
The Financial Conundrum for Mental Health Practice

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Abstract

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This article examines the ethical and legal considerations of pay arrangements between associated (nonmedical) mental health practitioners (MHPs), and concludes that, to avoid an elevated risk of improper fee splitting, caution is necessary when the financial arrangement involves a percentage arrangement. Not withstanding personal preferences, the direction and control within the relationship between associated MHPs may or may not justify the status of independent contractor. If there is a bona fide employment relationship, a percentage of billables (but not collections) for paying an associated MHP might be appropriate. Otherwise, one MHP would be entitled to reimbursement for only actual overhead expenses connected to the fees for services provided by the other MHP, but there should be no compensation for the referral per se. This article is a companion piece to Woody (2008).
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Mental health practice requires adherence to both ethics and laws. Ethics deals with the content and nature of moral judgments, which can lead to objective (normative) or subjective (meta-ethics) judgments based on in a professional code of ethics, whereas a law provides “a formally established rule regulating the conduct of people within a particular jurisdiction that must be obeyed in order to avoid legal sanctions” (VandenBos, 2007, p. 527). Effective blending of ethics and laws may pose a difficult challenge in pragmatic situations, such as the financial context of mental health practice. For family therapists, the reconciliation of ethics and laws if highly complex, notably because of how laws differ according to the age of the service recipient (e.g., laws applicable to children versus adults).

This article, which is a companion piece to Woody (2008), deals with (nonmedical) mental health practitioners (MHPs) from psychology, mental health counseling, clinical social work, and marriage and family therapy. The given discipline will influence, and potentially determine, the applicable ethics and laws. It is fundamental that: (1) licensed MHPs are governed by the laws of the particular jurisdiction(s) in which they practice, and (2) the legal tenets vary between jurisdictions.

When MHPs join together in practice, the financial arrangement presents special considerations. A common scenario involves an MHP who has an established practice with a vacant office or more requests for services than he or she can handle. The reasoning is that, rather than “lose business” and to “cut-down on overhead,” an on-site association with another MHP will garner needed revenues.
In American society, most employment contexts offer a salary (fixed compensation) for each hour worked by an employee. Some MHPs wish to avoid compensation based on a set hourly fee, preferring instead a pay arrangement that allows the MHP who is paying the overhead expenses to receive a percentage of all collections made by the associate MHP. When “collections” (as opposed to “billables”) are used, neither MHP is compensated for all services rendered, only for those services that bring payment. To be clear, the term “collections” refers to monies actually received for the services provided by an associated MHP, whereas “billables” refers to the total amount billed for the services provided by the associated MHP. In a society that lives on credit, a portion of the billables may go unpaid.

Collections Versus Billables

For MHPs, ethics are inherent to the collections versus billables issue. The code of ethics for the American Psychological Association (APA; 2002), Standard 6.07 Referrals and Fees states: “When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself” (p. 1068). Taken literally, “based on services” seems to support billables and denies acceptance of the collections approach. In other words, this ethical standard requires payment for presumably all services provided, unless it is an employer-employee relationship. The ethics code for the National Association of Social Workers (NASW; 1999) includes, in Standard 206 Referral for Services (c): “Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.” And in the ethics code
for the American Association of Marriage and Family Therapy (AAMFT; 2001), Principle VII Financial Arrangements, Standard 7.1 indicates: “Marriage and family therapists do not offer or accept kickbacks, rebates, bonuses, or other remuneration for referral; fee-for-service arrangements are not prohibited.” The term “fee-for-service” seems compatible with the “based on services” statement in the ethics code of the APA (2002). The ethics code for the American Counseling Association (ACA; 2005) does not address this issue.

Fee Splitting

By definition, a percentage arrangement is “fee splitting.” Although all fee splitting is not improper, caution is necessary to avoid any temptation to lessening quality care. Less diligence in financial matters might result in a loss of organizational efficiency that could jeopardize clients or service users. For safeguarding quality services, collections are less logical than billables.

In addition to a possible ethical issues, fee splitting is known to be potentially illegal: “Relationships involving kickbacks, fee splitting, or payment of commissions for client referrals may be illegal and unethical” (Koocher & Hill, 2005, p. 578). Note that Koocher (2005a) considers kickbacks, fee splitting, and commissions as equivalents, that is, “that part of a sum received for a product or service is returned or paid out because of a prearranged agreement or coercion” (p. 661). As an example, Fisher (2009) reports that a violation of state laws prohibiting kickbacks and fee splitting occurred when several psychologists formed a mental health referral service and “charged psychologists to whom they referred patients a first-time fee for each referral and a few for each subsequent session based on the patient’s monthly bill” (p. 182). It is difficult to
distinguish the foregoing example from a scenario in which the MHPs use a financial percentage for an independent contractor arrangement (to be discussed later). This is not to say that an MHP who is paying for the overhead expenses would not be entitled to reimbursement for actual overhead expenses from an associated MHP who is a bona fide independent contractor.

The term “fee splitting” has legal implications. Statutory and case laws provide the legal definition for any given jurisdiction, and do vary; there is also relevant Federal law. Recalling the previous discussion of “based on services,” fee splitting that involves other than reimbursement for relevant expenses may constitute an illegal kick back or patient brokering. For example, Florida Statute 456.054 states: (1) . . . the term ‘kickback’ means a remuneration or payment, by or on behalf of a provider of health care services or items, to any person as an incentive or inducement to refer patients for past or future services or items, when the payment is not tax deductible as an ordinary and necessary expense. (2) It is unlawful for a health care provider or any provider of health care services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients.”

Fee splitting also has ethical implications. As an example, consider what is required for obtaining third-party reimbursement (such as from a managed care or insurance company). Reimbursement requires a “billable diagnosis.” That is, there are certain types of psychological needs that are not eligible for reimbursement (e.g., parent-child or marital problems). The third-party reimbursement policy “combined with the client’s need for insurance coverage to help defray the costs of treatment, can lead to the practice of giving the client a ‘billable’ diagnosis even if such a diagnosis is not the most
accurate” (Haas & Malouf, 2002, p. 140). Fraud involves an intentional deception to the detriment of another (e.g., an insurance company is a protected “other”), and fraudulent practice could lead to criminal, civil, and licensing consequences.

Among health-care providers historically, fee splitting has a negative connotation. As Koocher and Keith-Spiegel (2008) describe it:

Fee splitting, often termed a kickback, refers to a general practice under which part of a sum received for a product or service is returned or paid out because of some prearranged agreement or coercion. As practiced in medicine and the mental health professions, the client usually remains unaware of the arrangements. Traditionally, nearly universal agreement existed among medical and mental health professionals that such practices are unethical, chiefly because they may preclude a truly appropriate referral in the client’s best interests, result in delivery of unneeded services, lead to increased costs of services, and generally exploit the relative ignorance of the client. (p. 166)

An often-heard rationalization is “other MHPs engage in fee splitting.” Public policies and laws clearly support the old adage “two wrongs don’t make a right.”

Giving preference to self-referrals between associated MHPs could jeopardize the best interests of the client. Among the ethics codes for MHPs, only the APA ethics code (2002), Standard 6.07 Referrals and Fees (discussed previously), spells out that fee splitting might be appropriate for an employment arrangement. Fisher (2009) adds: “This standard is meant to ensure that the client/patient referrals among professionals are based on the expertise of the professional to whom the referral is being made and the appropriateness of the services for the client/patient, and not on the basis of the referral
itself”; the standard “prohibits psychologists from charging other professionals for client/patient referrals, or conversely for paying another professional for a referral”; “A psychologist may divide fees with another professional only if both have contributed to the service” (p. 188). Also, she says: “The standard does not prohibit psychologists from (1) charging another psychologist payment for office space, (2) paying professionals who are employees a percentage of a client/patient fee, (3) paying an institution for referral, or (4) membership in an HMO” (p. 188). In other words, an independent contractor arrangement would likely create a potential conflict of interest for the senior psychologist, as might be in violation of APA ethics code (2002) Standard 3.06 Conflict of Interest, which proscribes psychologists being in roles that could reasonably be expected to “impair their objectivity, competence, or effectiveness” (p. 1065). The foregoing said, it should be acknowledged that neither the APA (2002) ethics code nor Fisher (2003) specify that fee splitting is not potentially relevant to an independent contractor arrangement; other issues, as discussed herein, also have to be considered. Whether these same notions apply to MHPs from the other disciplines remains for conjecture.

Employment versus Independent Contractor Arrangements

For employer-employee relationships, the long-standing “Master-Servant” legal principle supports that the clients seen within the practice are under the aegis of the “Master.” Thus, all of the clients seen in the employment context constitute the clientele of the practice (owned by the employer), and the employee is serving at the behest of the employer. In other words, the employer is not actually referring a client to an employee, the employer is assigning a client to an employee; and the employee has a fiduciary duty
(acting trustworthy) to provide acceptable services on the employer’s behalf. In this scenario, there would be no improper fee splitting. To the contrary, if an MHP channels clients to an independent contractor and has no direct involvement in the services (only overhead incurred), the full array of ethical and legal restrictions would seemingly be applicable to a percentage or any pay arrangement (other than payment for overhead expenses).

An association between MHPs has relevance to the rights of clients. All of the ethics codes pertaining to MHPs support being honest with clients, which requires full disclosure to avoid any semblance of deceit by omission. When MHPs have a percentage arrangement for either all billings or just collections for the services, informing the client is a threshold issue. The most specific statement is in the APA ethics code (2002), this seems to be implicit in Standard 6.04 Fees and Financial Arrangements, since it references that “psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements” and “Psychologists do not misrepresent their fees” (p. 1068). The ethics code for the NASW (1999), in Standard 3.5 Billing specifies: “Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.” The AAMFT (2001) ethics code provides, in Principle VII Financial Arrangements, Standard 7.2: “Prior to entering into the therapeutic or supervisory relationship, marriage and family therapists clearly disclose and explain to clients and supervisees: (a) all financial arrangements and fees related to professional services . . . .” The ACA (2005) ethics code does not address this issue.
It seems that the issue of employment versus an independent contractor arrangement should be made known to clients. Koocher and Keith-Speigel (2008) specifically state that the clients should be informed about payment for referral:

In all of the cases in which a commission is paid to someone not rendering services, the client should also be advised. By commission, we mean any payment made simply for a referral, as opposed a payment made for some services rendered in a joint practice or professional collaboration. (p. 167)

The AAMFT (2001) ethics code seems supportive, saying in Principle VII Financial Arrangements: “Marriage and family therapists make financial arrangements with clients, third-party payors, and supervises that are reasonably understandable and conform to accepted professional practices.”

It is not unusual for MHPs to prefer an “independent contractor” relationship. However, preference is not enough, the actual circumstances of the relationship must pass the “economic reality test.” Fishman (1997) points out: “Under this test, workers are employees if they are economically dependent upon the businesses for which they render services. Economic dependence equals an employment relationship” (pp. 3/15-3/16).

Whether there is an employment relationship must be considered regardless of whether an MHP is licensed. Although an unlicensed person may provide nonprofessional functions (e.g., serve as an assistant to a licensed MHP), engaging in a mental health service commonly requires licensure. If the MHP is not licensed, it is likely unlawful practice.
In a nutshell, there are legal principles and guidelines that determine whether an associated MHP is an employee or independent contractor. Koocher (2005b) indicates that an independent contractor is a:

Person who agrees with a party to undertake the performance of a task for which the person is not expected to be under the direct supervision or control of the party. Ordinarily this arrangement and relationship shield the party from liability for negligent acts of the independent contractor that occurred during the performance of the work. For example, a psychological consultant is an independent contractor for whose negligent acts the attending psychologist is not liable. (p. 574)

Woody and Zand (1989) summarized the stance taken by Internal Revenue Service (IRS):

“The relationship of employer and employee exists when the person for whom the services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as the details and means by which the result is accomplished” (p. 4). Therefore, if an MHP: (1) provides another MHP with office space, support services, furniture and equipment, and virtually all referrals; monitors or supervises the quality of services; and prescribes and proscribes the service delivery system (e.g., billings and receipts, recordkeeping, scheduling, etc.), an employment relationship may well exist, even though the MHPs may wish to designate it to be an independent contractor arrangement. Of importance, the determination made by Federal and State sources will consider the presence of direction and control. Thus, one rule of thumb might be allowing the MHPs to be free to compete
with each other by being associated concurrently with another mental health practice (located elsewhere).

At the Federal level, the legal factors used to determine direction and control relevant to a possible employer-employee relationship are derived from cases and rules. The weight or importance is influenced by the occupation and context for the services, but MHPs are not necessarily exempt from scrutiny.

Even if there is a bona fide independent contractor arrangement, vicarious liability may apply (Koocher, 2005b). To clarify the legal principle of vicarious liability:

“Derivative or secondary liability predicated not upon direct fault but by virtue of the defendant’s relationship to the actual wrongdoer, in which the former is presumed to hold a position of responsibility and control over the latter” (p. 576). In other words, having an association with an MHP who is an independent contractor does not provide an impenetrable shield from liability for the other MHP.

Although the factors used by the IRS are intended to be for guidance, they are, of course, of great importance when determining whether a relationship between a senior and an associate psychologist justifies independent contractor status. When analyzing the nature of the arrangement, an auditor would likely weigh as extremely important the factors according to the facts, conditions, and context of the particular situation, with special attention to the amount of direction and control existing in the relationship between the MHPs.

Another financial issue relates to the licensure status of an associate. Since statutes mandate that a licensed practitioner provide mental health services, any attempt to create an independent contractor agreement with an unlicensed person would quite
likely be void *ab initio* (from the beginning). A valid contract requires, among other things, “competence” by all parties. *Black’s Law Dictionary* (1968) defines “competent” as “Duly qualified . . . having sufficient ability or authority” (p. 355) and “incompetency” as “Lack of ability, legal qualification, or fitness to discharge the required duty” (p. 906). An unlicensed person (e.g., an intern, postdoctoral fellow, or otherwise) working under the auspices of an MHP seemingly lacks legal competence to contract and cannot be an independent contractor; and should, therefore, work within an employment arrangement.

The IRS guidelines do not specify that an employment relationship must be full time; part-time employment is possible. Even a part-time office/support worker who works under the direction and control of an MHP would likely be an employee, not an independent contractor.

Some MHPs seem willing to take legal risks (e.g., “I would rather take the chance, and if I get audited, I will just pay the money”). Aside from the seeming affront to professional ethics, it should be noted that relevant laws impose harsh penalties; for example, Florida Statute 443.071(2) states: “Any employing unit or any officer or agent of any employing unit or any other person who makes a false statement or representation, knowing it to be false, or who knowingly fails to disclose a material fact, to prevent or reduce the payments of benefits to any individual entitled to benefits, to avoid becoming or remaining subject to this chapter, or to avoid or reduce any contribution, reimbursement, or other payment required from an employer under this chapter commits a felony of the third degree . . . ,” which could lead to imprisonment and a fine—with a concomitant risk of a licensing complaint.
It is potentially foolish to attempt to bypass the employer-employee arrangement when the situation does not meet conditions required for an independent contractor. Trying to defend against an allegation of wrongdoing with “I didn’t know I was doing wrong” provides no assurance. When dealing with a particular legal situation, such as the distinction between employee versus independent contractor, it would be necessary to exercise due diligence, such as seeking consultation from a qualified attorney and/or accountant.

Even when legal or accounting advice has been received, erroneous advice may not be accepted by regulators or auditors as a legitimate rationale. Reducing or avoiding liability requires a reasonable basis, such as reliance on a court case, an IRS rule, a previous IRS audit having not raised the employee versus independent contractor issue, and/or advice from an attorney or accountable knowledgeable about the particular psychology practice, along with consistent reporting and filing of Forms 1099 for some (but not all) workers, and the like (PPC, 2007).

The bottom line is that a working relationship between MHPs may or may not be a legitimate independent contractor situation. Notwithstanding personal preferences, the direction and control that is inherent to the relationship between the MHPs may or may not justify an independent contractor relationship. In a goodly number of instances, the true nature of the relationship between the MHPs can be characterized as that of a landlord-tenant, perhaps with a payment provision for the management/support services provided by one MHP (who is paying the overhead expenses) to the other MHP.

In summary, three caveats are in order. First, even if associated MHPs are licensed, there may be vicarious liability. Second, if there is control and direction vested
with one MHP (such as a non-competition or non-solicitation agreement), the relationship is likely to be viewed as employment, not independent contracting. Third, there should be a well-defined written contract that considers the legal factors that will accommodate the “safe haven” (no liability) principle. Other financial issues may have legal implications for professional practice relationships, especially those that are relevant to the mandatory payment of employment-related taxes (e.g., social security, worker’s compensation, and unemployment compensation).

Conclusion

Given ethical and legal considerations, the preferred approach would seemingly be for associated MHPs to have an employer-employee relationship, and the payment arrangement to be a set wage for each hour worked, regardless of collections or billables. To do otherwise could elevate the risk of a violation of professional ethics and law, which could, of course, also lead to legal ramifications.

For almost two decades, MHPs have faced financial conditions that require higher overhead and yield lesser income. These negative conditions do not, however, justify resorting to financial arrangements that are unethical or illegal or degrade the mental health professions. To remain “professional,” MHPs must operate by ethics that benefit the public. As reflected in the laws pertaining to fee splitting and kickbacks and to independent contractor versus employment issues, there is a need for MHPs to be realistic. They should accept the modern limitations that are imposed by ethics and laws; in the alternative, there could be an effort to amend ethics and laws, albeit the mantle of “professionalism” may suffer degradation.
References


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