

5

CONTRACTUAL RELATIONSHIPS WITH HEALTH CARE PROFESSIONALS

Jim Miles, Esq.

Husch Blackwell LLP

SYNOPSIS

§ 5-1 INTRODUCTION

§ 5-2 EMPLOYMENT VERSUS INDEPENDENT CONTRACTOR RELATIONSHIP

§ 5-2(a) Federal Tax Considerations

§ 5-2(b) Medicare/Medicaid Requirements of Participation

§ 5-2(c) State Licensure Laws

§ 5-3 CONTRACTUAL RELATIONSHIPS WITH PHYSICIANS

§ 5-3(a) Fraud and Abuse Issues

§ 5-3(b) Medical Directorships

§ 5-3(c) Consulting Agreements

§ 5-3(d) SNFist Agreements and Call Coverage Agreements

§ 5-4 CONTRACTUAL RELATIONSHIPS WITH PHYSICIAN ASSISTANTS

§ 5-5 CONTRACTUAL RELATIONSHIPS WITH NURSE PRACTITIONERS

§ 5-6 CONTRACTUAL RELATIONSHIPS WITH THERAPISTS

§ 5-7 CONTRACTUAL RELATIONSHIPS WITH NURSES AND AIDES

§ 5-8 CONTRACTUAL RELATIONSHIPS WITH OTHER HEALTH CARE PROFESSIONALS

§ 5-1 INTRODUCTION

Post-acute care providers have a multitude of contractual relationships with licensed or certified health care professionals. These contractual relationships encompass employment contracts as well as independent contractor arrangements. Such professionals include physicians, physician assistants, nurse practitioners, nurses, nurse assistants, therapists (*e.g.*, physical therapists, occupational therapists, speech therapists, respiratory therapists, music therapists, massage therapists, etc.), and a variety of other licensed or certified professionals. Because it would be the subject of an entire book to describe the legal aspects of all such contractual relationships, this chapter focuses on several of the most legally complicated arrangements.

§ 5-2 EMPLOYMENT VERSUS INDEPENDENT CONTRACTOR RELATIONSHIP

A threshold matter is the determination whether the contractual relationship should be an employer-employee relationship or instead an independent contractor relationship. Federal income tax laws, state licensure laws, and Medicare/Medicaid requirements of participation largely control this determination. Failure to correctly determine the proper status of the health care professional can have a myriad of negative consequences for the post-acute care provider, including federal tax penalties, the obligation to pay overtime compensation, the obligation to provide employee welfare plan benefits, voidability of the contractual relationship, state regulatory and licensure sanctions, recoupment of payments for services, and, in extreme cases, temporary loss of Medicare/Medicaid certification or billing privileges.

§ 5-2(a) Federal Tax Considerations

Legal advisors should first begin with an analysis of federal income tax requirements. The Internal Revenue Service (IRS) uses a three-part test to determine whether a worker should be an employee or an independent contractor: (a) the “Behavioral Control Test,” which addresses whether the business has a right to direct or control how the work is done through instructions, training, or other means; (b) the “Financial Control Test,” which inquires whether the business has a right to direct or control the financial and business aspects of the worker’s job; and (c) the “Type of Relationship Test,” which takes into consideration how the business and the worker themselves perceive their relationship.¹ The tests are somewhat ambiguous and even the IRS concedes that “there is no ‘magic’ or set number of factors that ‘makes’ the worker an employee or an independent contractor, and no one factor stands alone in making this determination.” In the health care context, as a practical matter, the two most important factors tend to be whether (i) the post-acute care provider exercises control over the means and methods of how the health care professional performs his or her services, and (ii) whether the health care professional provides services for other businesses in addition to the post-acute care provider. Whenever a health care professional works solely for a single post-acute provider, regardless whether such professional has created his or her own entity, it becomes more difficult to justify treating such professional as an independent contractor. Health lawyers often consult with the clients tax advisor, whether a tax attorney or an accountant, to assist with the employee versus independent contractor determination. Because of the ambiguities inherent in the IRS tests, tax advisors occasionally disagree and there is often room for debate.

§ 5-2(b) Medicare/Medicaid Requirements of Participation

Legal advisors should also determine whether Medicare/Medicaid requirements of participation dictate a particular outcome. For example, Medicare regulations do not prohibit home health agencies (HHAs) from offering services through arrangements with independent contractors. In fact, certain services, such as any therapy services and home health aide services, may be “offered by an HHA directly or under arrangement.²” The Medicare conditions of participation for HHAs do not address whether an HHA must offer skilled nursing services through employees or may offer them through independent contractors, so presumably both approaches are available.

In contrast, Medicare regulations for hospice require “substantially all” of the hospice “core services” to be routinely offered by hospice employees unless a waiver is obtained.³ “Core services” include nursing services, medical social services, and dietary counseling. Additionally, the hospice administrator must be an employee.⁴ Non-core services, which a hospice may provide through independent contractor relationships, include physician, physical therapy, occupational therapy, speech-language pathology, and hospice aide services. Non-core services also include highly specialized nursing services that are so infrequent that the provision of such services directly by hospice employees would be impractical.⁵ A hospice may not employ its Medical Director, but rather must have an independent contractor arrangement with a Medical Director who is either a self-employed physician or a physicians employed by physician group practice.⁶

As these examples show, each type of post-acute care provider may have different requirements of participation. A full survey of all provider type Medicare requirements of participation is beyond the scope of this chapter, but legal advisors should review the applicable requirements of participation carefully.

§ 5-2(c) State Licensure Laws

State licensure laws include the specific licensure statutes and regulations applicable to each relevant

¹ IRS Pub. 1779, “Independent Contractor or Employee;” IRS Pubs. 15-A & 15-B, “Internal Training: Worker Classification.” The IRS no longer uses the “20-factor test.”

² 42 C.F.R. §§ 484.32 & 484.36.

³ 42 C.F.R. § 418.64.

⁴ 42 C.F.R. § 418.100.

⁵ See, e.g., 42 C.F.R. §§ 418.56(a)(1)(i), 418.64(b)(3), 418.106(a)(1), & 418.106(f)(2).

⁶ 42 C.F.R. § 418.102(a).

health care profession, state licensure laws applicable to the post-acute care provider, state laws that restrict the corporate practice of a health care profession, and even fee-splitting laws applicable to each relevant health care profession. State licensure laws applicable to the post-acute care provider often mimic the Medicare requirements of participation and, therefore, affect whether a health care professional must be an employee.

Because most post-acute care providers are owned, directly or indirectly, partly or wholly, by lay people who are not health care professionals, a state statute that restricts such an entity from employing a physician unless an exception is met (referred to generally as “corporate practice of medicine” prohibitions) could present an impediment to employment. Corporate practice prohibitions exist for professionals other than physicians, and such prohibitions may emanate from statutes, regulations, licensure board rules, and even case law. Similarly, state fee-splitting prohibitions may restrict a health care professional from sharing reimbursement for services rendered with a third party unless an exception is met. State-specific surveys of these restrictions are often available to legal advisors, which can shorten the time period it takes to perform the analysis. But even such state-specific surveys can become quickly outdated if not updated frequently, so re-verification of the information presented in state-specific surveys is usually necessary.

§ 5-3 CONTRACTUAL RELATIONSHIPS WITH PHYSICIANS

§ 5-3(a) Fraud and Abuse Issues

Without question, a post-acute care provider’s contractual relationships with physicians present the greatest area of potential regulatory risk when compared to other health care professionals. Section 1877 of the Social Security Act (the federal “Stark” law)⁷ and the federal Anti-Kickback Statute,⁸ both thoroughly discussed in Chapter 3 of this book, apply to virtually any contractual relationship between a post-acute care provider and a physician. Generally speaking, because physician certification and recertification is usually a prerequisite for admission and continued admission to a post-acute care provider, and because such certification and recertification are deemed to be “referrals” under Stark and the “generation of business” under the federal Anti-Kickback Statute, post-acute care providers are legally prevented from having direct or indirect compensation arrangements with physicians, whether through employment or an independent contractual relationship, unless a Stark exception and a federal Anti-Kickback Statute safe harbor are satisfied. Failure to satisfy an exception and a safe harbor could lead to the imposition of serious sanctions as described in Chapter 3 of this book.

The Stark exceptions typically utilized for post-acute care provider contractual relationships with physicians are the “Bona Fide Employment Relationships” exception,⁹ the “Personal Service Arrangements” exception,¹⁰ and the “Indirect Compensation Arrangements” exception.¹¹ The federal Anti-Kickback Statute safe harbors normally applicable to post-acute care provider contractual relationships with physicians are the “Employees” safe harbor¹² and the “Personal Services and Management Contracts” safe harbor.¹³ Generally speaking, most of these Stark exceptions and federal Anti-Kickback Statute safe harbors require the arrangement to be set out in writing, be signed by the parties before the commencement date of the services, have a term of not less than one year, be commercially reasonable, and have a compensation method that is determined in advance, and result in the payment of aggregate compensation that is within the range of fair market value.

The Stark law defines “fair market value” as “the value in arm’s length transactions, consistent with the

⁷ 42 U.S.C. § 1395nn; 42 C.F.R. §§ 411.350–411.361.

⁸ 42 U.S.C. § 1320a-7b; 42 C.F.R. § 1001.952.

⁹ 42 C.F.R. § 411.357(c).

¹⁰ 42 C.F.R. § 411.357(d).

¹¹ 42 C.F.R. § 411.357(p).

¹² 42 C.F.R. § 1001.952(i).

¹³ 42 C.F.R. § 1001.952(d).

general market value.”¹⁴ “General market value” means “the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to an agreement who are not otherwise in a position to generate business for the other party” at the time of the agreement.¹⁵ This definition of “general market value” is very similar to the IRS’s definition of “fair market value”—the price that would be agreed on between a willing buyer and a willing seller, with neither being required to act, and both having reasonable knowledge of the relevant facts (*i.e.*, the price that the property would sell for in the open market).¹⁶ Various physician salary surveys, which are publicly available for purchase, are typically utilized to determine whether physician compensation is within the range of fair market value.

§ 5-3(b) Medical Directorships

Pursuant to federal and state laws, nearly all post-acute care providers are required to have a Medical Director who is responsible for overseeing the quality of clinical services, formulating and implementing clinical care policies and treatment protocols, and advising the governing body regarding clinical services issues.¹⁷ Historically, Medical Directors for post-acute care providers have not been employees. Independent contractor relationships are thus the norm. Most Medical Directors are employed by an independent physician group practice.

Utilized compensation methods include hourly, monthly, and quarterly flat fees. Regardless of the frequency of the time-based compensation, Medical Directors should be required to keep simple written or electronic logs of their medical directorship activities to support and justify the compensation paid, and the post-acute care provider should periodically determine whether the medical directorship compensation paid to the Medical Director is within the range of fair market value for the amount of services provided. Compensation methods should not take into consideration the value or volume of referrals from, or the amount of business generated by, the Medical Director for the post-acute care provider.

Under certain circumstances, a post-acute care provider may have more than one Medical Director. For example, a short-term care nursing facility that specializes in cardiac and orthopedic surgery rehabilitation may contract with a cardiovascular surgeon and an orthopedic surgeon to each provide medical directorship services within their practice specialty areas (such contractual agreements are sometimes referred to as “specialty program director agreements”). Or, a long-term care nursing facility may contract with a geriatrician to be the primary medical director, but also contract with a neurologist for the purposes of creating a traumatic brain injury treatment program.

Multiple medical directorship agreements can present Stark law and federal Anti-Kickback Statute compliance difficulties if not implemented carefully. The general concern with multiple medical directorship agreements is that, if each agreement is not actually needed, one or more of them may be entered into simply to reward a physician for referrals, regardless whether the compensation is within the range of fair market value. When entering into multiple medical directorship agreements, especially those with overlapping duties, a post-acute care provider should make the following inquiries:

- Do the acuity levels justify multiple Medical Directors?
- Does the patient census justify multiple Medical Directors?
- Does the facility have specialty care units that require Medical Directors with a special expertise?
- If the Medical Directors have different duties, do the medical directorship agreements sufficiently describe the differing duties?

§ 5-3(c) Consulting Agreements

Usually on an independent contract basis, post-acute care providers may enter into consulting agreements

¹⁴ 42 U.S.C. § 1395nn(h)(3).

¹⁵ 42 C.F.R. § 411.351.

¹⁶ IRS Pub. 561; IRS Rev. Rul. 59-60.

¹⁷ 42 C.F.R. §§ 483.75(i) (nursing facilities), 418.102 (hospice). *See also* 42 C.F.R. § 484.16 (describing the “group of professional personnel” that is required to establish and annual review a home health agency’s clinical services and personnel qualifications, which must include at least one physician, but not requiring that the home health agency have a Medical Director).

with physicians. Examples include arrangements where a physician is asked to conduct utilization review or provide in-service trainings to staff on a particular subject matter. In such situations, especially if the physician is a referral source, the post-acute care provider should ensure that the arrangement not only satisfies a Stark law exception and a federal Anti-Kickback Statute safe harbor, but also that the consulting services are actually necessary, cannot be provided by the Medical Director, and that the physician's credentials support his or her ability to provide the consulting services.

§ 5-3(d) SNFist Agreements and Call Coverage Agreements

Historically, the great majority of nursing facilities have not employed or even had independent contractual relationships with the attending physicians of their residents (other than as Medical Directors). Rather, independent attending physicians, usually employees of a physician group practice or solo practitioners, “make rounds” at nursing facilities, often traveling from nursing facility to nursing facility. In part, this model is due to the resident's right to choose his or her attending physician,¹⁸ which often results in multiple attending physicians providing services at each nursing facility. Even in rural areas where there may be only one attending physician in the community, such rural nursing facilities often have fewer beds, requiring the attending physician to maintain an independent outpatient clinic practice to achieve sufficient volumes of patient visits to earn a living. This model also results from the general acuity of residents which, although increasing over recent years, may still be managed by physicians remotely with careful face-to-face care given by the post-acute provider's nursing staff.

For several reasons, this historical trend has begun to wane, with many nursing facilities starting to employ physicians or enter into independent contractor arrangements to obtain and ensure consistent, on-site, physician involvement. These reasons include the failure of the traditional model to adequately ensure access to attending physicians, concerns about hospital readmission rates, higher resident acuity levels, the specialization of nursing facilities that are focusing on specific diagnoses (*e.g.*, behavioral, cardio-pulmonary rehabilitation, orthopedic surgery rehabilitation, traumatic brain injury, stroke, etc.), and the perception that having a “doctor in the facility” will create a competitive advantage from a marketing perspective.

A new term has been coined to describe the physicians associated with these arrangements—“SNFists” which is a play on the term “hospitalists”—used to describe physicians who have only an acute care facility practice focus and no outpatient clinical practice. SNFist medicine is not a physician specialty approved by the American Board of Medical Specialties. SNFists are usually board-certified geriatricians, family practice physicians, internal medicine physicians, or physiatrists. In states that allow nursing facilities to employ physicians, SNFists may be employees assigned to cover one or more facilities in the same general geographic area. SNFists usually keep normal business hours (*i.e.*, 8:00 am–5:00 pm), but are also on-call for urgent care issues or significant changes of condition during nighttime hours.

In states that do not allow nursing facilities to employ physicians, SNFists may be independent contractors of the nursing facilities. Depending on the level of activity required by such independent contractor agreements, such SNFist arrangements are very similar to hospital on-call coverage agreements and, for that reason, these SNFist arrangements are now sometimes referred to as “call coverage agreements” even in the post-acute care provider context.

Determining the fair market value of SNFist employment agreement compensation is not difficult given the existence of several publicly available salary surveys. But determining the fair market value of SNFist independent contractor agreement compensation is more complicated given the lack of publicly available call coverage compensation surveys for the post-acute care market. Hospital call coverage rates, which can be publicly available or are at least known by independent valuation firms, are not necessarily applicable to the post-acute care market. For these reasons, it is safest to work with an independent valuation firm to arrive at a range of fair market value for SNFist independent contractor agreement compensation.

Whether the SNFist is an employee or an independent contractor, the SNFist may reassign his or her right

¹⁸ 42 C.F.R. § 483.10(d)(1).

to receive payment to the nursing facility for covered services payable under Medicare Part B.¹⁹ This may be accomplished by the completion and filing of a form CMS-855R with the Medicare Administrative Contractor for the applicable jurisdiction. The nursing facility does not need to separately enroll with Medicare Part B to bill and received payment for such services if it is already enrolled with Medicare Part A through the form CMS-855A process.²⁰

Even so, nursing facilities billing and collecting for the professional component of Medicare-covered SNFist services must be aware of certain complexities created by reassignment. Specifically:

- Medicare has specific rules that generally prohibit the payment of evaluation and management services performed by physicians and a physician assistant or nurse practitioner on the same date of service unless an exception is met (*e.g.*, the resident has a significant change of condition between such services, thus requiring the second evaluation), on the theory that paying for both services would be duplicative and not medically necessary.²¹
- The compensation paid to a SNFist employed by a nursing facility may not be included on a Medicare cost report if the SNFist services are covered services under Medicare Part B, regardless who bills and collects for such services, because physician services are not a covered benefit under Medicare Part A.
- At the time of this chapter's publication, it was not yet resolved whether a nursing facility may validly claim on its Medicare cost report its costs of subcontracting with a SNFist who provides call coverage services at the nursing facility, where the SNFist's employer bills and collects from Medicare Part B for the professional component of his or her services. Many people believe that such costs should be allowable in the same manner that the costs of subcontracting with a Medical Director are allowable.
- Medical directorship services, because they are not covered services under Medicare Part B, may be included on the Medicare cost report by the post-acute care provider. And, unlike certain other Medicare Part B covered services, physician services are not part of nursing facility consolidated billing under the Medicare Skilled Nursing Facility Prospective Payment System.²²

§ 5-4 CONTRACTUAL RELATIONSHIPS WITH PHYSICIAN ASSISTANTS

In many states, a physician assistant (PA) may not practice independently of his or her supervising physician. The PA's scope of practice is limited to the medical specialty practiced by the supervising physician (*e.g.*, family practice, cardio-thoracic surgery, dermatology, etc.). Before authorizing a PA to perform any medical procedure, the supervising physician is responsible for evaluating the PA's education, experience, knowledge, and ability to perform delegated functions safely and competently. For these reasons, it is rare for post-acute care providers to have contractual relationships directly with PAs unless the post-acute care provider employs the supervising physician, in which case it may also employ the supervised PA.

More and more frequently, however, post-acute care providers are entering into indirect contractual arrangements to access PA services, usually by contracting with the entity that employs the supervising physician, whether that entity by an independent physician group practice, a hospital, or even a health insurance plan. For example, a nursing facility that specializes in cardiovascular surgery rehabilitation may contract directly with a cardiovascular surgery group to provide post-surgical follow-up care by PAs at the nursing facility. Such contractual arrangements often may be analyzed, from a legal perspective, as

¹⁹ 42 C.F.R. § 447.10(g).

²⁰ 42 C.F.R. § 424.80(b)(5); Medicare Carrier's Manual § 3060.

²¹ Centers for Medicare and Medicaid Services, "Evaluation and Management Services Guide," located at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-icn006764.pdf.

²² 42 C.F.R. § 411.15(p).

contractual arrangements with a physician under the preceding section of this chapter.

Notably, because PAs are not defined as “physicians” under the Stark law,²³ in situations where a post-acute care provider contracts directly with a PA, the contractual relationship need not satisfy a Stark law exception. But the federal Anti-Kickback Statute nonetheless applies to compensation arrangements with PAs, so care must still be taken in those situations to comply with the applicable federal Anti-Kickback Statute safe harbor.

Like a physician, a PA may, but need not, reassign his or her right to bill and collect from Medicare for covered services.²⁴ If a PA provides professional services for the Medicare-eligible residents of a nursing facility, such services will be reimbursed by Medicare Part B at 85% of the physician fee schedule.²⁵

§ 5-5 CONTRACTUAL RELATIONSHIPS WITH NURSE PRACTITIONERS

In most states, in contrast to a PA, a nurse practitioner (NP) has an independent scope of practice and may practice independently of a physician. State laws vary regarding whether a NP with prescriptive authority must have a physician supervisor or a collaborative agreement with a physician, and such laws also vary regarding the amount of supervision and collaboration required, if any. Typically, though, regardless whether supervision or collaboration is required by state law, the NP may still practice independently of the supervising or collaborating physician, meaning that the NP need not be an employee of the same legal entity that employs such physician. Indeed, in many states, NPs may jointly form and own professional or service corporations or limited liability companies without needing any physician involvement at the ownership level. For this reason, post-acute care providers enter into contractual relationships with NPs more frequently than with PAs. Such contractual relationships with NPs may be employment or independent contractor arrangements if other legal requirements are met (as discussed in Section 5-1 of this chapter).

Historically, NPs have meshed well with post-acute care provider services. NP services tend to complement the acuity levels of post-acute care providers’ patients. The cost of employing or having an independent contractor relationship with a NP is less than the cost of having such a relationship with a physician. Furthermore, in most states, a NP may be directly employed by a post-acute care provider because the corporate practice of medicine doctrine does not extend to nurse practitioners. Lastly, a NP may perform certain certifications and recertifications for the necessity of nursing facility care as further described below.

Like a physician, a NP may, but need not, reassign his or her right to bill and collect from Medicare for covered services.²⁶ For most post-acute care provider types, if a NP provides professional services for the Medicare-eligible patients of a post-acute care provider, the post-acute care provider and the NP may agree to either (a) refrain from including on the Medicare cost report the costs of employing or contracting with the NP, bill Medicare Part B, and receive reimbursement at 85% of the physician fee schedule,²⁷ or (b) refrain from billing Medicare Part B and include the costs of employing or contracting with the NP on the Medicare cost report.

The federally mandated certifications attesting to the need for nursing facility care must be performed by the physician except as otherwise permitted.²⁸ For Medicare, the initial certification must be made by the attending physician and may not be delegated to a NP. For Medicaid, a NP who is not employed by the nursing facility or an affiliate of the nursing facility (an entity under common ownership and control) may perform the initial certification if permitted by state law.²⁹ Accordingly, nursing facilities that choose to

²³ 42 C.F.R. § 411.351.

²⁴ 42 C.F.R. § 447.10(g).

²⁵ 42 C.F.R. § 414.52; Medicare Claims Processing Manual, Ch. 12, § 110.

²⁶ 42 C.F.R. § 447.10(g).

²⁷ 42 C.F.R. § 414.52; Medicare Claims Processing Manual, Ch. 12, § 110.

²⁸ Social Security Act §§ 1819(b)(6)(A) (Medicare) & 1919(b)(6)(A) (Medicaid); 42 C.F.R. §§ 483.40(c)(4), (f); Centers for Medicare and Medicaid Memorandum No. S&C-04-08.

²⁹ 42 C.F.R. §§ 483.40(c)(4), (e)(2).

employ NPs must ensure that independent physicians remain available to perform initial Medicaid certifications.

§ 5-6 CONTRACTUAL RELATIONSHIPS WITH THERAPISTS

Generally, two models exist for contractual relationships with therapists (*e.g.*, physical therapists, occupational therapists, speech therapists, respiratory therapists, music therapists, massage therapists, etc.). The first model is direct employment, in which case the post-acute care provider directly employs the therapist on a full or part-time basis. In most states, a therapist may be directly employed by a post-acute care provider because the corporate practice of medicine doctrine does not extend to therapists. Because most physical, occupational, and speech language pathology therapy services during a post-acute care Medicare admission are covered services and reimbursed through the post-acute care provider's Medicare Part A reimbursement rate,³⁰ typically it is not necessary for the therapist to reassign his or her right to bill for therapy services to the post-acute care provider through the filing of a form CMS-855R with the Medicare Administrative Contractor.

The second model, known as obtaining therapy services “under arrangements,” is an independent contractor relationship. Under this model, the therapists are provided by an independent therapy group practice owned by therapists, a hospital that employs the therapists, or a privately or publicly-held therapy company. The entity supplying the therapists is paid a contractual rate for the therapy services and the post-acute care provider seeks reimbursement from the applicable health plan, either Medicare or a non-governmental health plan.

§ 5-7 CONTRACTUAL RELATIONSHIPS WITH NURSES AND AIDES

Except for high-ranking supervisory positions and external nurse consultants, such as directors of nursing services, post-acute care providers normally do not enter into contractual arrangements with nurses (*i.e.*, Registered Nurses and Licensed Practical Nurses) and nurse aides. Nurses and nurse aides frequently do not have written employment agreements and are deemed to be “at-will” employees, with the post-acute care provider or the nurse/nurse aide having the right to terminate the employment relationship with or without cause at any time.

§ 5-8 CONTRACTUAL RELATIONSHIPS WITH OTHER HEALTH CARE PROFESSIONALS

A myriad of other health care professionals may enter into contractual relationships with post-acute care providers. They include pharmacy consultants, nurse consultants, registered dietitians, social workers, dentists, chiropractors, psychologists, podiatrists, acupuncturists, acupressurists, and psychotherapists. Generally speaking, such other health care professionals may be employees or independent contractors of the post-acute care provider. As noted above in Section 5-1 of this chapter, legal advisors should take great care in establishing these contractual relationships and determining the structure and content of such contracts.

³⁰ 42 C.F.R. § 411.15(p) (nursing facility); Centers for Medicare and Medicaid Services Medicare Benefit Policy Manual Ch. 7, § 40.2 (HHA) & Ch. 9, § 40.1.8 (hospice).