisions of a health policy through the language of a wellness-type plan. In particular, the Wisconsin Statutes at § 943.395 and as reflected in the regulations at Chir 6.02 (14) prohibit a chiropractor from engaging in payment arrangements which may constitute insurance fraud. The use of "no out-of-pocket-expense" payment arrangements when claims are submitted through health insurance are commonly regarded as a fraudulent practice. Consequently, if a patient under a wellness plan attempts to submit treatment charges under a health insurance policy, the doctor would need to ensure that the patient is appropriately billed for any portion of those charges which the patient is obligated to pay under the terms of the health insurance policy.

This situation involving reduced rates often occurs in situations involving "same day discounts for cash payment". The Board addressed this type of situation with the office of the Commissioner of Insurance in late 2002. It is likely that any of the "discounts" from normal charges presented through a wellness plan would be subject to the provisions of a patient's health insurance plan should the patient unilaterally submit charges to a health insurer.

Finally, staff should also be advised of the importance of continuing to monitor health insurance information from all patients, including those individuals who may participate in your plan. There may be situations where the patient (or family members) are members of some type of managed care plan in which you are or may become a preferred provider. A chiropractor who is a member of such a plan is likely to be contractually obligated to follow the payment obligations of payments should that patient elect to participate in your wellness plan. A system of "cross-checks" should be

established to note those patients who are members of a managed plan serviced by your office.

Consideration with respect to this issue:

1. Expressly indicate that neither the office nor the patient is expected to submit claims for reimbursement under the plan to a health insurer or similar entity

2. Clearly describe the basis for this policy of non-submission of insurance claims. An explanation can be provided that the charges for specific forms of care under the wellness plan are lower than those typical charges for similar services. Consideration can be given to expressly stating the amount of discount or reduction for each specific form of service.

3. Clearly indicate that the patient has an obligation to promptly notify the office should a claim be submitted to insurance or the patient becomes a member of a managed care plan in which the office is enrolled.

4. Clearly indicate the consequences should a claim be submitted by the patient. Those consequences should include an understanding that the patient will be charged all applicable deductible/co-pay charges and that standard office rates may be applied in the future. It is not clear from the regulations whether a doctor can apply standard office charges <u>retroactively</u> for services previously provided to the patient. However, it is very likely that the patient will be subject to payment of a deductible/co-pay and the office will need to take a corresponding reduction for the reduced charges incurred by the patient under the plan.

5. Establish a procedure by which the patient can notify your office of any of the matters, referenced above. Such notification should be in writing or e-mailed.

6. Establish a process by which the patient expressly notes (in writing) a request and understanding that no claims will be submitted to insurance unless the program is suspended to provide acute care for a specific work-place, automobile, or other form of known injury.

7. Consider limiting the overall duration for treatment under any plan to a defined number of visits or set number of months. Such policy should allow the plans to be "renewed" as many times a mutually agreed upon by the patient and doctor. Renewal should only occur when each individual plan has come to an end.

8. Have patient acknowledge, in writing, that the plan does not apply in the event of an acute or new traumatic injury.

B. Advance Payments for Care

Many wellness-type plans involve situations where the chiropractor bills in advance for future service. The ethics of this type of advanced payment arrangement is currently being debated. Although any consumer can generally authorize pre-payment for future service through a checking or credit card account, there are three (3) major concerns regarding advanced payment arrangements for health care.

First, some have argued that pre-payments by a patient could constitute a violation of insurance laws. An argument is made that the amount accepted as an advance payment is in the nature of an insurance "premium" for future healthcare services. These individuals assert that the doctor would be subject to the Wisconsin Statutes as they relate to the administration and operation of an insurance company. It is likely that this type of argument is unpersuasive if appropriate language is added to the plans' document expressly stating that the plan is not insurance coverage for broad-based health care.

Second, concern has been raised over whether the doctor has an ethical obligation to retain any advanced payments "in trust" pending the actual delivery of services to the patient. These advanced payments from the patients could potentially be unearned if the patient should withdraw from the plan, develop an acute injury, die, or the doctor should terminate operations. Some professions, such as the legal profession, allow the professional to accept an advance payment from a client ("retainer"), but prohibits the professional from drawing on those funds until services have actually been rendered on behalf of the client. Any funds which have not yet been earned must be retained in a Trust Account. There presently is no Trust Account requirements applicable to chiropractors in the state of Wisconsin. It is likely that this concern regarding advance payment can also be addressed through appropriate language in the Plan documents.

Finally, the issue of advance payments can be complicated if there is uncertainty as to the types of services offered and the actual charges for those services. As referenced above, there are various reasons for the early termination of a plan which

may require a partial refund to the patient. Both the doctor and patient should have a clear understanding of the cost of services under the plan and manner of refund.

Given these concerns regarding advanced payments, the following ***considerations*** are provided:

1. Plan documents should clearly indicate that the plan is not intended to constitute an insurance policy.

2. Plan documents should clearly indicate that advanced payments are not in the nature of premiums. Patients should be advised that payments are applicable for the plans services offered only by a specific doctor(s) at a specific location.

3. Plan documents should establish a "refund" policy should the plan be terminated. The grounds and manner for terminating or suspending the plan should be expressly stated.

4. Plan documents should indicate whether the benefits of the plan can be transferred or assigned to others as an alternative to a refund.

5. Plan documents should specify which specific services are offered under the plan. Those services should specify the charges for all services of the doctor, ancillary care, therapies, initial and re-exams, customized products, x-rays, etc.

6. Office staff should maintain ongoing billing charges for all services provided during a particular month of patient care under the plan. These invoices should be readily available to the patient upon request.

7. Staff should be advised of procedures for promptly refunding unearned payments and addressing other payment related issues.

8. Consider providing notification that the patient may request and receive an accounting of the balance in their plan at any given time.

9. Consider providing a written process for reimbursing the patient in the event of early termination by either party to the agreement.

10. Consider offering a three day right of recitation for accepting the plan.

11. Consider establishing a policy for notifying the patient when their funds in the plan have reached or are close to reaching zero dollars.

12. Some states require that funds obtained under an advance payment plan be maintained in a separate account. Although such arrangement is not required in

Wisconsin, it is generally understood that the doctor could only disburse payment to the office from the prepaid account after services are actually provided and the funds are earned. A detailed record should be maintained of all funds received from a patient and actual disbursements paid to the doctor.

C. Extent or Scope of Care

These types of plans often provide for indefinite or long term chiropractic care. Regulators and others occasionally argue that a chiropractor should not be providing long term care for various reasons. These reasons ultimately center upon an individual's perspective of the scope or extent of chiropractic care. Wisconsin's definition of "chiropractic science" is contained within Chir 4.02. Within the "organized knowledge" of chiropractic, there is a common understanding that long term wellness or maintenance care is beneficial for patients in order to maintain optimal health. Although the actual duration of long term care is often debated, it is important that the patient have any understanding of the scope or nature of the chiropractor's care under the language of a specific plan. Several of the major concerns relating to the scope of chiropractic care which should be addressed in the plan documents are described below:

Initially, the patient should have a clear understanding of the distinction between acute care for a specific traumatic injury and longer term preventative/wellness addressed under a wellness plan. The patient should be advised that acute care resulting from a specific traumatic injury is likely to be treated differently, require more frequent care, and result in significantly higher treatment expenses. Patients need to be aware that the charges for this type of care are usually addressed through a health insurance, worker's compensation, or automobile liability insurance policy. The patient should clearly understand the distinction between acute care and long term care of a preventative or wellness nature as addressed through the plan.

In addition to clearly understanding this distinction, the doctor must also understand the importance of re-examinations as they relate to the scope of chiropractic in Wisconsin. There are several sections of the Administrative Code which prohibit a chiropractor from providing "excessive care" which could endanger a patient's health.

Specific attention should be given to Chir 4.05(2); 6.02(8) and 6.02(9). Although it could be argued that re-examinations are necessary only for the treatment of a traumatic injury, a conservative analysis of these sections would support the need for the chiropractor to provide re-examinations even under a wellness plan.

Third, the significance of re-examination relates directly to a Wisconsin chiropractor's ongoing "duty to inform" a patient. A duty of informed consent and "duty to refer" may be applicable and impose an ongoing duty upon a treating chiropractor to inform a patient of any condition which is not treatable through chiropractic means and recommend that the patient seek additional advice or care. This obligation on the part of the chiropractor may expose the doctor to a malpractice claim if an important ailment is misdiagnosed or overlooked during an extensive course of wellness treatment. The pace of re-evaluation should be carefully considered since the doctor not only has an obligation to re-examine the patient, but comply with his duty to inform a patient if a situation should develop which cannot be treated through chiropractic means.

Consideration with respect to this issue:

1. Ensure that the plan describes the scope or nature of care which is covered under the plan.

2. Have patient expressly acknowledge that they are knowingly and voluntarily agreeing to accept wellness-type care. Patient should understand that the plan may be suspended or terminated for acute injuries following a specific traumatic event. The nature of such traumatic events should be stated in the plan documents.

3. Maintain appropriate re-evaluations as part of the plan.

4. Maintain a procedure for informing the patient of the necessity to consider other forms of non-chiropractic care. It is recommended that a notation is made in the patient's file and that a separate notice is sent to the patient under this "duty to inform".

D. Maintaining Patient Records

Wisconsin's Administrative Code contains a chapter which requires a chiropractor to maintain patient records regardless of the nature of care rendered to a patient. Often doctors utilizing a wellness plan will keep only minimal records or do an

abbreviated version of the standard "S.O.A.P." protocol. It is important to ensure that records are properly maintained on each patient who participates in the wellness plan.

Consideration with respect to this issue:

1. Ensure that patients "informed consent" is provided at inception and upon renewal of each separate period under the wellness plan.

2. Have a provision in the plan explaining why fees are higher if an acute or traumatic injury develops necessitating chiropractic care.

E. Promotion and Marketing

These types of wellness plans can be challenged when the doctor inappropriately promotes or markets the plan to patients. Sections of chapter 6 from the Administrative Code address aspects of chiropractic marketing. In particular, Chir 6.02 (15) prohibits advertising which is "false, deceptive, or misleading". The Code contains several examples of inappropriate advertising.

Based upon this information, the following ***considerations*** may be contemplated:

1. Ensure that program language does not "over-state" the results or benefits of the Plan.

2. Accurately describe the purpose for the Plan without "understating" the potential benefits for the patient of a long-term, wellness-oriented chiropractic treatment.

3. Do not create false or unjustified expectations of favorable results for all patients. The language can clearly indicate that there may be no noticeable or objective improvement in a patient's over-all health as a result of participation in the plan.

4. Maintain a policy of "informed consent" on all patients so that they are aware of potential risks of chiropractic adjustments and ancillary care.

5. Consider maintaining testimonials from patients participating in the plan or other forms of surveys which may be relied upon by the doctor in addressing patient concerns or questions.