

To be a Stark group practice

What it takes and 1.33 million reasons why it matters

BY ALICE G. GOSFIELD, ESQ. AND DANIEL F. SHAY, ESQ.



Every month, *Dermatology World* covers legal issues in *Legally Speaking*. This month's authors, attorneys Daniel F. Shay, Esq. and Alice G. Gosfield, Esq., are health care attorneys at Alice G. Gosfield and Associates, P.C.



Designated health services (DHS)

For dermatologists in single-specialty practices, the primary DHS likely to be at issue are clinical laboratory services, including anatomic pathology, and outpatient prescription drugs. Within multi-specialty group practices, where dermatologists receive and give referrals from and to others, other designated health services may well be implicated: Imaging including MRI, CT, ultrasound and PET; physical and occupational therapy; durable medical equipment; prosthetic and orthotic devices and supplies; parenteral and enteral nutrients, equipment and supplies; home health agency services; radiation therapy; and inpatient and outpatient hospital services.

When the Stark statute was enacted, its primary purpose was to curb unnecessary utilization of designated health services (DHS) by imposing restrictions on the circumstances under which physicians might refer their Medicare patients to entities with which they had financial relationships. But, too many restrictions would impede patient access to care, particularly within a legitimate group practice. Consequently, the drafters adopted a definition of a group practice which must be met for physicians to be able to refer for DHS within a group, including for in-office ancillary services.

In the almost 20 years since the law was enacted, there has been virtually no enforcement activity focused around the definition and its implications. That changed in the summer of 2014 when a private practice cardiology group entered into a settlement with the Office of the Inspector General and the Department of Justice for more than \$1.33 million for its internal compensation practices, which a whistleblower challenged as noncompliant with the group practice definition. The detailed requirements for group practice compensation, which are addressed in the Stark definition and also apply to the anti-kickback statute, are certainly now a high-profile target of whistleblowers. More than that, the implication of the settlement is that all aspects of the group practice definition could be the basis for similar charges, with penalties of up to \$11,000 per claim submitted pursuant to an improper transaction, plus triple the charges.

The regulators have created eight components to the definition, each of which must be met for compliance.

1 Single legal entity

Here, the regulators have been liberal, allowing any legal form of a medical practice that would qualify under state law, whether a partnership, limited liability company, foundation, corporation, or other legally organized configurations. The practice entity may be owned by any kind of other entity, including another practice, as long as the owning practice or practices are not functioning as practices. This provision was intended to allow existing professional entities to join together to form a new practice entity. Hospitals can own group practices but the regulators have made clear that physicians employed directly by hospitals, even if there are many of them, do not qualify as a group practice unless they are employed in a separate legal entity. This entity might be owned by the hospital or, in the non-profit setting, the hospital or the health system may be the single member of the corporation which forms the group practice. "Sister" corporations or corporations under common control may not be considered together to be one single legal entity.

2 At least two physicians

In order to be a group, the statute requires at least two "members" of the group which are defined by regulation to be shareholders, partners, or W-2 employees. They must be



“physicians,” which under Stark includes allopaths, osteopaths, chiropractors, optometrists, podiatrists, and dentists. Mid-level practitioners, such as nurse practitioners and physician assistants, do not count as physicians, even when they are performing precisely the same services that physicians would. Independent contractors are not included in the calculation of the members of the group. On call and locums physicians substituting for members do qualify as members for the time period when they are substituting for the members.

The requirements to be a member are further heightened by the application of the next three aspects of the definition.

3 Full range of care

Each member, as defined above, must provide substantially the full range of patient care services he routinely provides. This means, as an example, that if a dermatologist with a full-bore dermatology practice in one situation is hired by another dermatology group to only perform Mohs surgery, this would not meet the full range of care requirement. By contrast, independent contractors can be hired to perform a single service. The regulators have not elucidated much with regard to this component, stating only that they would expect that any physician member performs the same scope of services within the group and outside the group.

4 75 percent of the encounters

The members of the group must personally conduct no less than 75 percent of the physician-patient “encounters” of the group practice. Interestingly, the term “encounters” is not defined, but is more narrow than the definition of a physician service for which Medicare allows reimbursement. That definition requires that the physician interact face-to-face with the patient or be able to visualize some aspect of the patient’s condition without the interposition of a third party’s judgment. The Stark regulators have specifically stated that interpretations-only do not qualify as encounters.

(The use of the term “encounters” in the context of Medicare physician reimbursement is a relatively new term since other face-to-face encounters were traditionally either “visits” or “procedures.” The term “encounter” is used in the requirements associated with billing for care plan oversight, to qualify durable medical equipment and home health for reimbursement, in shared visits, and where more than half of the visit is counseling or coordination of care.)

The import of this 75 percent encounter rule is that independent contractors in a practice could not perform many of the physician-patient encounters and maintain compliance.

5 75 percent of patient care services

Substantially all of the patient care services of the members must be provided through the group. This calculation requires an analysis of the time that each of the members spends with the group and then averaging it. The average must total at least 75 percent.

This calculation is not as straightforward as it might initially seem. For example, a physician who works as a medical researcher, for a pharmaceutical company, or as a hospital administrator who spends only one day with the group, but that is his only clinical service, would be counted at 100 percent. Similarly, a part-time physician who spends all of his or her clinical time with the group would count at 100 percent. Still further, “patient care services” are not merely clinical services but include the physician teaching the group’s staff, ordering equipment, managing the group, performing quality assurance in the group, or otherwise engaging in activities that benefit the group. However, wholly outside activities like teaching and research don’t count as patient care services for the group.

Start-up groups get 12 months to comply if they are making a reasonable good faith effort to meet the 75 percent test. If a new physician relocates to the practice, as defined in accordance with the geographic area restrictions in the physician recruitment exception, the group has 12 months to comply with the 75 percent rule. This rule does not apply to group practices in health professional shortage areas (HPSAs).

The rest of the requirements for compliance turn on the financial operations of the group practice.

6 Distribution of expenses and income

Many people are concerned about the allocation of expenses under the group practice definition. The regulators appear to have not been so concerned. They have merely stated that overhead must be allocated according to formulas established before the money to be attributed to overhead is received. Unlike other exceptions under Stark, the formulas can be adjusted prospectively ad infinitum and not just once a year. The expenses allocated within the group must relate to shared facilities that are used in common by the group, which does not mean that

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DHS safe harbors

There are three ways regulators say practices can be sure to steer clear of regulatory issues related to profit-sharing:

1

Profits may be shared equally per capita.

2

Profits may be allocated based on the distribution of the group practice's revenues attributed to services that are not DHS payable by any federal health care program or private payer. This is the most typical approach.

3

Revenues derived from DHS constitute less than 5 percent of the group practice's total revenues and the allocated portion of those revenues to each physician in the group constitutes 5 percent or less of his or her total compensation from the group.

each physician must use all of the facilities, but rather relates to the unified business test which is the next requirement.

The regulators have explicitly acknowledged that it is permissible to have location-specific (e.g., the Elm Street office versus the Maple Street office) allocations of overhead, as well as specialty-specific allocations, such as where there is less overhead allocated to physicians who spend most of their time in the hospital or even to primary care physicians in a multi-specialty group because they don't do procedures or use expensive equipment.

7 Unified business

The group practice must operate as a unified business with centralized decision making by a body representative of the group that maintains effective control over the group's assets and liabilities, including but not limited to budgets, compensation, and salaries. This permits the modern version of the "group practice without walls." It also means that, with regard to compensation, subgroups may not have complete autonomy.

The group itself must have consolidated billing, accounting, and financial reporting. Billing can be conducted functionally in different locations, but the revenues received must be considered the revenues of the group as a whole. This essentially means that the group must operate utilizing one tax ID number.

8 Compensation

Here, the drafters of the legislation were intending to blunt the financial incentive to refer for DHS, even within a group, by the adoption of the following provision:

"A physician in a group practice may be paid a share of overall profits of the group or a productivity bonus based on services personally performed or incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician."

There are a host of lurking pitfalls. The separate components of profit sharing, productivity, and 'incident to' are elucidated below.

A. Profit sharing

Profit sharing is the allocation of dollars to the physicians in the group which entail physicians benefitting from the fruits of others' labors from DHS. The prime example is sharing diagnostic testing revenues among

the physicians in the group. For any subgroup of physicians to share in profits, there must be a pod of at least five physicians. However, if the group consists of fewer than five, all must be paid in accordance with the same formula, which is not necessarily the same amount.

In determining what formula to use for profit sharing, it is improper to include current DHS ordering patterns. In other words, physicians may not be paid directly for the DHS which they order but do not perform. On the other hand, the use of surrogates for ordering patterns is legitimate, including the volume of E/M services, work RVUs excluding DHS unless personally performed, numbers of patients, or even numbers of procedures. Almost any verifiable formula which does not directly reward the ordering of DHS may be utilized.

There is no requirement that all the physicians in the group or even all the members need be included in profit sharing. Non-shareholders who are employees can be paid a share of profits, as can independent contractors. The profit sharing may be paid as compensation and need not be paid as dividends.

It is legitimate to use historical ordering patterns, such as a two-year rolling average in the past, to establish a formula to be used prospectively going forward. It is legitimate to have multiple pods within a group such as the physical therapy pod, the infusion pod, the clinical laboratory pod, or the imaging pod. Different physicians might participate in each of these, depending on the size of the group. In very large groups, pods can be established based on low, mid, and high historical utilization, but not current utilization.

B. Productivity

Paying productivity in compensation is paying the physician for the fruits of his own labors, plus services that are 'incident to' his services. 'Incident to' cannot be used for diagnostic services, which means physicians may not be allocated the technical component of diagnostic services, which is what happened in the New York cardiology settlement. Interestingly, the settlement in 2014 was for compensation paid in 2007 and 2008. It is noteworthy that the change in prohibiting diagnostic testing from being considered an 'incident to' service was made in



2007. The technical components of diagnostic testing revenue now must be allocated in a profit sharing formula, unless the physician literally personally performs the technical component.

Some people get concerned about how to allocate the dollars from mid-level visits, but these are not DHS and can be handled any way the group wants, including allocating those dollars directly to the primary treating physician, or in profit sharing, or in some of each. Productivity can be paid as a percentage of revenues; and independent contractors can be paid productivity.

Incident to

The reference to ‘incident to’ services draws into the compensation rules a fundamental principle of Medicare reimbursement which was enacted with the inception of the Medicare program. The allocation of ‘incident to’ revenues runs counter to the idea that the physician cannot be paid for the volume or value of referrals since ‘incident to’ services are, by definition, referred by the treating physician. But the regulators have stated no less than three times that ‘incident to’ dollars may be allocated directly on a dollar for dollar basis to the ordering and treating physician.

To meet the ‘incident to’ requirements, the services of non-physicians must be rendered under the direct supervision of the physician, which means on premises and within the office suite. This is as distinct from the Stark standard for rendering services “in the same building” where the premises are measured by the street address. For ‘incident to’ services to qualify, a supervising physician must be in the office suite and immediately available to assist at all times that the ancillary personnel are rendering services. The ancillary personnel need not be employees or leased employees, except that Medicare will not pay anyone other than the W-2 employer of a physician assistant for those services.

There must be a physician professional service to which the ancillary services are incident, which means that mid-level practitioners, even if recognized by Medicare to bill on their own numbers, may not bill ‘incident to’ for an initial visit. Still further, the services of the ancillary personnel must be provided in a course of treatment initiated by a physician. Some Medicare Administrative Contractors have gone so far as to say a new symptom requires that the physician see the patient again to establish a new course of treatment.

‘Incident to’ revenues include revenues from services and supplies, but not from durable medical equipment. The services billed ‘incident to’ must be of a kind commonly furnished in a physician’s office or clinic and commonly rendered without charge or included in the physician’s bill.

The supervising physician need not be the treating physician, but must be a physician in the group who is engaged in seeing other patients while he is supervising. Supervision alone does not qualify the non-treating physician to be counted as supervising. If four categories of advanced practice personnel (physician assistants, nurse midwives, nurse practitioners, and clinical nurse specialists) perform visits, they can bill the highest level of applicable E/M code ‘incident to’ the physician. All other personnel conducting visits without the physician’s involvement may only bill a 99211. In no event can ancillary personnel provide counseling or coordination of care billing without physician involvement, since the only time that counts for a physician to bill based on counseling or coordination of care is the physician’s “face time” with the patient.

A related concept is that of shared visits, which permits a physician and a non-physician practitioner (NPP) in the same group seeing patients in the hospital inpatient setting, outpatient departments, or emergency department to perform separate services and bill them as if the physician performed all of them. The NPP can see the patient first and the physician can follow. If the physician performs any part of an E/M visit in an encounter with the patient face-to-face, he may gross up the work he has done with that of the NPP, select the appropriate E/M code based on the resulting combination, and bill it all under the physician’s number. This is not technically ‘incident to,’ which is an office setting-only concept, but it is “personally performed” for Stark purposes. However, since these visits are not DHS, they should not pose much of a problem.



Conclusion

The Stark group practice definition is surprisingly complex. It reaches directly into the internal operations of a group, opening the door to whistleblowers with inside knowledge to cause problems. Given the draconian impact of the penalties in this context, all groups should be re-examining their compliance with the Stark group practice definition if they provide designated health services. *dw*



PRODUCTIVITY safe harbors

There are three ways regulators say practices can be sure to steer clear of regulatory issues related to paying productivity:

1

It may be based on the physician’s total patient encounters or RVUs.

2

It may be based on an allocation of the physician’s compensation attributable to services that are not DHS payable by any federal health care program or private payer.

3

Like profit sharing, revenues derived from DHS constitute less than 5 percent of the group practice’s total revenues and the allocated portion of those revenues to each physician in the group constitutes 5 percent or less of his or her total compensation from the group.