

STARK SURPRISES IN THE PROPOSED 2008 MEDICARE PHYSICIAN FEE SCHEDULE

The Centers for Medicare and Medicaid Services (“CMS”) have proposed a 10 percent reduction in physician reimbursement as part of the proposed 2008 Medicare physician fee schedule. The proposed rule, published on July 12, also includes changes to the Stark Law that would negatively impact physician income if finalized in their current form.

CMS claims the proposed changes will close loopholes that expose the Medicare program to abuse. In particular, CMS has focused on alleged abuses in the provision of diagnostic tests by physicians and physician-owned entities. If finalized, the revisions would prohibit certain relatively common business arrangements generally believed to be permissible under the Stark Law.

1. Scaling back permissible “per click” lease arrangements.

In publishing prior regulations, CMS expressly stated the rental rate for an office or equipment lease may be based on the number of times the physician uses the space or equipment, as opposed to a set rate for a specified period of time. Such arrangements currently are permissible if the “per click” rate represents fair market value and does not vary in a manner that takes into account referrals of designated health services (“DHS”).

Concerned such arrangements may provide physicians with an improper motive to order unnecessary diagnostic tests, CMS has announced its intention to reverse its position on “per click” lease payments, at least in those cases in which the physician is the lessor and makes referrals to the lessee. We can expect such arrangements will have to be unwound and restructured if the proposed rule is finalized.

CMS also is soliciting comments on whether it should prohibit “per click” payments by a physician to an entity from which the physician leases space or equipment if that entity refers patients to the physician lessee.

2. Limiting percentage-based compensation arrangements.

Under Stark, a compensation arrangement between a physician and a DHS provider, (i.e., personal services arrangements, an office or equipment lease), may be based on a formula as opposed to a flat rate. The regulations require the formula to be set forth in detail in a written agreement signed by the parties prior to the provision of any good or service. It cannot be altered in any way that reflects the volume or value of referrals or other business generated by the referring physician.

CMS proposes to limit the use of percentage-based compensation formulas to compensation arrangements involving professional physician services. While the use of such formulas in other contexts is not common, CMS believed it necessary to clarify that the use of percentage-based compensation in non-physician services arrangements is inconsistent with Stark requirements.

3. Undoing “Under Arrangements”.

With a few exceptions, Stark prohibits a physician from owning an interest in an entity that furnishes DHS if the physician refers patients to that entity. An entity is considered to be “furnishing” DHS if it receives payment from CMS for those services.

Based on this definition, lawyers have advised physicians that they can invest in entities that perform DHS so long as the entity does not bill Medicare or any other payor for those services. Instead, the entity contracts with a hospital to provide such services for its patients. The hospital – not the entity – then bills for the services purchased from the entity as if the services had been provided by the hospital. The entity, therefore, is not furnishing the service, and thus the physician may hold an investment in the entity.

As many expected, CMS proposes to cut off such investments by modifying the definition of “furnished” to include the entity providing the service as well as the entity that receives payment. Again, numerous arrangements would have to be unwound and restructured if this change is finalized in its current form.

4. New restrictions on purchased diagnostic tests.

In addition to the revisions to the Stark regulations, the proposed physician fee schedule rule also includes changes to the purchased diagnostic test rule. Under the current rule, a physician or medical group that purchases the technical component of a diagnostic test from an outside supplier cannot bill Medicare more than the physician or group paid the supplier.

CMS proposes expanding this anti-markup provision to apply to the professional component as well as the technical component of diagnostic tests. Further, CMS wants to define “outside supplier” to include anyone other than a full-time employee of the physician or medical group billing for the test.

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Finally, CMS proposes to limit the amount the physician or medical group can bill Medicare for the professional component of the test (whether purchased or reassigned) to the lesser of: (a) the outside supplier's "net charge" to the physician or medical group for such component; (b) the physician's or medical group's actual charge for such component; or (c) the fee schedule amount for such component that would be allowed if the outside supplier billed for the component directly.

In calculating the "net charge," CMS wants to net out against the actual amount charged by the outside supplier for such component any amount paid by the outside supplier to the physician or medical group for the rental of space or equipment in connection with the provision of diagnostic tests. CMS has offered no explanation addressing how this rule should be applied in practice. For example, how would a provider calculate the amount paid to a part-time X-ray technician for tests he or she performs in a physician office?

These are only a sample of the proposed changes to the Stark and reimbursement regulations included in the proposed 2008 Medicare physician fee schedule rule. If finalized in their current form, these changes will have a significant impact on a wide variety of business ventures.

Finally, rumor has it CMS will publish the long-awaited final Stark II Phase III regulations within the next few weeks. We expect this regulation to include changes to the definitions, the physician recruitment and indirect compensation exceptions, and the physician hourly compensation fair market value "safe harbor."

The proposed fee schedule rule remains open for public comment until September 7. The final rule probably will be published in late November or December. If you desire additional information concerning the proposed rule or assistance preparing comments for submission to CMS, please contact your Lathrop & Gage attorney or any of the following members of our health care team.

**If you have questions about this Legal Alert, please contact your
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