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Paying Hospital-Employed Physicians for Services Performed by Others

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The Ethics in Patient Referrals Act ("Stark") prevents hospitals from paying employed or contracted physicians in the same way that physicians are or were paid by independent physician groups. Specifically, physician groups may generally pay physicians a share of the profits from services performed by others, but hospitals may not pay physicians in a way that varies with the volume or value of referrals for certain services payable by Medicare or Medicaid, which usually precludes paying physicians a share of profits or a percentage of fees for services referred or ordered by the physician but performed by others.

Stark Requirements. Per Stark, if a physician (or a member of the physician's family) has a financial relationship with an entity, the physician may not refer patients to that entity for certain designated health services[1] payable by Medicare or Medicaid unless the financial arrangement is structured to fit within a regulatory safe harbor. (42 USC § 1395dd; 42 CFR § 411.353). Under Stark's "group practice" safe harbors, physician groups that qualify as a "group practice" may pay physician group members based on services the physician personally performs, services billed "incident to" the physician's personally performed services, or, subject to certain limits, a portion of the overall profits of the group, including profits from services derived from services performed by others. (*See* 42 CFR §§ 411.353 and 411.355(a)-(b)). These "group practice" safe harbors are not available to physicians who are employed by the hospital.

Bona Fide Employee Safe Harbor. Once a physician is employed by a hospital, the physician's compensation must generally be structured to fit within Stark's "bona fide employee" safe harbor, which requires the following:

> (1) The employment is for identifiable services.
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> (2) The amount of the remuneration under the employment is—
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> (i) Consistent with the fair market value of the services; and
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> (ii) … is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.
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> (3) The remuneration is provided under an arrangement that would be commercially reasonable even if no referrals were made to the employer.
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> (4) Paragraph (c)(2)(ii) of this section does not prohibit payment of remuneration in the form of a productivity bonus based on services

> performed personally by the physician …

(42 CFR § 411.357(c), emphasis added). Compensation formulas that depend on or vary with "referrals" by the physician will not satisfy the employment safe harbor.

Referrals. Stark defines "referral" as:

> the request by a physician for, or ordering of, or the certifying or recertifying of the need for, any designated health service [("DHS")] for which payment may be made under Medicare Part B [or, as later amended, Medicaid], … but not including any designated health service personally performed or provided by the referring physician. A designated health service is not personally performed or provided by the referring physician if it is performed or provided by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members.

(*Id*. at § 411.352, definition of "Referral", emphasis added). The net result is that Stark allows the hospital to pay employed physicians based on services the physician personally, physically performs, but not based on his or her referrals or orders for services performed by others, including services performed by persons supervised by the employed physician or billed "incident to" the physician's services.

In its commentary to the Stark Phase I rule, CMS explained:

> [W]e are amending our definition of "referral" to exclude services that are personally performed by the referring physician (that is, the referring physician physically performs the service)…. All other Medicare-covered DHS performed at the request of a referring physician are "referrals" for purposes of [Stark]. …
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> With respect to services performed by others, including a physician's employees, we think the issue is more complicated. Services performed by others are reasonably considered to be performed as a result of a "request." Moreover, the statutory language in [Stark] indicates that the Congress considered there to be a difference between personally performed services and services performed by others. On balance, we have chosen to include services performed by others, including a physician's employees, in the definition of referral. We are concerned that a blanket rule exempting services performed by a physician's employees from the definition of "referral" could, in some circumstances, undermine the intent of [Stark]. [Accordingly,] under the final rule, services performed by anyone other than the referring physician (whether an employee, a staff member, or a member of the physician's group practice) is a "referral" for

> purposes of [Stark].

(66 FR 871-72, emphasis added).

The foregoing rule applies even if the services are billable as “incident to” a physician's services. In issuing its Phase I “referral” rule, CMS stated:

> We recognize that, in many cases, services performed by a physician's employees are, for practical purposes, tantamount to services performed by the physician (for example, a physician's assistant applying a neck brace ordered by a physician for an individual who has been in an auto accident, when the face-to-face encounter with the patient, including the physical examination by the physician, indicates the need for a properly adjusted neck brace.) While such services are included in the definition of "referral" under this final rule, given the significance of this issue, we are soliciting comments as to whether, and under what conditions, services performed by a physician's employees could be treated as the physician's personally performed services under [Stark].

(66 FR at 872, emphasis added).

When CMS issued its Stark Phase II rules, CMS considered the comments but declined to modify the “referral” rule to accommodate “incident to” or other services ordered by hospital-employed physicians but performed by others:

> *Comment:* A number of commenters urged that the definition of referral exclude services that are performed “incident to” a physician's personally performed services or that are performed by a physician's employees. According to the commenters, such services are integral to the physician's services. Another commenter suggested that services by licensed professionals that are separately billable should be considered referrals, but services that are only billable as part of a physician's service should not be considered referrals. One commenter suggested the appropriate test should be whether there is significant physician involvement in the provision of a service.
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> *Response:* This is an issue about which we specifically solicited comments in the Phase I rulemaking. After careful consideration of the comments and the issues raised, we are adhering to our original determination that “incident to” services performed by others, as well as services performed by a physician's employees, are referrals within the meaning of [Stark]. …
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> *Comment:* A group representing allergists and immunologists requested clarification that no referral occurs when a physician prepares an antigen and furnishes it to a patient. Another commenter requested clarification that there is no referral if a

> physician personally refills an implantable pump. Yet another commenter requested clarification that there is no referral if a physician personally provides durable medical equipment (DME) to a patient.
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> *Response:* The commenters are correct. There is no "referral" if a physician personally performs a designated health service. However, as noted above, there is a referral if the designated health service is provided by someone else. ….

(69 FR 16063, emphasis added). CMS reaffirmed its position in 2007 when it issued its Stark Phase III rules:

> In Phase I, we defined "referral" to exclude services personally performed by a physician who ordered the services, but to include DHS provided by the physician's employees or contractors or by other members of the physician's group practice (66 FR 871–872). In Phase II, we confirmed that a "referral" includes services performed by others "incident to" the physician's services (69 FR 16063). …
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> We received several comments addressing the issue of services performed by a physician's employees that are "incident to" the physician's personally-performed services. …. We are making no changes to the definition of "referral" in this Phase III final rule.
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> *Comment:* Several commenters requested clarification of the statement in Phase II regarding whether there is a "referral" when antigens are prepared and furnished by a physician, or whether there is a "referral" when a physician refills an implantable pump (69 FR 16063). The response in Phase II appeared, in the commenters' view, to indicate that, if a physician personally prepares and furnishes antigens or personally refills an implanted pump for a patient, there is no "referral" for purposes of the physician self-referral statute. …
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> *Response:* In Phase II, we stated that the definition of "referral" excludes services personally performed or provided by the referring physician, but specifically includes any services performed or provided by anyone else (69 FR 16063). This interpretation is codified in the definition of "referral" at § 411.351. It is possible for a physician to order and personally furnish antigens to a patient and to order a refill for, and personally refill, an implantable pump. In such instances, there would be no "referral" for a designated health service, and no exception is needed.

(72 FR 51019). CMS's example confirms that a hospital-employed physician must personally, physically perform the service to receive compensation based on the service; billing "incident to" is insufficient.

Compare Physician Groups. The "incident to" rule differs between

hospitals and physician groups. Stark allows physicians in a group practice to compensate group physicians based on services performed by others "incident to" the physician's personally performed services. (42 CFR § 411.352(i)(1)). In contrast, Stark prohibits hospitals from doing so. (*See id.* at § 411.357(c)). As CMS explained:

> [Stark] permits group practices to divide revenues among their physicians in ways that are very different from the ways other DHS entities are permitted to share revenues with employed or independent contractor physicians. The statute recognizes the differences between physicians in a group dividing income derived from their own joint practice and a hospital (or other entity) paying a physician employee or contractor who generates substantial income for the facility that would not ordinarily be available to a physician group. In effect, group practices receive favored treatment with respect to physician compensation: they are permitted to compensate physicians in the group, regardless of status as owner, employee, or independent contractor, for "incident to" services and indirectly for other DHS referrals. This preference is statutory.

(69 FR 16066, emphasis added).

> [Stark] contemplates that employed physicians can be paid in a manner that directly correlates to their own personal labor, including labor in the provision of DHS. What the statute does not permit are payments for an employee's productivity in generating referrals of DHS performed by others (66 FR 876). Except as permitted under the group practice definition for employees of group practices, "incident to" DHS may not be the basis for productivity bonuses paid to employed physicians.

(69 FR 16087, emphasis added).

Conclusion. The bottom line is that groups may pay physicians a portion of the fees received for services performed by others (either as a share of profits or as "incident to" services) so long as certain conditions are satisfied; however, Stark prohibits hospitals from paying physicians based on their orders or referrals for designated health services performed by others, which prohibition usually applies to profit-sharing arrangements as well as a portion or percentage of fees performed by others. Although it might be possible to structure a profit-sharing arrangement for an employed physician (not a contractor) based on non-designated health services, such arrangements are often difficult to implement or maintain in a compliant manner. Accordingly, hospitals should carefully scrutinize any arrangement that would compensate physicians based on their referrals to others.

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[1]Stark generally defines "designated health services" as the following services payable by Medicare or Medicaid: (i) clinical laboratory services;

(ii) physical therapy, occupational therapy, and outpatient speech-language pathology services; (iii) radiology and certain other imaging services; (iv) radiation therapy services and supplies; (v) durable medical equipment and supplies; (vi) parenteral and enteral nutrients, equipment, and supplies; (vii) prosthetics, orthotics, and prosthetic devices and supplies; (viii) home health services; (ix) outpatient prescription drugs; and (x) inpatient and outpatient hospital services. (42 CFR § 411.351).

For questions regarding this update, please contact:

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