

# MEDICAL/LEGAL NEWSLETTER



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## STARK REALITY III

On September 5, 2007 the Centers for Medicare and Medicaid Services (“CMS”) published the third installment of the Stark II regulations (“Phase III” or the “Phase III Regulations”) with an effective date of December 4, 2007. The Stark II regulations implement the 1993 amended Stark Law known as Stark II. CMS issued the Phase I regulations on January 4, 2001 and the Phase II regulations on March 26, 2004. Phases I, II and III are intended to be read together.

Phase III, including its comprehensive preamble, primarily clarifies certain aspects of the Phase I and Phase II Regulations. Although the Phase III preamble is not part of the Phase III Regulations, it provides insight into CMS’ thinking and important guidance to physicians and their counsel. The impact of Phase III on physicians generally in Onondaga County is not especially significant. However, based on CMS’ commentary and on the changes proposed – but ultimately not adopted – in the 2008 Physician Fee Schedule Proposed Rule, significant changes can be expected in the future.

**“Phase III provides that a physician (which includes all of the members, employees and independent contractor physicians of the group) has a direct compensation arrangement with a DHS entity if the only intervening entity between the referring physician and the DHS entity is his or her group practice. When a physician stands in the shoes of his or her group practice, he or she will be deemed to have the same compensation arrangement as the practice has with the DHS entity.”**

A comprehensive analysis of the Phase III Regulations is outside the scope of this Article. However, the following are selected aspects of the Phase III Regulations which might be of interest to local physicians.

**“Stand in the Shoes.”** Prior to Phase III, if a DHS entity (such as a hospital) had a financial relationship with a physician’s group practice the arrangement was not considered a direct compensation arrangement between the DHS entity and the individual physician. Instead, a two-part analysis was required to determine whether the physician could make a referral to the DHS entity under Stark. First, did the relationship create an indirect compensation arrangement? If it did not, the arrangement was outside of the Stark Law. Second, if there was an indirect compensation arrangement, did it satisfy the indirect compensation exception? Certain agreements between hospitals and group practices have, by necessity, been structured to rely on the indirect compensation exception.

In the Phase III preamble CMS noted that the definition of indirect compensation arrangement was sometimes construed too narrowly, leading to the conclusion that the Stark Law did not apply to a particular arrangement. CMS sought to close this “unintended loop-hole” in Phase III by adopting a “stand in the shoes” requirement. Phase III provides that a physician (which includes all of the members, employees and independent contractor physicians of the group) has a direct compensation arrangement with a DHS entity if the only intervening entity between the referring physician and the DHS entity is his or her group practice. When a physician stands in the shoes of his or her group practice, he or she will be deemed to have the same compensation arrangement as the practice has with the DHS entity. For example, a compensation arrangement between a hospital and a physician group is now considered to be a direct compensation relationship between the hospital and each physician in the group. Certain types of compensation arrangements between hospitals and group practices, which formerly satisfied Stark’s indirect compensation exception, will not satisfy one or more of Stark’s direct compensation exceptions and so will need to be restructured or unwound.

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## GIVING A BREAK TO THE UNINSURED

With almost 47 million uninsured in this country, physicians are often willing to give a payment discount to self-pay patients. But many are fearful that if they don't charge everyone the same amount they will be doing something illegal under the Medicare rules. This issue has been under review by CMS for the past several years and recently it clarified its position in a manner that should give physicians the guidance they need.

The Social Security Act gives the Office of Inspector General (OIG) the authority to exclude any provider who charges Medicare or Medicaid "substantially in excess of such individual's or entity's usual charges" unless good cause for such charges can be demonstrated. The regulation promulgated by the OIG pursuant to this authority does not define "substantially in excess" or "usual charges."

In 2003, the OIG published a proposed rule that a provider's "usual charges" would include charges billed directly to cash paying patients, but not charges for services provided to uninsured patients free of charge or at a substantially reduced rate. The rule would also have defined "substantially in excess" to mean those charges that are more than 120 percent of the provider's usual charges. Fortunately for physicians, the OIG decided that the rule should not apply to claims for physician services reimbursed under the Medicare fee schedule. The OIG felt that the reimbursement scheme under Medicare – the payment of the lower of actual charges or the fee schedule amount – was the functional equivalent of a prospective payment methodology and therefore should not raise any concern about claims substantially in excess of usual charges. However, the OIG solicited further comments as to whether any services reimbursed based on the physician fee schedule should be subject to these regulations. It also noted that ancillary services, such as laboratory tests and drugs, would remain subject to the regulations, even when furnished by physicians.

The OIG was still reviewing the proposed rule in 2004 when it stated that it would continue to be the OIG's enforcement policy that when calculating their "usual charges" individuals and entities need not consider free or substantially reduced charges to (i) uninsured patients or (ii) underinsured patients who are self-paying patients for the items or services furnished.

Then in somewhat of a turnabout, in June of this year the OIG declined to promulgate a final rule that would define the terms "substantially in excess" and "usual charges". It confessed that it didn't have enough information to establish a benchmark for "substantially in

excess" and in addition had concerns that a final rule would have the unintended effect of increasing health care costs across the industry.

**“ OIG again reiterated its policy that in calculating “usual charges” providers do not need to consider free or substantially reduced charges to uninsured patients or underinsured patients who are self-paying for the items or services furnished.”**

Despite the withdrawal of the proposed rule, OIG again reiterated its policy that in calculating "usual charges" providers do not need to consider free or substantially reduced charges to uninsured patients or underinsured patients who are self-paying for the items or services furnished. The OIG policy, however, only applies to claims for reimbursement under the Medicare and Medicaid programs. Commercial insurers and HMOs may or may not adopt the same policy. Some provider agreements with commercial payers may limit reimbursement to the lesser of the usual charges of the provider or the payer's fee schedule and therefore any medical practice with a significant number of uninsured or underinsured patients should carefully review its participating provider agreements and proceed cautiously until it determines the payer's policy with respect to discounted care.

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## THE EXPANDED ANTI-MARKUP PROVISION: THE MORE YOU DO, THE MORE YOU LOSE

Under the Stark Law a physician may provide diagnostic testing services – such as lab and imaging services – to its Medicare patients and bill Medicare for such services at the Medicare fee schedule if it satisfies Stark’s in-office ancillary service exception. Consistent with this exception a physician may provide the services in the “same building” as its medical office or in a “centralized facility,” provided that it has exclusive use of the facility 24/7. There is no requirement that the services be provided within the confines of the physician’s office. Effective January 1, 2008, however, physicians providing diagnostic testing services to their Medicare patients in locations other than their own office will be precluded from earning a profit – and, in fact, will be required to absorb a loss – from providing such services.

Medicare currently prohibits physicians from marking up – or profiting from – the technical component of purchased diagnostic tests (the “Anti-Markup Provision”). If a physician purchases a diagnostic test performed by another supplier and wishes to bill Medicare for the test, the physician may not bill more than the actual cost of purchasing the test. CMS’ 2008 Medicare Physician Fee Schedule final rule, which was released on November 1, 2007 and will become effective on January 1, 2008, extends this ban to the purchase of the professional component of diagnostic tests and, more importantly, to situations in which the test is ordered by the billing physician and the professional or technical components of the test are performed at a location other than the office of the billing physician.

Unless the professional and technical components of a diagnostic test ordered by a physician are performed at the “office of the billing physician,” the Anti-Markup Provision applies. Under the Anti-Markup Provision the amount a physician or other supplier may bill Medicare may not exceed the lowest of: (1) the performing supplier’s net charge; (2) the billing physician or other supplier’s actual charge; or (3) the fee schedule amount for the test that would be allowed if the performing supplier billed Medicare directly. For a physician providing

diagnostic testing services, the lowest charge always will be “the performing supplier’s net charge.” In determining the “net charge” the billing physician cannot take into account the cost of equipment, space or general overhead. What can be included? It appears only the salary and benefits of personnel performing the tests. CMS ominously warned physicians and suppliers against trying to “game” the application of the Anti-Markup Provision.

What qualifies as an “office of the billing physician?” For a solo physician, it means the medical office space where the physician “regularly furnishes patient care.” For a group practice, it means space in which the group “provides substantially the full range of patient care services” that the group generally provides. This means that the services must be provided within the four walls of the office in which the physician group regularly provides its patient care services. Although Congress permits a physician to provide diagnostic tests to Medicare patients in locations other than the physician’s office provided the applicable Stark Law requirements are met, CMS has eviscerated this by requiring the physician to absorb a loss each time tests are provided to Medicare beneficiaries from those sites. Many physicians have made substantial investments in equipment, facilities and personnel to provide diagnostic testing services to their patients in compliance with the Stark Law. The Anti-Markup Provision may put many of these arrangements in jeopardy.

CMS’ reason for expanding the Anti-Markup Provision was to guard against potential overutilization of diagnostic tests. Although many consider this expansion to be a reaction to the pathology pod lab phenomenon, it will certainly impact other arrangements that are not considered abusive.

Wood & Smith, P.C. represents physicians, physician organizations and other health care providers on regulatory, business, real estate and tax matters. Our mission is to help our clients plan for and respond to the challenges and opportunities that exist in the health care industry.

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Compliant indirect compensation arrangements in effect as of September 5, 2007 will be grandfathered during their original term or current renewal term. Upon the expiration of such term, the “stand in the shoes” provision will apply. Parties will need to re-examine ongoing arrangements and determine whether they can be restructured to meet a direct compensation exception. If not, they may need to be unwound. Note that application of the “stand in the shoes” requirement for academic medical centers and nonprofit integrated health care systems has been delayed for one year.

#### **Physician Recruitment/Restrictive Covenants.**

Under the Phase II regulations a physician group could not impose “additional practice restrictions” on a recruited physician, other than conditions related to the quality of care. Phase III modified this restriction to prohibit only those restrictions that “unreasonably restrict the recruited physician’s ability to practice medicine in the geographic area served by the hospital.” In the Phase III preamble CMS noted that it never intended to prevent practices from restricting the recruited physician from moonlighting or prohibiting the solicitation of patients or employees or prohibiting the disclosure of confidential or proprietary practice information. CMS also noted that a practice could require the recruited physician to pay reasonable liquidated damages if the physician leaves the practice and remains in the community (CMS warned that a liquidated damages clause requiring a significant or unreasonable payment may be an impermissible practice restriction). Finally, CMS acknowledged that a hospital providing financial assistance may prohibit the hiring practice from imposing a non-compete or other practice restrictions.

**Direct Contracts with Independent Contractors.** Stark permits group practices, under certain circumstances, to use independent contractor physicians to provide designated health services billed by the group. Such relationships are structured in a way that allows the group to comply with Stark’s physician services and in-office ancillary services exceptions. Compliance with these exceptions requires, among other things, that the contracted physician qualify as a “physician in the group.” In Phase III, CMS provides that for an independent contractor to qualify as a “physician in the group,” the group’s contract must be with the individual physician, and not a separate legal entity, such as the physician’s practice.

**Incident-To Services.** There had been some ambiguity under Stark as to whether a group practice could provide a physician who ordered a diagnostic test with production credit for such test if the test was provided “incident to” other services rendered by the ordering physician. CMS clarifies in the Phase III preamble that services, such as diagnostic services, that have their own benefit category cannot be billed as “incident to” a physi-

cian service and credited to the performing physician. For example, Medicare-covered imaging services comprise a single benefit category and cannot qualify as “incident to” services, and thus should not be credited to the ordering physician under a productivity-based compensation methodology. This, however, will not prevent a group practice physician (including the ordering physician) from receiving credit for personally performed services, including professional interpretations of diagnostic tests performed by the physician.

**Office Sharing.** In response to questions about physician office sharing arrangements in the preamble, CMS clarified that physicians must satisfy the applicable space and/or equipment lease exception. CMS reiterated that for space and equipment leases to comply with the Stark space and equipment lease exceptions the lessee must have exclusive use of the rented space or equipment during established blocks of time. In other words, multiple parties cannot have the right to use the same facilities at the same time. Common areas may be shared, provided that rent is appropriately prorated among the lessees. Note that exam rooms are not considered common areas for purposes of the exception. Some shared lease arrangements may need to be restructured to include block time.

#### **Income Guarantees and Allocated Costs.**

Prior to the Phase II regulations, an income guaranty provided by a hospital to a physician recruited into an existing practice could cover the recruited physician’s overhead expenses calculated on a pro rata or per capita method. Stark’s Phase II regulations limited overhead expense allocation to the actual additional incremental costs attributable to the physician. Phase III now provides limited relief from this restriction to practices located in a rural area or a HPSA. If a physician is recruited to a practice in one of these locales to replace a physician who retired, relocated or died within the prior year, the overhead allocation may be based on the lower of a per capita allocation or 20% of the practice’s aggregate costs (if greater than the additional incremental costs attributable to the recruited physician).

**It’s a Party.** Stark’s nonmonetary compensation exception permits a DHS entity – like a hospital – to give referring physicians non-cash items of value such as gifts, meals, and entertainment that do not exceed \$300 (as adjusted annually by the CPI) in value per year. Phase III amends this exception to permit a DHS entity with a formal medical staff to exclude from this cap the value of one medical staff appreciation function (such as a holiday party) for the entire medical staff. Any gifts or gratuities provided in connection with the event, such as door prizes, must still be included in the calculation.

**UPDATE to "The Expanded Anti-Markup Provision: The More You Do, the More You Lose":** On December 31, 2007, following the publication of the Winter 2007 Newsletter, the Centers for Medicare & Medicaid Services (CMS) issued a final rule delaying the effective date of the Anti-Markup Provisions from January 1, 2008 to January 1, 2009, except with respect to the technical component of purchased diagnostic tests (which historically have been subject to anti-markup limitations) and anatomic pathology diagnostic testing services provided in a "centralized building" which does not qualify as the "same building" under the Stark Law. CMS opted to delay the effective date one year so it could further study certain features of the Anti-Markup Provisions which "may not be entirely clear" or "could have unintended consequences."