

Understanding Group Practice Compensation Arrangements: How to Drive Yourself “Stark” Raving Mad!

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I. Introduction

The Stark Law (“Stark”)¹ creates an imposing set of rules that define in what limited circumstances physicians may refer to businesses that provide “designated health services” (DHS), where the physician has a financial relationship with the business and Medicare is implicated. Stark contains a myriad of exceptions, so that if certain defined facts are satisfied Stark does not apply. If a group practice intends to provide DHS within its practice, an exception to Stark must be met. Generally that exception is the one for in-office ancillary services. To meet that exception the group must, among other things, satisfy the Stark definition of “group practice.” This definition is multifaceted and complex.

One of the most important yet misunderstood areas of Stark is the compensation requirement of a group practice. We have discovered that the compensation test is much more intricate than readily meets the eye. For example, group practices are not permitted to distribute profits derived from DHS based *directly* on the volume or value of referrals.² However, there are a number of ways that a group practice can distribute profits, including DHS profits, to its physicians, based *indirectly* upon referrals, without running afoul of Stark. Further, group practices generally do not realize the many ways in which they may be able to divide profits not implicated by Stark. The width and breadth of the compensation requirement is widely misunderstood; this article sets out to clarify these issues.

II. Overview of Stark

Stark provides that neither a physician nor his or her immediate family members may make a referral to an entity, or make or cause to be presented a claim to the Medicare program or any individual, third party payer, or other entity, for DHS, if such physician or family member has a “financial relationship” with such entity.³ A financial relationship includes an ownership or investment interest in the entity or a compensation arrangement with the entity. DHS currently consists of 11 different types of services, which includes such items as laboratory services, physical therapy, radiology services (MRI, tomography and ultrasound), radiation therapy, home health services, and outpatient prescription drugs.⁴ Both the professional (i.e., personally performed by a physician or other medical professional) and technical (i.e., payment for the use of

¹ 42 U.S.C. § 1395nn; 42 C.F.R. § 411.351 et seq.

² *Id.*

³ 42 C.F.R. § 411.353..

⁴ 42 U.S.C. § 1395nn(h)(6); 42 C.F.R. § 411.351.

machines, space, personnel and supplies) components are DHS, subject to certain exceptions.

Stark only applies to DHS reimbursed in whole or in part by Medicare, including Medicare Choice and Medicare Part D Plans, and does not include reimbursement by any other payers.⁵ The Centers for Medicare and Medicaid (“CMS”) publish a list of certain DHS by CPT codes. The list is updated annually and can be accessed at http://www.cms.hhs.gov/PhysicianSelfReferral/11_List_of_Codes.asp. Diagnostic and certain therapeutic nuclear medicine services, including positron emission tomography (“PET”), will become a DHS on January 1, 2007.⁶

It is important to understand that Stark is a “black and white,” strict liability law. There is no middle ground, and the penalties for violating the law (such as financial penalties, expulsion from the Medicare program, and potential liability under the Federal False Claims Act) are severe.⁷

A. **In-Office Ancillary Services Exception**

1. **Group Practice Requirements**

The threshold requirement for a medical practice to qualify for the in-office ancillary services exception is to satisfy the definition of a group practice. The definitional requirements are generally described below.

The Single Legal Entity Test – The group practice must be organized as a single legal entity. The entity can be any form allowed by local law and generally must bill under a single Medicare number. Depending on local law, it need not be owned solely or even at all by physicians, but it may not be owned by any other operating medical practice.⁸ It is permissible for the group practice to own and operate subsidiary entities.⁹

The Two Physician Test – The group practice must have at least two “member” physicians providing medical services. A member may be either an owner or employee of the group or, under certain conditions, an on-call or *locum tenens* physician. An

5. Stark only applies to referrals for certain DHS payable by Medicare; CMS stated that “we had intended to address in this Phase II rulemaking section 1903(s) of the Act, which applies section 1877 of the Act to referrals for Medicaid covered services and which we interpreted in the proposed rule at § 435.1012 and § 455.109. However, in the interest of expediting publication of these rules, we are reserving the Medicaid issue for a future rulemaking with one exception. In this rulemaking, we are amending the prepaid plans exception at § 411.356(c) to cover Medicaid managed care plans.” 69 Fed. Reg. 16054, 16055 (Mar. 26, 2004).

6. 70 Fed. Reg. 70115 (November 21, 2005).

7. See Fabrikant R, Kalb PE, Hopson MD, Bucy PH. *Health Care Fraud: Enforcement and Compliance*. New York, NY: Law Journal Press. 1996:§4.05[5]; 42 USC §1395nn(g); 42 USC §1320a-7a(a)(7).

8. 42 C.F.R. § 411.352(a).

9. *Id.*

independent contractor cannot be a member.¹⁰ Leased employees will be treated as members if they are bona fide employees of the group under IRS rules.

The Full Range of Services Test – Each member physician must provide for the group the full range of services that the physician routinely provides.

The Substantially All Services Test – Substantially all (defined as at least 75% in the aggregate) of the services of the group’s member physicians must be provided to the group and billed by the group under its billing number, and collections from such billings must be group receipts. This test limits the ability of the group to have part-time physician employees since they will make it more difficult to meet the 75% rule. This test does not apply to any medical practice located in a health professional shortage area.¹¹ Further, there is a “good faith” exception to this test for the first 12 months after a new group practice goes “live.”¹²

The Distribution of Income and Expenses Test – The group practice’s overhead expenses must be charged and its income distributed in a manner determined prior to their occurrence. A group’s distribution method may be modified as often as desired, so long as the changes are only applied prospectively and are not based upon the pattern of referrals.¹³

The Unified Business Test – The group’s governance documents must provide for decision-making by a centralized body (such as a Board of Directors), which has effective control over the group’s assets and liabilities, including physician compensation. The group must also provide consolidated billing, accounting and financial reporting.¹⁴

The Patient Encounters Test – Members of the group must, in the aggregate, personally conduct at least 75% of the physician-patient encounters of the group practice. This test is intended to make certain that the group practice is legitimate and not primarily organized to perform ancillary services.¹⁵

The Compensation Test – This test (the “Compensation Test”) directly affects the group’s internal compensation system. It allows a physician member of a group practice to be paid a share of overall group DHS profits or a productivity bonus based upon personally performed or “incident to” services, so long as the share or bonus is not

10. 42 U.S.C. § 1395nn(h)(4)(A); 42 C.F.R. § 411.351. The term used in Stark Regulations is “member of the group.”

11. “Health professional shortage area means any of the following which the Secretary [of the Department of Health and Human Services] determines has a shortage of health professionals: (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.” 42 C.F.R. 5.2.

12. 42 U.S.C. § 1395nn(h)(4)(A)(ii); 42 C.F.R. § 411.352(d).

13. 42 U.S.C. § 1395nn(h)(4)(A)(iii); 42 C.F.R. § 411.352(e).

14. 42 U.S.C. § 1395nn(h)(4)(A)(i); 42 C.F.R. §§ 411.352(f)(i) and (ii).

15. 42 C.F.R. § 411.352(h).

determined in a manner that is *directly* related to the physician's volume or value of referrals.¹⁶ Note that an *indirect* relationship to the volume or value of referrals is acceptable; the relationship simply cannot be *direct*. Overall profits can include the profits generated by the entire group or any subset of the group consisting of at least five physicians. Stark includes safe harbor formulas for distribution of DHS profits, whether part of overall profits or as a productivity bonus. The form of DHS distribution need not meet one of these safe harbors, but doing so provides certainty that the distribution arrangement is Stark compliant. Overall profits may be further segregated and pooled within a subset of the full group practice, so long as the subset contains at least five physicians (any grouping will suffice if all other requirements are met).¹⁷

2. In-Office Ancillary Services Requirement

Even if the physician organization qualifies as a group practice, three additional tests must be met before the in-office ancillary services exception is satisfied.

The first test is the **Performance and Supervision Test**. This test requires that DHS be performed by either the referring physician, another member physician, or an individual properly supervised by either (a) the referring physician or (b) another physician in the group. Pursuant to 42 C.F.R. § 411.351, "a physician in the group" may be an independent contractor, so long as his or her contract complies with Stark's personal services exception.¹⁸ The level of supervision required for Stark is the same level required for Medicare billing purposes.

An independent contractor physician may furnish DHS resulting from his or her referrals, or supervise DHS furnished by a non-physician, but the general rule is that he or she may not personally furnish DHS referred to him or her by an other group physician.¹⁹ However, other exceptions to Stark may allow him or her to furnish the services. For example, the physician services exception enables physicians in group practices to make referrals to other physicians within their group practices. CMS has interpreted the physician services exception to apply to referrals to (or referral services supervised by) a member of the group practice or an independent contractor who qualifies as a "physician in the group."²⁰

The second test is the **Site of Service Test**. There are two alternative methods to satisfy this test. The first alternative is the "same building" test. It requires that the physician making the referral (or any other physicians who are members of the group)

16. 42 C.F.R. § 411.352(g). A member of a group practice may be an owner, employed physician, or under certain circumstances an on-call or locum tenens physician, but the definition does not include an independent contractor. *Id.* Leased physicians will be treated as members if they are bona fide employees of the group under IRS rules. *Id.*

17. 42 C.F.R. § 411.352.

18. 42 C.F.R. § 411.357(d). Pursuant to the personal services exception, a physician's services provided personally by, or under the personal supervision of, another physician in the same group practice as the referring physician are not prohibited by Stark. 42 U.S.C. § 1395nn(b)(1).

19. 42 U.S.C. § 1395nn(b)(1)-(2)(A); 42 C.F.R. § 411.355.

20. 66 Fed.Reg. 856, 879 (Jan. 4, 2001).

provide a certain amount of physician services (see paragraph below), unrelated to the furnishing of DHS, in the same building where the DHS is furnished. “Same building” means a structure or combination of structures that share a single street address.²¹

Stark establishes three optional methods that may be utilized to meet the “physician services” part of the same building test. Option 1 requires that the group’s office in the building be open for medical services (not including DHS) at least 35 hours per week, and that the referring physician or one or more group members regularly practice medicine in the building at least 30 hours per week. Option 2 requires that patients receiving DHS in the building also normally receive physician services in the building from the referring physician or a group member, the office be normally open for medical services at least eight hours per week, and the referring physician (himself or herself personally) regularly practice medicine in the building at least six hours per week. Option 3 requires that the referring physician or a group member be on the building premises while DHS is being furnished, the office in the building be open for medical services for the group’s patients at least eight hours per week, and the referring physician or a group member or members normally practice medicine on the premises at least six hours per week.²²

The second alternative is the “centralized building” test. Some or all of the group’s DHS may be delivered in a “centralized building” where no general medical practice is conducted. A “centralized building” may be a part of a building (or a mobile van or trailer), but the space must be owned or leased on a full-time basis (24 hours per day, 7 days per week for not less than six months in a year) and used exclusively by the group. A group may have more than one centralized building.²³

More than one medical group practice located within the same building may share equipment to provide DHS within the building. This sharing structure has become a popular method of creating multiple opportunities for DHS within a single structure utilized by many group practices.²⁴ Creating a structure that meets all legal requirements (including compliance with federal and state laws) and satisfies all of the parties to the transaction is possible, but can be extremely difficult, complex and expensive. Even if a structure complies with Stark it must also comply with federal fraud and abuse laws.²⁵

21. 42 U.S.C. § 1395nn(b)(2)(A)(ii); 42 C.F.R. § 411.355.

22. 42 C.F.R. §§ 411.351, 411.355(b)(2).

18. *Id.*

24. The ability to enter into sharing arrangements would be restricted if the proposed rule regarding the requirements to satisfy the definition of “centralized building” recently announced by CMS were to become final. 70 Fed. Reg. 48982, 49054-57 (August 22, 2006); *See* David Armstrong, *U.S. May Tighten Rules That Let Doctors Profit From Medical Tests*, WALL STREET JOURNAL, October 23, 2006, at A1 and A10.

25. Two Office of Inspector General (“OIG”) opinions, 04-08 and 04-17, issued in 2004, found unacceptable, from a Federal fraud and abuse context, structures apparently designed to meet the “Site of Service” test. The lesson is that even if a structure complies with Stark, it also must be analyzed to determine whether it complies with other fraud and abuse laws.

The final test is the **Billing Test**. For this requirement to be satisfied, DHS must be billed by the performing or supervising physician, the group practice, an entity wholly-owned by the group or the performing or supervising physician, or by an independent third party under an arrangement that complies with Medicare billing and reassignment requirements.²⁶

B. Compensation Arrangements

Group practices generally are not permitted to distribute profits derived from DHS, or pay compensatory bonuses, based directly on the volume or value of referrals for DHS. However, it is permissible for a group practice to distribute DHS profits to its physicians without violating Stark. The most current regulations interpreting Stark (the “Stark Regulations”)²⁷ provide how this can be done.

There are a number of methods that a group practice can utilize to distribute DHS profits to its physicians without violating Stark. For example, the Stark Regulations permit a group practice to subdivide into groupings (which we will call “centers”) of five or more physicians without limitation (commonly referred to as the “Rule of Five”).²⁸ Decisions about distributions of DHS may be made within the context of each center, provided that the manner of distribution meets the Compensation Test discussed below.²⁹

1. **Compensation Test (Distribution of DHS Profits)**

As described above, to satisfy the definition of group practice under Stark the group practice must meet the Compensation Test. The Compensation Test only applies to the group’s allocation of DHS; therefore, it directly affects the group’s compensation structure with regard to DHS revenue. While physicians may always be directly compensated for personally performed services, they may not receive compensation that is based on referrals except through certain permitted *indirect* methods discussed below.

The Compensation Test is defined in two parts:

i. In general, “[n]o physician in the group practice may receive compensation that is directly or indirectly based on the volume or value of the designated health service referrals of the physician, *except* through certain indirect methods that are deemed to be acceptable under the law.”³⁰

ii. As for the allowed indirect methods, “a physician in a group practice may be paid a share of overall DHS profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed

26. 42 U.S.C. § 1395nn(b)(2)(B).

27. 42 C.F.R. § 411.351 *et. seq.*

28. 69 Fed. Reg. 16054, 16080-16081 (Mar. 26, 2004).

29. 42 C.F.R. § 411.352(e).

30. 42 C.F.R. § 411.352(g).

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.”³¹

Stark clearly permits a group practice to include incident to services in determining a productivity bonus, but not overall profits. While “incident to” services (e.g., services performed by a non-physician practitioner but supervised by the referring physician) are not considered to be personally performed by the supervising physician, the physician may receive financial credit as if the physician personally performed the services.

There is an unresolved issue as to whether an incident to service that is not personally performed but is a DHS, such as outpatient prescription drugs or physical therapy, can be included within a compensation formula. These types of incident to services are not personally performed by the ordering physician, and thus could be construed as referrals. A physician that is given credit for such incident to services that are also DHS would be compensated based on the volume or value of referrals. Therefore, one could argue that including these services in the formula would violate Stark because it results in the allocation of DHS revenue based directly on the volume or value of referrals. Stark does not provide any guidance on this issue.

For a group practice to provide incident to credit when determining a productivity bonus for allocating DHS profits to a physician in the group, the group must be certain that it has satisfied all of Medicare’s requirements for such services.

a. **Medicare Incident to Requirements**

Services performed by auxiliary personnel are considered incident to a physician’s service as long as they are part of an overall plan of care determined and directed by the physician. Incident to services may be billed to Medicare Part B as though the physician personally performed the services. Incident to services are submitted as part of the physician’s bill and paid pursuant to the physician’s fee schedule.

Incident to services and supplies are covered by Medicare as long as they meet the following requirements:

- 1) they are an integral, although incidental, part of a physician’s professional services;
- 2) they are commonly rendered without charge or included in the physician’s bill;
- 3) they are commonly rendered in physician’s offices;
- 4) they are furnished under the direct supervision of a physician; and
- 5) they are furnished by the physician or an individual who qualifies as an employee³² of the physician.

31. 42 C.F.R. § 411.352(i).

32. Although many Medicare publications use the term “employee” when discussing incident to services, that term has a broader meaning and auxiliary personnel may be employees, leased employees or independent contractors. For example, incident to services include cardiac rehabilitation, providing non-

If a service is submitted incident to a physician's service, the supervising physician's Medicare provider number must be used to submit the claim. Thus, the payment for the services is made to the physician or the legal entity billing and receiving payment.

If all of the requirements set forth above are satisfied, a group practice can distribute its DHS revenue through a productivity bonus based on a formula that provides physicians credit for each physician's personal productivity, including incident to services.

b. **Indirect Compensation Methodologies (Distribution of DHS Profits)**

Pursuant to the Stark Regulations, a group practice may distribute DHS profits to physicians under either or both of the two indirect methodologies: the overall profit method of distribution and the productivity bonus method of distribution.³³ The Stark Regulations do not prohibit other methodologies to be adopted, so long as the method is reasonable, verifiable and not directly based on the volume or value of referrals.

Although there can be no *direct* relationship between the distribution to a physician and the volume or value of referrals, both the overall profits and productivity bonus methodologies set forth several safe harbors by which DHS profits may be distributed to physicians in the group practice in a manner that indirectly takes the volume of value or referrals into account.

Overall profit methodologies will fit within a safe harbor if the DHS overall profits are distributed:

- i. Per capita (e.g., per member of the group or by equity owned in the group);
- ii. Based on the distribution of revenues attributed to services that are not DHS; or
- iii. In any manner, if the revenues of the group derived from DHS constitute less than 5% of the group's total revenues and the allocated portion of those revenues to each physician in the group practice constitutes 5% or less of his or her total group compensation.³⁴

Productivity bonus methodologies may be based on the group's overall profits, total revenues or any amount between these two measures. A productivity bonus will meet the safe harbor and will not be deemed to be directly related to the volume or value of referrals if any of the following three conditions are met:

self-administrable drugs and other biologicals, and supplies furnished by the physician in the course of performing his or her services, such as gauze, ointments, bandages and oxygen.

33. 42 C.F.R. § 411.352(i).

34. 42 C.F.R. § 411.352(i).

- i. The bonus is based on the physician's total patient encounters or relative value units produced, including each physician's incident to services;
- ii. The bonus is based on the allocation of the physician's compensation that is not related to DHS; or
- iii. DHS revenues of the group practice are less than 5% of total revenues, and the allocated portion of those revenues to each physician in the group constitutes 5% or less of his or her total group compensation.³⁵

As stated above, a hybrid of overall profits and productivity bonus, as well as other methodologies, may be adopted and may be Stark compliant, even if they do not fall within a safe harbor.

2. "Rule of Five"

With the overall profits method, DHS profits may be segregated and pooled, in a Stark compliant manner, within one or more subsets, so long as each subset contains at least five physicians. After the DHS profits are so divided, the physicians within the subsets can be paid a share of the profits or productivity bonuses accruing to the subsets, consistent with the Stark Regulations as described above. According to the Stark Regulations, any subset grouping is permissible.³⁶ Thus, for example, an allocation of a portion of the group's total revenues to a particular specialty or location is acceptable.³⁷ Based upon the Stark Regulation discussed above, the authors believe it would also be permissible to segregate a specific DHS business of the group among five or more group physicians. Of course, the DHS profits allocated to a subset must be distributed in a Stark compliant manner. CAUTION: Notwithstanding the broad language supporting group subsets in the Stark Regulations, it should not be interpreted as providing a loophole around the "directly" limitation. Thus, groups of five physicians should not be established based on the amount of referrals made by them to the group.

As a result, it is possible to adopt a "center" approach to group practices, and to allow each center to make decisions about compensating physicians within the center. However, these decisions must be reviewed and approved by the group's governing body. Further, the Stark Regulations require that the governing body do more than simply "rubber stamp" the decisions of the centers.³⁸

3. Other

CMS published extensive commentary regarding the Stark Regulations, referred to as the Preamble. The Preamble explains that "if a group practice wants absolute assurance that its productivity bonuses or profit shares are not directly related to referrals, the group practice may employ one of the safe harbors set forth in § 411.352 of the

35. 42 C.F.R. § 411.352(i).

36. 66 Fed Reg. 856, 909; 69 Fed. Reg. 16054, 16081 (Mar. 26, 2004).

37. See, *Id.*

38. 42 C.F.R. § 411.352(f)(2).

regulations.” Group practices are not required, however, to use these methods. The Stark Regulations clarify that other methods “are acceptable so long as they are reasonable, objectively verifiable, and indirectly related to referrals.”³⁹

Any such method must be reasonable, verifiable and not directly based on the volume or value of referrals. For example, overall profits could be distributed or a compensation structure could be created based wholly or partly on years of experience, a physician’s percentage of professional services produced (other than DHS), RVUs for evaluation and management, patient visits, or any combination of these measures.⁴⁰

A group practice may want to implement a compensation arrangement that is not based on a per capita allocation or any other safe harbor. Since the distribution would not fit within one of the safe harbors, it would need to be reasonable and verifiable and not related directly to the volume or value of referrals.⁴¹ For example, many groups want to exclude a physician who does not refer DHS to the group from sharing in DHS profits. However, this arrangement could easily be construed as directly related to referrals and thus would not likely be acceptable.

C. Distribution of Non-Stark DHS

Stark only applies to Medicare; thus, it does not apply to group distributions of any non-Medicare DHS revenue (“non-Stark DHS”).

Capturing non-Stark DHS revenue can have a significant impact on the compensation structure adopted by the group practice to allocate revenues to each physician or selected physicians. It can provide a group with broader latitude to develop a compensation structure outside of the paradigms of Stark. However, a group must consider whether it generates sufficient revenue from non-Stark DHS to support developing a separate compensation structure. If this is to be done, it is critical that the Medicare reimbursed DHS and expenses allowable to it be separated from the non-Stark DHS and expenses. Thus, the group must be able to effectively and carefully track DHS and non-Stark DHS revenues and expenses, including a verifiable system of allocating between them. The group may incur significant additional costs to implement such a tracking system.

A group practice can tailor the distribution of non-Stark DHS revenue to fit its individual needs without being restricted by the Compensation Test. By way of example only, below are two possible DHS distribution structures analyzed under federal law. Due to the overlap between state and federal laws in this area, the authors have found that state laws may limit the application of these examples. One must carefully review the applicable state laws prior to implementing any compensation structure not explicitly set forth under Stark. The two compensation structures are:

39. 66 Fed Reg. at 909-910.

40. 66 Fed Reg. 856, 909-10 (Jan. 4, 2001)

41. 42 C.F.R. § 411.352(i).

1. Distributing non-Stark DHS revenue only to physicians that refer DHS (“Example 1”); or
2. Distributing non-Stark DHS revenue based on the volume or value of non-Stark DHS Referrals (“Example 2”).

In Example 1, a group practice determines to distribute non-Stark DHS revenue among a pool of physicians who refer DHS. The group must determine how the physicians referring DHS will split the non-Stark DHS revenue. The distribution may be based on the Stark permissible overall profits or productivity bonus methodologies, or another Stark permissible method. If the group decides to distribute non-Stark DHS revenue in some other manner, it must be certain that the distributions are not based on the volume or value of referrals that fall within the ambit of Stark. Doing so runs the risk of violating Stark under a circumvention scheme.

Distributing non-Stark DHS revenues in this manner may not be desirable. For example, if non-Stark DHS revenue is distributed per capita regardless of proportion of referrals, each such referring physician would share in the non-Stark DHS revenue equally. Thus, physicians who refer very few patients would be entitled to the same share as a physician who generates substantially higher DHS business. One option to reduce this inequity is to implement a threshold so that only physicians that refer a certain amount of DHS may share in the distribution of the non-Stark DHS revenue.

This method is not without concern. Indeed, a group practice that decides to implement Example 1 (even if it does not set a threshold) could find this compensation challenged by OIG or CMS as a violation of Stark. Under a conservative approach, the theory would be that physicians are, through a circuitous route, being compensated for referrals. This argument would be tenuous as long as the distribution is not directly related to the volume or value of referrals. As discussed in the “Overview of Stark” above, one should be conservative when developing and implementing a group’s compensation structure.

As for Example 2, a group practice could pool all of its non-Stark DHS profits and distribute it directly based on referrals of non-Stark DHS. Since Stark only applies to DHS, and is not implicated in this example, Stark is not an issue. However, this distribution presents other issues that must be analyzed in conjunction with state specific laws.

As stated above, should a group decide that another methodology would better serve the needs of its practice, it must be analyzed prior to implementation to determine that it is compliant with other federal and state laws.

1. Anti-Kickback Statute

The Federal Anti-Kickback Statute (the “Anti-Kickback Statute”)⁴² generally prohibits a physician from receiving remuneration in return for the referral of patients. However, certain arrangements fit within a statutory exception or regulatory safe harbor.

Examples 1 and 2 implicate the Anti-Kickback Statute because the physicians will be in a position to refer, or recommend that other health care providers refer, Medicare and Medicaid patients. If such remuneration is intended to induce the physician to refer or recommend referrals to the group, these compensation structures will result in the payment of remuneration to the physicians.

The Anti-Kickback Statute contains an exception for “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services” (the “Employment Exception”).⁴³ In addition, the OIG has promulgated regulations (“Safe Harbors”) which recognize a safe harbor for payments made to employees (the “Employment Safe Harbor”).⁴⁴

The OIG established the criteria for a bona fide employment relationship by indicating that the Internal Revenue Service’s definition of an employee would be applied, as codified in its regulations and other interpretive sources.⁴⁵

Neither the Employment Exception nor the Employment Safe Harbor explicitly limits how an employer may pay an employee. This would appear to imply that any form of compensation should be acceptable. Moreover, the Federal government has typically not enforced the Anti-Kickback Statute against compensation arrangements with bona fide employees of an organization, presumably because such arrangements meet the criteria for the Employment Safe Harbor. These views are supported by comments made by the OIG in the preambles to the proposed and final Safe Harbor regulations.⁴⁶

The risk of increased scrutiny and negative assumptions will be reduced if each physician is employed in a bona fide employee relationship, taking into consideration the various factors that would be applied in an Internal Revenue Service determination of whether such individual was an employee or an independent contractor.⁴⁷ The medical services contract for a physician owner of a group practice can be structured to meet the Employee Exception and the Employment Safe Harbor. Therefore, neither Example 1 nor Example 2 would likely violate the Anti-Kickback Statute so long as all of the physicians satisfy the Employment Safe Harbor.

42. 42 U.S.C. § 1320a-7b.

43. 42 U.S.C. § 1320a-7b(b)(3)(B).

44. 42 C.F.R. § 1001.952(i); 56 Fed. Reg. 35,952, 35,953 (July 29, 1991).

45. 42 C.F.R. § 1001.952(i).

46. See 54 Fed. Reg. 3088, January 23, 1989; 56 Fed. Reg. 35952, July 29, 1991.

47. 42 C.F.R. § 1001.952(i).

2. Examples

a. Patient X is a Medicare patient of Dr. A. Dr. A orders an MRI for patient X. A technician in the group practice performs the MRI and Dr. A reviews the MRI. The MRI is a DHS that includes a professional and technical component. Dr. A can receive the professional component because he personally reviewed and interpreted the MRI. There is no referral and thus Stark is not implicated. The technical component was not personally performed by Dr. A; therefore, he cannot receive direct financial credit for that service. The group practice can bill and retain the full payment for the MRI. However, Dr. A may not receive any financial credit for the technical component of the MRI that he referred (other than indirectly through an allocation of the overall profits or productivity bonus).

b. Same facts as example a., except that the MRI interpreted by Dr. A was a referral from Dr. B. Dr. B generally cannot receive financial credit for the professional or technical component because he made a referral. Dr. A can receive direct credit for the professional component that he performs and the technical component performed by the technician because he did not make a referral for the MRI.

c. Patient Z is a Medicare patient and a cancer patient of Dr. C. Dr. C orders the in-office infusion of an oncology drug. The oncology drug is a DHS. A nurse in the group practice administers the drug; these services are incident to Dr. C's services and are supervised by Dr. C. Dr. C may not receive direct financial credit for the DHS because Dr. C made a referral for DHS. However, some would argue that Dr. C may receive a productivity bonus that includes credit for the oncology drugs that Dr. C ordered because they were properly administered on an incident to basis. Again, this issue has not been resolved, so it could still be challenged as a violation of Stark.

3. Conclusion

Clearly, a group has much greater latitude in compensating its physicians from non-Stark DHS. However, in creating the compensation structure the group must be careful to clearly separate DHS from non-Stark DHS. Further, the group should make certain that the structure is not likely to violate any federal or state roadblocks.