WEEK OF MAY 12, 2008 • VOL. 34, NO. 19 WWW.CTLAWTRIBUNE.COM

Connecticut Law Tribune ALM

ENTREPRENEURIAL PHYSICIANS FACE SQUEEZE

By JENNIFER N. WILLCOX

In an era of declining reimbursement and increasing costs, physicians are looking for ways to improve their bottom line. Some are increasing their caseload and spending less time with each patient, hoping that more visits will translate into higher revenues. Others are taking the opposite approach and adopting the "concierge practice" concept, where a limited number of patients pay additional fees or a subscription charge for an enhanced menu of services.

Many physicians have taken the entrepreneurial tack by "diversifying" and offering ancillary services. Government payers and regulators, however, always have been skeptical of the potential for over-utilization and self-referral inherent in these setups. Recently, the Centers for Medicare and Medicaid Services (CMS) has taken steps that suggest it is clamping down on physicians providing ancillary services.

The Stark statute prohibits physicians from referring patients to "entities" with which they have a financial relationship for "designated health services" (which includes clinical laboratory services, imaging services, durable medical equipment, physical therapy, and inpatient and outpatient hospital services) unless an exception applies. One exception created by Congress allows physicians to refer their patients for "in-office ancillary services" provided either at the physician's regular office or at a "centralized building." This exception is the one utilized by primary care physicians that provide cardiac rehabilitation services at their practice, or orthopedists that offer physical therapy.

In some facilities, physicians "outsource" services by leasing the equipment, space and personnel used to provide these ancillary services from a vendor. Physicians still bill for the services, but the arrangement avoids the start-up expenses of a new service line. Although CMS has not revised the in-office ancillary services exception to prohibit this practice, the agency has expressed skepticism about the practice in the commentary to both the Medicare Physician Fee Schedule issued last summer and the final "Stark III" regulations that went into effect in December 2007.

In 1988, Congress enacted a rule that prohibits a physician from "marking up" the technical component of a test (i.e., the equipment and the technician required to operate it) that it has purchased from an outside supplier. In other words, a physician cannot purchase an MRI scan from a vendor and then bill Medicare for the scan at a higher rate, pocketing the difference. Only the actual acquisition cost can be billed, so that Medicare gets the benefits of the cheaper price. In the fee schedule issued last summer, CMS issued rules that expanded the "anti-markup rule" to the professional component of such diagnostic tests as well (i.e., the interpretation by the physician who "reads" the scan or test), and expanded the scope of the rule in general. If the diagnostic test was either purchased from an outside supplier or performed at a site other than the "office of the billing physician," the anti-markup rule would apply.

If adopted, this rule would severely restrict the ability of physicians to contract with vendors to provide diagnostic tests to patients at a markup. CMS delayed implementation for most services until January 2009, and a federal court entered an injunction blocking implementation for remaining services. Some commentators predict that CMS will withdraw these regulations, but even if that happens, CMS likely will be back with another attempt to curb what it sees as abuse in these relationships.

Another avenue for physicians involves investing in ambulatory surgery centers (ASCs) or independent diagnostic testing facilities (IDTFs), or providing durable medical equipment (DME) to patients. Physicians can have an ownership interest in an ASC and refer patients for services there as long as they perform a certain percentage of their procedures at the ASC and meet other requirements. In 2008, CMS reduced the reimbursement rate for some procedures provided in centers, thus limiting their attractiveness an investment option.

New rules for IDTFs also prohibit the facilities from sharing or subleasing space or equipment with any other entity, which

Jennifer N. Willcox is a partner in the Health Care Department of Pullman & Comley LLC. Based in the Bridgeport office, she represents hospitals, ambulatory surgery centers, home health agencies and others in a wide range of matters.

This article is reprinted with permission from Connecticut Law Tribune. ©2008 ALM Properties, Inc. Further duplication without permission is prohibited. All rights reserved.

arguably would prohibit physician practices from leasing blocks of time in order to provide diagnostic imaging to their patients on an in-office basis. Physicians who have been certified as DME suppliers may face similar restrictions, as CMS has proposed regulations that would prohibit such suppliers from sharing space with any other Medicare supplier, including a physician group (although CMS is soliciting comments on whether there should be an exception to the space-sharing prohibition for physician practices).

Many of the rules are only in proposed form, and CMS may yet change its tune. But as Medicare consumes a larger chunk of the federal budget, CMS will continue to try to find ways to cut spending, and many commercial insurers will follow suit. Attorneys representing physicians groups in ventures involving ancillary services should be aware of these new rules, and advise their clients about both the financial impact and compliance risks that may be present. ■