

# The Stark realities your group needs to know

What you can and cannot do when formulating  
a compensation plan in your practice

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## HIGHLIGHTS

**01** The Stark statute relates to overhead, productivity, profit-sharing, incident-to services, and revenue allocation associated with shared visits.

**02** To comply with the Stark statute, be sure your group meets the definition of a group that Stark puts forth.

**M**any physicians don't understand that the laws covering self-referral—known collectively as the Stark statute—reach inside their practices by prescribing acceptable compensation models that entail referrals within a group for Stark “designated health services” (DHS).

To be Stark-compliant, a practice has to meet the statutory definition of a group practice, so as to meet the exceptions that allow referrals to physicians in the group or for in-office ancillary services. It is in the definition of a group that the statute addresses compensation. The basic premise, according to the U.S. Code, is that a physician “in a group practice may be paid a share of overall profits of the group or a productivity bonus based on services personally performed or services ‘incident to’ such personally performed services, so long as the shared work bonus is not determined in any manner which is directly related to the volume or value of referrals.”

This article looks at overhead issues, productivity, profit sharing, incident-to services, and shared-visit revenue allocation. It explains why

compliance matters, even after passage of the Affordable Care Act (ACA). If a group practice has no patients covered by Medicare patients (such as in the case of a pediatric practice) or offers no DHS, such as imaging, physical therapy, or clinical laboratory in the practice, then none of these rules will apply.

## OVERHEAD AND COST CENTERS

Among the indicia of a group, the statute addresses overhead and expenses, requiring that joint use of shared office space, facilities, equipment, and personnel exist. The overhead expenses from the practice must be allocated according to previously determined methods.

The statutory definition of a group has been addressed in fairly detailed regulations, but many misconceptions exist. The regulations address overhead but take no position regarding cost allocations as long as they are applied prospectively and not retrospectively considering the volume of referrals for DHS. Practices can use cost centers by location, by specialty, or by any other reasonable measure that does not directly reward the volume or value of DHS referrals.

## PRODUCTIVITY

The regulations take the position that permissible payment for productivity means compensating the physician for the fruits of → 39

# Clarifying Stark confusion

Myth	Reality
<b>Overhead and cost centers</b>	
The regulations address cost allocations.	The regulations address overhead, but they take no position regarding cost allocations as long as they are applied prospectively and not retrospectively considering the volume of referrals for designated health services (DHS). Practices can use cost centers by location, by specialty, or by any other reasonable measure that does not directly reward the volume or value of DHS referrals.
<b>Productivity</b>	
A practice cannot pay independent contractors a percentage of what they generate.	Productivity compensation for independent contractors is specifically recognized in the prefatory discussion to the regulations.
Physicians can only receive a base salary and cannot be paid on productivity.	No such condition exists.
Practices cannot allocate DHS revenues to a physician as productivity.	Practices may do so, but only if the physician performs the service himself or herself.
<b>Incident-to revenues</b>	
Practices cannot allocate DHS revenues that are incident-to the ordering physician.	Regulators have repeatedly recognized that incident-to services and supplies may be allocated directly to the ordering physician.
It is not permissible to credit the treating doctor for non-incident-to evaluation and management services rendered by non-physicians and billed on their own numbers at 85% of the fee schedule.	Stark has nothing to say about these services, which have nothing to do with DHS.
Doctors can receive credit for the professional component of a diagnostic study they order if it meets the requirements for in-office ancillary services.	This practice is not permissible.
<b>Profit-sharing</b>	
Profits only can be allocated as a per-capita division, as a distribution of DHS revenues based on a group's revenues attributable to the services that are not DHS, or any distribution of the DHS revenues with no physician's allocated portion being more than 5% of the doctor's or group's total compensation.	Revenues also can be allocated per ownership interest, based on seniority, or any other method that is adequately documented for which supporting information can be made available on request. All profits on the technical component of diagnostic testing DHS services must be allocated according to a profit-sharing formula. The professional components of diagnostic testing can be allocated to the physician who performed that service or according to a profit-sharing formula.
All revenues generated by productivity must be allocated as productivity.	Some practices allocate some of their profits from interpretations of studies performed by interventionists to others in the practice. Others approaches are to divide into separate pods the historically high, middle, and low utilizers or to allocate profits according to quality or value metrics.

→ 36 his or her own labors. The doctor must be the one to perform the service that generates the revenue, with three exceptions:

- cases in which the productivity bonus is based on the physician's total patient encounters or relative value units,
- instances in which the bonus is based on non-DHS revenues, or
- cases in which revenues derived from DHS are less than 5% of the group's total revenues and the allocated portion is less than 5% of the physician's total compensation from the group.

Productivity can be calculated before or after expenses are deducted.

Among the myths about productivity is that a practice cannot pay independent contractors a percentage of what they generate. In reality, productivity compensation for independent contractors is specifically recognized in the prefatory discussion to the regulations.

Another myth is that physicians can only receive a base salary and cannot be paid on productivity. No such condition exists.

Some physicians believe they must treat all revenues—DHS, non-DHS, non-Medicare—the same way. The Stark statute, however, only pertains to Medicare; a referral, as defined in the regulations, is only for Medicare DHS.

Another common belief is that practices cannot allocate DHS revenues to a physician as productivity. In fact, practices may do so, but only if the physician performs the service himself or herself. For example, if a physician performs an ultrasound without a technician and also interprets it, then he or she could be given credit for both the technical and revenue components of the procedure.

## INCIDENT-TO REVENUES

To meet Medicare's incident-to standards, the services of non-physicians must be rendered under the direct supervision of a doctor in the group who is on the premises and in the office suite. The ancillary personnel need not be employees or leased employees, although Medicare will not pay for the services of physician assistants (PAs), other than to their direct W-2 employer.

As is the case in incident-to services,

generally, a physician professional service must be rendered to which ancillary services are incidental. Supervision itself is not a physician service. Diagnostic services never can be considered "incident to," so the revenues from the technical components of DHS diagnostic services must float up to an overall profit distribution pool unless the physician personally performed them. The services must be of a kind commonly furnished in a doctor's office or clinic and commonly rendered without charge or included in the physician's bill.

PAs, nurse midwives, nurse practitioners, and clinical nurse specialists are permitted under general Medicare reimbursement rules to bill their own relevant evaluation and management (E/M) codes incident to a physician. For any other personnel, the only E/M code that may be billed is a 99211. In no event can ancillary personnel provide counseling or coordination-of-care billing incident to a physician.

A concept related to, but not strictly "incident to," is that of shared visits. Where the doctor and a non-physician practitioner are in the same group and in a hospital setting, either clinician may see the patient first. The non-physician could perform almost the entire visit. If the doctor performs any portion of the visit in a face-to-face encounter with the patient, then their entire combined services are billable at 100% of the physician fee schedule under the doctor's number.

This scenario is similar to incident-to services where the ancillary personnel are invisible on the claim. In shared visits, however, the two clinicians do not have to be in the hospital at the same time. These shared visits count as personally performed services for Stark purposes.

Similar to productivity, myths abound regarding "incident to." Some people believe that practices cannot allocate DHS revenues that are incident to the ordering physician. In fact, regulators have repeatedly recognized that incident-to services and supplies, such as chemotherapy and physical therapy rendered incident to a doctor, may be allocated directly to the ordering physician. Some people believe it is not permissible to credit the treating doctor for non-incident-to evaluation and management services rendered by non-physicians and billed on their own num-

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If you don't repay within 60 days monies received related to non-compliant Stark transactions, then the claims you submitted to Medicare will be converted into false claims, opening the door to whistleblowers challenging the compensation within the group.”

bers at 85% of the fee schedule. Of course you can. Stark has nothing to say about these services, which have nothing to do with DHS.

Other people believe you can give doctors credit for the professional component of a diagnostic study they order if it meets the requirements for in-office ancillary services. This practice is not permissible. The professional component of a diagnostic service, as an example, is not covered by the in-office ancillary services exception. It is covered by the exception that allows referral to another physician. Because someone other than the doctor performs this service, he or she cannot get credit for those revenues.

## PROFIT-SHARING

Unlike productivity, profit-sharing is where physicians are allocated a portion of the revenues that are the fruits of others' labors. These monies can be revenues from the entire group or any subgroup of at least five physicians (a "pod"). The regulators offer three safe harbors:

- a per-capita equal division of the profits,
- a distribution of DHS revenues based on the distribution of the group practice's revenues attributable to the services that are not DHS, and
- any distribution of the group practice DHS revenues with no physician's allocated portion of those revenues more than 5% of the doctor's or the group's total compensation.

The regulators have made it abundantly clear that other methods are fine. They mention allocation of these revenues per ownership interest, based on seniority, or any other method that is adequately documented for which supporting information can be made available on request. All profits on the technical component of diagnostic testing DHS services (such as ultrasounds, x-rays, and echocardiograms but not electrocardiograms, nerve conduction velocity tests, or

electroencephalograms) have to be allocated according to a profit-sharing formula. The professional components of diagnostic testing can be allocated to the physician who performed that service or according to a profit-sharing formula.

Much more flexibility is available under these rules than you may realize. Not all doctors in the practice have to participate in all pods. For example, in a larger practice, some physicians might be in the imaging services pod, whereas others are in the infusion services pod and still others are in the physical therapy pod. As long as each pod includes at least five physicians, these allocations are legitimate.

No requirement says that all revenues generated by productivity must be allocated as productivity. Some practices allocate some of their profits from interpretations of studies performed by interventionists to others in the practice. In a multispecialty group, this practice is a common way of supporting the primary care physicians, who cannot generate the kinds of revenues that specialists can.

Another legitimate approach is to put the historically high, middle, and low utilizers in separate pods. As long as you are not currently rewarding physicians for the volume or the value of their current referrals, you can use past volumes of referrals to project a compensation formula on a prospective basis.

Using historical data such as a previous 2-year average to determine the allocation also is legitimate. You can mix and match pods among specialties, if necessary. You can allocate profits according to quality metrics, such as patient satisfaction or adherence to guidelines, without running afoul of the law. You also could use value metrics, such as length of stay or lowered resource use within a physician group practice.

## NOW IS THE MOMENT

Why does any of this matter when no one can point to a single enforcement action by the government with regard

to whether a group has met the compensation rules? With passage of the ACA, Congress eliminated any question as to whether Stark violations can be pursued by whistleblowers.

The failure to repay within 60 days monies received pursuant to non-compliant Stark transactions will convert the claims submitted to Medicare into false claims. This opens the door to whistleblowers challenging the compensation within groups. Because the penalties for a Stark violation are not only false claims but also overpayments made to the entity submitting the claims, where a group practice does not meet the definition of a group, including in its compensation formulas, all of the claims that it submits to Medicare become tainted.

An additional fear-inducing aspect of the whistleblower laws is that when a whistleblower files a complaint, the government must respond. Therefore, even if the government previously was not interested in these kinds of claims, once the relator-plaintiff comes forward to say, "Here is my story about a violation of the law," the government has 60 days to declare whether it will intervene.

It has long been the case that plaintiffs have wanted the power of the government in the case, so they have routinely extended the allowable time for the government to respond to the filed case, often for years. Recently, however, plaintiffs have been more willing to pursue these cases without the government's involvement.

Don't be anxious about whether your compensation formulas meet the relevant standard. Given the change in the law with the ACA, your group should examine its compensation practices now rather than wait for disgruntled former employees or the government to tidy up the matter. ■



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