Stark, diagnostic testing, and group compensation

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Medicare's rules on diagnostic testing can be dizzying. If your practice does any diagnostic testing, you must also grapple with the intersection of Stark and Medicare's rules regarding diagnostic testing. This article attempts to shed light on the connections and provide practical advice for compliance.

The basics

Before diving into the Stark Law and its implications, it is important to understand basic Medicare concepts relating to diagnostic testing. Under Medicare's rules, "diagnostic testing" means all diagnostic X-rays, laboratory tests, and other diagnostic tests. (This article does not address clinical laboratory services, which are paid under the Clinical Laboratory Fee Schedule.)

Only a physician or practitioner, including some non-physician practitioners (NPPs), who has a treatment relationship with the patient may order the test. Treating physicians include MDs and doctors of osteopathic medicine (DOs), as well as dentists and dental surgeons, podiatrists, and optometrists. NPPs who can order diagnostic tests include clinical nurse specialists, clinical psychologists, physical therapists, occupational therapists, speech language therapists, audiologists, certified social workers, certified nurse midwives, certified registered nurse anesthetists, and anesthesia assistants.

Although Medicare's rules generally require written orders for services, an order for a diagnostic test may be: (1) a written document signed by the treating physician/practitioner that is hand delivered, mailed, or faxed to the testing entity; (2) a telephone call by the treating physician/practitioner or their office to the testing entity; or (3) an email from the treating physician/practitioner or their office to the testing entity. Orders for diagnostic tests need not be signed, but the treating physician/practitioner must indicate in the medical record an intent that the test be performed.

Under Medicare's reimbursement rules, most diagnostic tests may be interpreted by a physician or qualified NPP. The technical component (TC) of a diagnostic test may be performed by any qualified physician or NPP, as well as a qualified technician under appropriate supervision.

Physician supervision

Physicians and qualified NPPs are paid for personally performing diagnostic test components. However, for TCs, Medicare permits only physicians to supervise someone else performing the test. The TC is paid at 100% of the supervising physician's fee schedule rate for a technician's performance of the TC.

There are three levels of supervision, which the rules specify apply to each test:

General supervision: The physician provides overall direction for performing the test and is responsible for training the non-physician personnel who perform the test as well as the maintenance of the equipment used. The supervising physician need not be physically present when the test is performed.

Direct supervision: The physician must be in the office suite and immediately available to provide assistance and direction throughout the procedure, but need not be in the same room when the test is performed.

Personal supervision: The physician must be in the same room with the patient when the test is performed.

A test may be supervised at a higher level of supervision than required (e.g., a test requiring direct supervision may be performed under personal supervision, but not vice versa). The required level of supervision for each test can be found through the Medicare Physician Fee Schedule Lookup Tool.[1] The column listing "PHYS SUPR" includes a number from 1 to 3, which corresponds with general (1), direct (2), or personal (3) supervision.[2]

Although the language surrounding supervision may sound similar to the language of Medicare's "incident-to" billing rules, as of 2007, diagnostic tests may *never* be billed incident-to. This can create some wrinkles for physician group practices with respect to compensation, due to restrictions under Stark.

Stark: General rules and the group practice definition

The Stark statute generally prohibits physicians from referring certain "designated health services" (DHS) to entities with which they have a financial relationship. When a physician orders a DHS diagnostic test to be performed by an entity with which the physician has a financial relationship, Stark applies. With respect to diagnostic testing specifically, not all diagnostic tests are DHS. For example, imaging studies are DHS, but electromyography and Holter monitoring (i.e., a form of mobile heart ECG) are not DHS. There are exceptions to

Stark, however. Several exceptions relate to the definition of a "group" under Stark. Therefore, before tackling issues relating to group compensation, you must know if your group qualifies as a "group practice" under Stark.

Stark's "group practice" rules generally require the group to be a single legal entity in any organizational form recognized under applicable state law. The group must also consist of at least two physician members. "Members" of the group are defined as: (1) direct or indirect physician owners, (2) full- or part-time physician employees of the group, or (3) locum tenens or on-call physicians providing services in place of a physician member. Independent contractors are not "members." However, the definition of a "physician in the group" includes independent contractors when they are providing services in the group's facilities to the group's patients, are not paid on the volume or value of referrals they generate for the group, and otherwise reassign their rights to payment to the group.

Members of the group must render "substantially the full range of patient care services" that they normally provide. So, a physician with a full cardiology practice elsewhere could not be a part-time employee member of a group solely to perform only nuclear stress tests and echocardiograms for the group.

Group members must, in the aggregate, perform 75% of the services through the group, billed under the group's billing number, and the group itself must receive the payments. The measurement of patient care services to meet this 75% requirement may be based on time, but can also be based on any alternative measure that is fixed in advance, reasonable, uniformly applied, verifiable, and documented. So, a group might have three members spending 100% of their time working for the group, and two members who each spend half of their total time working for the group, and the group will still qualify. A group with three members performing 100% of their services for the group, and *four* members each performing only 25% of their services for the group would *not* qualify. Members of the group must also conduct at least 75% of all patient encounters performed by the group. In other words, independent contractors may not perform more than 25% of the group's total patient encounters.

Overhead, expenses, and income for the group must be distributed in accordance with a method or methods determined prior to receiving payment for services, although compensation methodologies may be adjusted going forward. The group must also operate with centralized decision-making by a body that is representative of the group's membership, which is responsible for the group's budgets, determining compensation, etc. The group must also use consolidated accounting, billing, and financial reporting.

It is not a simple matter to be considered a "group" under Stark. This is by design. The rules are meant to prevent groups from being mere associations of physicians, created for the purpose of granting a fig leaf of regulatory protection to otherwise prohibited referral

relationships. Qualifying as a group is essential in navigating diagnostic testing relationships under Stark. Being a group affects several issues with respect to Stark exceptions, as well as compensation arrangements within the group itself.

Group practice compensation

Stark implicates how group practices approach compensation relating to diagnostic testing. As noted above, Stark allows for two mechanisms: (1) productivity bonuses, and (2) profit sharing.

Physicians in the group (including independent contractors) may be paid a productivity bonus for services they personally perform, for services rendered incident to personally performed services, or both. However, the bonus itself must be calculated in a "reasonable and verifiable manner that is not directly related to the volume or value of the physician's referrals of DHS." The regulations offer three examples of methods deemed not to relate to the volume or value of the physician's DHS referrals: (1) bonuses based on total patient encounters or relative value units; (2) bonuses based on the allocation of the physician's compensation attributable to services that are not DHS payable by any federal healthcare program or private payer; and (3) when revenues derived from DHS make up less than 5% of the group's total revenues, and the portion of those revenues to each physician in the group constitutes 5% or less of each physician's total compensation from the group. Unless the physician personally performs the TC of a study, they may *not* be paid a productivity bonus for those revenues. Those revenues may be paid only on a profit-sharing basis.

In 2014, a cardiology group in New York entered into the first Stark-related settlement with the Department of Justice involving productivity bonuses. The cardiology group agreed to pay more than $1.33 million for alleged violations of the federal False Claims Act and Stark.[3] Partner physicians in the group were paid using a formula that took into account the volume or value of that physician's referrals for nuclear and CT scans. (The services in question were rendered in 2006 and 2007, when the incident-to rules changed. Prior to 2007, they would have been permissible.) Clearly, the federal government is serious that productivity bonuses may only apply to services that are personally *performed* by the physician, not those which are only personally *supervised*.

Under Stark, a group may also pay physicians compensation based on a share of the group's overall profits. Profit sharing may be based on the group's total compensation, or on the compensation of "pods" of at least five physicians in the group, but the share of overall profits may not be based on the volume or value of DHS referrals.

The regulations describe several permitted methods:

- Profits may be distributed on a per-capita basis;

- DHS revenue may be distributed on a basis unrelated to revenues attributable to DHS not payable by any federal or other healthcare program, including private payers; or,
- DHS revenues make up less than 5% of the group's total revenues, and the allocated portion of those revenues to each physician in the group makes up 5% or less of the physician's total compensation from the group.

Other profit-sharing mechanisms may be used, however. The regulations permit any profit-sharing arrangements where profits are divided in a manner that is reasonable and verifiable, and is not directly related to the volume or value of the physician's DHS referrals. As a result, groups may opt to allocate profits to physicians based on their rendering non-DHS services. There are a wide variety of options for allocating profits as long as they do not *directly* reflect orders and referrals. These revenues can be handled any way the group wants, including directly to the ordering physician. For example, we represent a multispecialty clinic that has multiple separate pods (e.g., for physical therapy, imaging services) and permits physicians to be members of multiple pods simultaneously. The group bases its payments on historical ordering patterns for high-, medium-, and low-ordering brackets.

Another way the group could enhance the ordering physicians' compensation would be by a productivity bonus tied to each physician's total number of evaluation and management (E&M) services, since such services are not DHS. Although the physicians would not be paid directly for diagnostic testing, they would still be paid for E&M services, which might include the ordering of diagnostic testing.

Conclusion

Negotiating the vagaries of Medicare's diagnostic testing rules and how they relate to Stark, and how all of that affects physician compensation can be headache-inducing. One must understand how diagnostic testing may be billed at a baseline, and then comprehend the various permissible compensation models outlined in Stark. Moreover, none of those models are even available if the physicians cannot meet the definition of a "group practice" in the first place, which necessitates additional understanding of Stark's requirements. However, physicians do not need to understand every nook and cranny of Stark and Medicare reimbursement rules; they only need to know enough to recognize that the issues exist. Competent legal counsel can guide you the rest of the way.

Takeaways:

- Understanding of Medicare's required supervision levels for diagnostic testing is critical.

- Whether your group meets the Stark definition of a “group practice” determines which Stark exceptions apply to your group.
- Stark regulatory terminology is complicated and nuanced. For example, a group “member” means something different from a “physician in the group.”
- Stark allows group practices to pay productivity bonuses and to offer profit sharing. Group compensation models, however, must be carefully crafted to meet Stark’s exceptions.
- Groups can use multiple different “pods” for profit-sharing, with physicians belonging to more than one pod.

1 Physician Fee Schedule Look-Up Tool, CMS.gov, https://go.cms.gov/2LfyHSz.
2*Medicare Benefit Policy Manual*, Chapter 15, Section 80.
3 “New York Heart Center to Pay More Than $1.33 Million to Settle Allegations of False Claims Act and Stark Law Violations,” Dept. of Justice, U.S. Attorney’s Office, NDNY (August 14, 2014), https://bit.ly/32h4jMR.