A SLACK Incorporated® publication

OCULAR SURGERY NEWS®

Vol. 25, No. 17 | OSN® Get the Whole Story | September 1, 2007

OSN COMPLIANCE and the Law

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OCULAR SURGERY NEWS brings you issues in compliance with billing and coding regulations.

CMS proposes several reforms for Stark Law in 2008

The proposed changes involve unit-of-service payments, percentage compensation arrangements and profits from diagnostic tests.

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Special to OCULAR SURGERY NEWS

On July 2, the Centers for Medicare and Medicaid Services issued its proposed Medicare Physician Fee Schedule for calendar year 2008, in which CMS proposes numerous reforms to the Physician Self-Referral (Stark Law) regulations and purchased diagnostic test rules. Any proposal that is finalized will go into effect Jan. 1, 2008, and as currently written, there would be no grandfather clause. Given the scope of some of the proposed changes and that there would be relatively little time to come into compliance, physicians and health care organizations are well-advised to review their existing arrangements and determine how they could be affected. A further degree of uncertainty is created by the fact that the long-awaited Stark II/Phase III regulations could be finalized any time in the next several months, and it is not clear exactly which issues Phase III will address.

Three of the many important proposals are summarized here.

1. Prohibition on unit-of-service (per-click) payments to physician lessors in space and equipment leases. The proposed rule would prohibit unit of service, or "per click," leases in which the physician is the lessor to the extent that the payments reflect services provided to patients referred by the physician to the lessee. Currently, "per click" payments that meet certain criteria can be used in connection with the Stark Law exceptions for the rental of office space and equipment as long as all of the requirements of the exception are satisfied. CMS is particularly concerned that a physician lessor has a financial incentive to refer a higher volume of patients to the lessee when the physician receives a per-click payment. For example, a physician may lease equipment that he or she owns to a hospital or independent diagnostic testing facility on a per-click basis and receive a fee each time the equipment is used for a patient who was referred to the hospital or independent diagnostic testing facility by the physician. The proposed regulations would require the "per click" fee paid to the lessor physician to exclude amounts associated with the use of the equipment for patients referred by the physician.

CMS is soliciting comments as to whether the prohibition also should apply when the physician is the lessee.

2. Prohibition of percentage compensation arrangements (other than for services personally performed by the physician). CMS is proposing that percentage compensation arrangements (1) may be used only for paying for personally performed physician services

and (2) must be based on the revenues directly resulting from the physician services rather than based on some other factor such as a percentage of the savings by a hospital department (which is not directly or indirectly related to the physician services provided). CMS indicates clearly that arrangements in which equipment and office space is leased for a percentage of the revenues raised by the use of the equipment and office space are suspect. Management services agreements based on percentage of revenue provision may also be affected.

To restrict percentage arrangements, CMS is proposing to change the definition of "set in advance" used in most Stark Law exceptions, thereby prohibiting percentage-based compensation not involving revenues directly resulting from personally performed physician services. By their nature, percentage arrangements are not set in advance because there is no way to calculate the full value of the arrangement at any point in time.

3. Prohibition on physicians from making a profit on the professional or technical components of diagnostic tests performed by an outside supplier. Regulations currently prohibit physicians from marking up the technical component of a purchased diagnostic test. The proposed rule would expand this rule and prohibit physicians and medical groups from marking up the professional component or technical component of purchased diagnostic tests, regardless of whether the physician or medical group purchases the professional component or technical component or whether the performing supplier reassigns its right to bill to the physician or medical group.

This new limitation would apply to most types of outside suppliers, including independent contractors and part-time employees. (it would not apply to full-time employees). Accordingly, Medicare would only pay the physician/group billing for the professional component service performed by a physician outside of the group the lesser of (1) the supplier's net charge, (2) the physician/group's actual charge or (3) the fee schedule amount that the supplier would have been paid had it billed directly.

Furthermore, while the physician would continue to be able to bill the lesser of certain charges for the test, including the supplier's "net charge," the proposed regulations would revise the definition of supplier's "net charge" to exclude any costs or charges associated with equipment and/or space leased to the outside supplier by the billing physician or physician group. For example, if an ophthalmologist performs reads in a cardiology group's offices for $100 per read and leases space and equipment from the group for $25 per read, the group could only charge Medicare $75, even if the $25 rental charge was commercially reasonable and fair market value for the space and equipment provided.

Narrowing the in-office ancillary services exception. CMS also is soliciting comments on how to limit the in-office ancillary services exception so as to curtail perceived abuses. In particular, CMS notes with disapproval that there is often little interaction between the physicians who treat patients and the staff who furnish the ancillary services, often in a separate "centralized" location. Further, CMS questions the proliferation of in-office labs, the "migration of sophisticated and expensive imaging or other equipment to physician offices" and the use of turnkey operations. Any changes to the 'in-office ancillary services' exception likely will minimize the financial incentive and otherwise limit physicians' and groups' ability to provide ancillary services, including diagnostic imaging, as part of their practice. OSN

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■ The full text of the proposed rule can be read at www.cms.hhs.gov/physicianfeesched/downloads/CMS-1385-P.pdf?agree.