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FRAUD & ABUSE

U.S. Files False Claims Suit Against Tenet's Former Chief Compliance Officer and Former General Counsel

On September 18, 2007 the United States Attorney for the Southern District of Florida filed a 40-page complaint against Christi Sulzbach ("Sulzbach"), Tenet Healthcare Corporation's ("Tenet") former Chief Compliance Officer and General Counsel, for violations of the False Claims Act, 31 U.S.C. § 3729-33.

The Federal government alleges that Sulzbach submitted false certifications, failed to stop Tenet from violating Stark, and failed to report Tenet's violations to the government, all of which resulted in Tenet receiving improper payments. The government also alleges that Sulzbach withheld documents, thereby obstructing the government's ability to discover the fraud.

The complaint seeks to recover from Sulzbach between \$5,000 and 10,000 for each violation, plus treble damages under the False Claims Act.

The allegations arose out of the North Ridge Medical Center ("North Ridge"), a member of Tenet in Ft. Lauderdale, Florida.

Between 1993 and 1994, North Ridge hired several physicians. At the request of Sulzbach, McDermott, Will and Emery ("McDermott") reviewed the employment agreements and concluded in a memo to Sulzbach that most of the physician arrangements violated Stark.

The government alleges that after receiving this memo, Sulzbach did nothing to remedy the situation, and moreover, she withheld the McDermott memo from the government during a recent *qui tam* action against Tenet.

The government also charges Sulzbach with falsely certifying that Tenet was in compliance with federal laws in a report to the Department of Health and Human Services.

Tenet settled the *qui tam* lawsuit, paying \$22.5 million dollars and, in 2006, agreed to pay an additional \$920 million for defrauding the Medicare program. It was in this settlement that the McDermott memo was uncovered and handed over to the government.

For the government's complaint, see: http://www.healthlawyers.org/email/pg/070920fraud/USv%20ChristiR%20Sulzbach_Complaint.pdf

CMS to Send Mandatory Disclosure of Financial Relationships Report to 500 Hospitals in September

The Center for Medicare and Medicaid Services ("CMS") announced its plan to send mandatory disclosure forms to 500 designated hospitals in an effort to review the financial relationship between hospitals and physicians.

The Mandatory Disclosure of Financial Relationships Report ("DFRR") requires detailed information pertaining to physician ownership in hospitals and compensation arrangements between hospitals and physicians. In response to comments received by CMS, the DFRR now includes two worksheets to capture indirect ownership: (1) one titled "Indirect Ownership in Hospitals"; and (2) another titled "Payments Made to Hospital by Indirect Owners". The data derived from the DFRR will be used to assist CMS in proposing a regular financial disclosure process that would apply to all Medicare participating hospitals.

Once received, hospitals have only 60 days to complete the disclosures. Those not responding within 60 days face civil penalties of up to \$10,000 for each day beyond the deadline established for disclosure. The time period

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begins after receipt of an electronic spreadsheet or hard copy.

The mandatory disclosure process follows a voluntary survey distributed last year under the Deficit Reduction Act of 2006. Hospitals that received a survey last year (around 290), but did not respond, should receive a mandatory survey. CMS is still selecting the other 210 hospitals to participate, and will contact them before sending a DFRR.

A copy of the disclosure form can be found at the CMS website, www.cms.hhs.gov, then click on the link for CMS-10236 (Disclosure of Financial Relationships Report).

**OIG Approves Charitable Donations
Between Referral Sources**

The Office of Inspector General (“OIG”) recently issued Advisory Opinion No. 07-07 addressing a cash donation from a charitable foundation affiliated with a non-profit health system to a non-profit senior residence program. In its opinion, OIG stated that the donation could potentially generate prohibited remuneration under the anti-kickback statute, but it would not further investigate the arrangement because of the built in protections to the Medicare program.

The recipient of the donation was a non-profit senior residence program that operates a retirement community that provides affordable housing to senior citizens who otherwise may not qualify based on their ability to pay. The program was financed in part through a fundraising drive wherein the charitable foundation was requested to make an unrestricted cash donation of \$100,000, which donation amount was comparable to amounts donated by other similarly sized businesses in the region.

OIG focused on whether there was any connection between the donation and the generation of federal healthcare program business by the retirement community from the health system. OIG concluded the donation in this case would unlikely result in fraud and abuse under the anti-kickback statute as: (i) the donation was unrestricted and thus would not influence the retirement community’s use of the funds; (ii) the donation was a one-time, fixed-in-advance payment and not determined based on referrals or other business generated by the retirement community for the health system; and (iii) the arrangement included several safeguards against improper influence by the health system.

Comments to this Advisory Opinion will be accepted through mid October. Read OIG Advisory Opinion 07-07 at:

http://www.healthlawyers.org/email/pg/070801a/0/AO_07-07.pdf

**Mississippi Appeals Court Gives New
Trial after Medicaid Fraud Conviction**

On August 21, a Mississippi state appeals court ordered a new trial in a Medicaid fraud case, finding a lower court erred in failing to properly instruct the jury. *Woods v. State*, No. 2005-KA-02372COA (Miss. Ct. App. 2007) The defendant Woods appealed his conviction on four counts of Medicaid fraud alleging the court erred when it granted, over his objection, supplemental jury instructions after the jury had begun its deliberations.

Upon review, the state appeals court determined the trial court erred in its granting of instructions that created confusion for the jury and not from the granting of a supplemental instruction. The court said “Although it is presumed that the jury follows the instructions it is given, in this case it was impossible for the jury to follow all the instructions it was given, as the phrase ‘case management services’ was never defined for the jury.” The appeals court concluded allowing the verdict to stand would not “sanction an unconscionable injustice” in the absence of improper jury instructions.

Additionally, the appeals court denied bond, citing: “in view of the area in which [Woods] lives, being in the hurricane Katrina disaster area, the fields are ripe for harvest for his expertise . . . the situation is going to be a gold mine to folks that wish to practice fraud.”

**District Court Rejects Allegations
Whistleblower Filed Against
HealthSouth**

A Louisiana federal district court recently rejected all allegations of False Claims Act (“FCA”) violations against a rehabilitation facility from 1996 to 2000 by a whistleblower because he did not satisfy essential elements of the False Claims Act. U.S. ex rel. *Mathews v. HealthSouth Corp.*, No. 1:99cv00604-JTT-JDK (W.D.La, July 18, 2007). The whistleblower, a former employee of HealthSouth Corp. (“Mathews”), filed a FCA *qui tam* action, alleging that HealthSouth violated 31 U.S.C. § 3729(a)(1) when it submitted documentation that certified its compliance with the 75 Percent Rule and that the false claims were perpetrated by the creation of false records.

HealthSouth argued that the complaint did not establish a violation of the FCA because the payments HealthSouth received were not conditioned on compliance with the 75 Percent Rule.

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The district court determined that the whistleblower failed to satisfy the FCA elements because he did not demonstrate that the trending reports reflected inaccurate coding and patient assignments that resulted in a truly noncompliant rehabilitation facility during 1995. Additionally, the court found no evidence that noncompliance with the 75 Percent Rule would necessarily have resulted in payment under the PPS.

OIG Targets Vendor-Physician Relationships

Some physicians are facing heavy scrutiny from the federal government regarding their relationship with vendors. Vendor gifts to physicians, off-label marketing, and sham or excessive payment agreements are a few of the areas targeted.

A recent survey published in the New England Journal of Medicine ("NEJM") indicates that most physicians have some type of relationship with pharmaceutical or medical device manufacturers, despite recent efforts to curb such relationships. For instance, over 94% of physicians reported having a relationship with the pharmaceutical industry, with 83% receiving food in the workplace and 78% receiving free drug samples. Eric Campbell, Ph.D., [A National Survey of Physician-Industry Relationships](#), 356 N.E.J.M. 1742 (Apr. 26, 2007).

Last year two South Florida pulmonologists agreed to pay \$65,066 and \$57,030, respectively, and enter into a three-year Integrity Agreement to resolve their liability under the Anti-Kickback Statute ("AKS") provision of the Civil Monetary Penalties Law ("CML") and Stark. OIG alleged that the doctors violated those laws by accepting gifts, including Miami Dolphins tickets and meals, from a durable medical equipment supplier in exchange for patient referrals.

In an article published last year in The Journal of the American Medical Association ("JAMA"), the authors suggested that hospitals should ban all vendor gifts and free samples. Troyen Brennan, M.D., MPH, [Health Industry Practices that Create Conflicts of Interests](#), 295 J.A.M.A. 429 (Jan. 25, 2006).

Health care facilities may also want to add provisions prohibiting physicians from accepting gifts for personal use; requiring physicians to sign a conflict of interest statement; prohibiting honors for presentations unless from educational or non-profit institutions; and prohibiting reimbursement from vendors for attendance at product demonstrations.

In addition, off-label use and improper marketing activities occur where a manufacturer's sales force or consultants, including physicians, promote or market the use of a drug for uses that have not been approved by the Food and Drug Administration ("FDA"). See 21 C.F.R. § 201.56(c) for the prohibition on off-label uses. Physicians have been involved in prosecutions for this activity because the off-label use may be viewed by OIG as allowing physicians to submit false claims under Medicare. See *United States v. Cell Therapeutics, Inc.* No. 06-0168-MJP (W.D. Mich. Apr. 17, 2007).

Consulting or service relationships between physicians and pharmaceutical manufacturers are also cause for concern. Payments above fair market value for services rendered or payments for services not legitimately rendered or meeting a legitimate business purpose implicate the anti-kickback statute and may violate the False Claims Act.

As a result of the increasing enforcement focus on physicians, effective compliance should be top priority. Physicians and healthcare facilities should adopt conflict of interest policies and re-evaluate current arrangements with vendors. Payments should be reviewed to ensure that the services being provided are legitimate and reimbursed at fair market value.

Additional cases against physicians can be found on OIG's website at www.oig.hhs.gov/fraud/enforcementactions.html.

DISASTER PREPARATION

Proposed Regulations for Off-Site Emergency Care

On August 29, the Health Resources and Services Administration ("HRSA") posted draft policies outlining new procedures for funding by Medicaid for health centers providing emergency services provided outside of their facilities.

The policy addresses the fact that health centers are likely to participate in an organized State or local response and provide primary care services at temporary locations during an emergency.

Under the proposed regulations, health centers providing medical care in temporary locations for longer than 90 days after a declared emergency (hurricanes, fires, or terrorist attacks) must submit a formal request that the location be added as part of their approved project scope of service. The formal request must be submitted "with sufficient time for HRSA processing."



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The draft proposal is on the HRSA website at <http://bphc.hrsa.gov>, in a section called "Change in scope during emergencies for non-deemed health centers."

EMPLOYMENT

Court Holds That Coverage of One Part-Time Employee Brings Health Plan under ERISA

On August 15, 2007 the U.S. District Court for the Middle District of Alabama held that the Employee Retirement Income Security Act of 1974 ("ERISA") governs an entire health insurance plan where just one part-time employee was covered. *Boone v. Health Strategies Inc.*, No. 3:01cv445-MHT, slip op.2007 WL 2332696 (M.D. Ala. 2007).

The plaintiffs in the case were a group of hairstylists who leased space from Master's Touch, a salon in Alabama. The stylists operated their own hairstyling business, paying rent to Master's Touch to work out of that location. Glenn Britton also worked as a hairstylist, but, Master's Touch also employed him directly to perform a variety of managerial tasks.

Needing health insurance, Master's Touch turned to the American Hospitality Association ("AHA") and enrolled in a group health insurance plan. The stylists enrolled individually in the AHA health plan, but brought suit when the AHA plan administrator failed to reimburse their medical expenses. The plaintiffs brought a state law action against the administrator.

The state court dismissed the claims as preempted by ERISA, finding that the plan fell under ERISA because Britton was an employee of Master Touch and because one employee was covered under the plan, the entire plan was governed by ERISA. The U.S. Court of Appeals for the Eleventh Circuit vacated the district court's decision, and directed the district court to conduct additional fact-finding on the issue of whether Britton was a "covered" employee under the plan.

Britton's part-time permanent employee status made him a covered employee under the plan, and since at least one employee was covered by the plan, the plan fell under ERISA, which preempted any state law claims.

Antitrust

Evanston-Highland Merger Held to Violate Antitrust Laws, But Not Ordered to Divest

The Federal Trade Commission ("FTC") released a unanimous opinion on September 6 finding the 2000 merger of Evanston Northwestern Healthcare Corp. ("ENH") and Highland Park Hospital violated federal antitrust laws. Notably, the ruling does not require ENH to divest the acquisition of Highland Park, despite a contrary order by an administrative law judge ("ALJ").

The FTC instead ordered ENH to establish separate and independent contract negotiating teams—one for Evanston and Glenbrook Hospitals and another for Highland Park—to allow managed care organizations ("MCOs") to again negotiate separately for the competing hospitals.

ENH acquired Highland Park in January 2000. The acquisition combined ENH's Evanston and Glenbrook Hospitals – located in Cook County, Illinois – with Highland Park, the nearest hospital to the north. The FTC filed an administrative complaint against ENH after it acquired Highland Park. The FTC alleged that ENH could now "raise its prices . . . far above increases of other comparable hospitals."

The ALJ found that the merger "substantially lessened competition," resulting in higher prices for insurers and consumers for general acute care inpatient services. The ALJ ordered ENH to sell Highland Park within 180 days. ENH subsequently appealed the ALJ's decision to the FTC.

The FTC agreed with the ALJ that the deal violated § 7 of the Clayton Act, but refused to require divestiture, because of the "potentially high costs inherent in the separation of hospitals that have functioned as a merged entity for seven years."

According to the FTC, the separate negotiation teams would serve to "re-inject" competition between the hospitals for the business of the MCOs. The FTC's order (<http://www.ftc.gov/os/adjpro/d9315/070806order.pdf>) gave ENH 30 days to submit to the FTC a plan of action for implementing the ordered injunctive relief.

Read the FTC's press release, opinion, and order at:
<http://www.ftc.gov/opa/2007/08/evanston.shtm>.

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MEDICARE

Proposed Revisions to ASC Rules Take a Patient-Centered Approach

On August 24, 2007, CMS announced a proposed rule that changes the reimbursement rules for ambulatory surgery centers ("ASCs").

The proposed rule revises three existing requirements regarding the governing body and management, evaluation of quality (renamed quality assessment and performance improvement or "QAPI") and laboratory and radiological services. The rule would also create three new conditions surrounding patient rights, infection control, and patient admission, assessment, and discharge.

These revisions serve to "focus on a patient-centered, outcome-oriented process that promotes patient care foremost, rather than a prescriptive, inflexible approach that penalizes providers of substandard care," CMS said. 42 Fed. Reg. 50470, 50471 (Aug. 31, 2007).

MEDICAID

Georgia Supreme Court Revives Challenge to Medicaid Exclusion of Medically Necessary Abortions

The Georgia Supreme Court, reversing a state trial court decision, reinstated the claims brought by Leslie Roe, the Feminist Women's Health Center, and other providers who alleged Georgia's Medicaid program violated the Georgia Constitution's provisions guaranteeing privacy and equal protection rights. *Feminist Women's Health Ctr. v. Burgess*, No. S07A1039, (Ga. 2007).

The lawsuit involves a challenge to reimbursement policies instituted by the Georgia Department of Community Health. Those policies generally provide payment for medically necessary covered services but, in the case of abortions for Medicaid-eligible women, provide payment only if the life of the mother would be endangered if the fetus were carried to term or if the mother was a victim of rape or incest.

The main issue before the Court was whether Roe and the providers had standing to challenge Medicaid's policy without first exhausting administrative remedies. The Supreme Court found that the plaintiffs had standing because they had a direct financial interest in obtaining State funding to reimburse them for the cost of abortion services provided to Medicaid-eligible

women and have alleged that they performed and will continue to perform medically necessary abortions for which they will not be reimbursed under Georgia's Medicaid program. Moreover, the Court found that the administrative remedies were inadequate.

The case will now go back to the state court for trial on the merits. A copy of the Supreme Court's opinion can be found at: <http://op.bna.com/hl.nsf/r?Open=psts-77dl26>.

Proposed Rehabilitative Services Rule Seeks to Protect Fiscal Integrity of Medicaid Program

In a proposed rule published in the Federal Register on August 13, CMS aims to ensure the fiscal integrity of Medicaid expenditures by clarifying the service definition. CMS's proposal provides that "Rehabilitation services may be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met."

CMS explained in its proposal that the broad definition of rehabilitative services under the current regulations 42 C.F.R. § 440.130(d) has resulted in the rehabilitation benefit serving as a "catch-all" category to cover services included in other federal, state, and local programs. CMS additionally noted that over the years, the scope of services that states have provided under this rehabilitation benefit expanded from physical rehabilitation services to include mental health and substance abuse treatment resulting in payments to "inappropriate other third parties."

Under the new proposal, qualified providers of rehabilitative services must meet qualification standards outlined in Medicaid state plans that states will now be required to develop. Additionally, reimbursements will only be available for rehabilitation treatment that states include in their state Medicaid plans. The proposal also eliminates reimbursements for rehabilitative services that include room and board.

INSURANCE

Physicians Demand Prompt Payment Bill

On August 1, doctors and medical associations urged the House Committee on Small Business to enact legislation to force insurers to pay physicians promptly and establish a uniform definition for "clean claim."

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Delayed payments arise from: 1) assertions that claims are not clean; 2) assertions that a patient is not a covered beneficiary; 3) assertions that services provided were not medically necessary or covered by the contract; and 4) assertions that the manner in which the services were accessed or provided was faulty or not consistent with the contract.

Late payments from health insurance companies cause physicians to pay additional costs to pursue those payments. Physicians have been forced to hire office staff to collect delayed payments from insurance. For small businesses in particular, the late payments drain revenues.

Complicating the problem, the legal requirements for prompt payment are unclear and easily skirted. Physicians are therefore calling for a clear definition of a "clean claim" to ensure more prompt payment. More specifically, the American Medical Association ("AMA") recommended legislative changes including a federal prompt payment standard and penalties for unpaid claims that should not have been contested or remain unpaid without good cause.

Representative Charles Gonzalez (D-Texas) described the payment delays as unfair business practices that allow insurance companies to earn interest on money owed.

Many states already have prompt payment laws, but the enforcement of these state laws may be lacking. "Short-changing our physicians is counterintuitive to having an effective health care system," said Rep. Lynn A. Westmoreland (R-Ga.).

More information is available at <http://www.house.gov/smbiz/>.

COMMENTARY

If at First You Don't Succeed: CMS Releases Phase III

On August 27, 2007, CMS released Phase III amendments to Stark. The amendments propose to simplify and clarify changes made by Phase I and II revisions to Stark.

"Stand in the shoes" revision collapses indirect relationships

Perhaps most significantly, Phase III redefines "physician organizations" to include corporations, partnerships and LLCs. 42 C.F.R. § 411.352, p. 51062. Now a direct compensation arrangement will exist for Stark purposes if compensation passes directly

between a designated health services ("DHS") entity and a physician or a physician organization.

CMS states that it will treat physicians as "standing in the shoes" of their physician organization for financial purposes. Many physician arrangements previously analyzed under Stark's indirect compensation exception must now be reevaluated under the more stringent requirements of the direct compensation exception.

CMS clarifies the term "incident to"

The revisions in Phase III alter the rule regarding payment of productivity bonuses to members of a group practice. A physician's productivity bonus may now include services and supplies billed "incident to" under current Medicare rules. The term "incident to" clearly excludes services and supplies, such as x-rays and diagnostic imaging procedures, which have a separate Medicare benefit category. Some physicians may find that diagnostic tests previously billed as "incident to" are no longer attributed to them for the calculation of productivity bonus.

Hourly compensation safe harbor proves impractical

Phase III eliminates the safe harbor for hourly compensation paid to physicians. 42 C.F.R. § 411.351, p. 51015. The safe harbor proved impractical because it relied on physician compensation surveys that were expensive to obtain or no longer available. CMS will continue to scrutinize the fair market value of physician compensation arrangements, so providers should rely on multiple, objective, independently published salary surveys to support a claim of fair market value.

Phase III assists physician replacement by revising "incremental costs"

With respect to incremental costs for physicians recruited to replace a physician who retired, died or relocated outside of the recruiting hospital's service area in the preceding 12 months, the costs allocated to the physician practice need not be limited to actual additional incremental costs attributable to the recruited physician, but they can alternatively be the lower of a per capita allocation or 20% of the practice's aggregate costs.

This revision may provide needed assistance for practices in rural and underserved areas, but Phase III does nothing to help smaller or non-rural practices from replacing retiring or deceased physicians.

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Only “unreasonable” practice restrictions prohibited

Phase III permits recruitment agreements to include restrictions if they do not “unreasonably restrict the recruited physician’s ability to practice medicine” in the hospital’s service area (emphasis added). This rule softens the previous bright line prohibition on imposing practice restrictions on physicians. The following clauses are not unreasonable:

- Moonlighting restrictions;
- Patient and employee non-solicitation provisions; and
- Required treatment of Medicaid and indigent patients.

Phase III amends the relocation of practice exception

Phase III addresses confusion surrounding the relocation requirement in the physician recruitment exception. Phase III clarifies that established physicians must relocate their practices from outside the hospital’s service area to inside that service area, in addition to showing the following: (1) the physician has moved his or her medical practice at least 25 miles; or (2) the physician’s new medical practice derives at least 75% of its revenues from professional services from patients not seen or treated by the physician in his or her prior medical practice.

Moreover, Phase III adds new exceptions to the relocation requirement for: 1) certain federally employed physicians; and 2) physicians the Secretary determines do not have an established medical practice that serves or could serve a significant number of patients who are or could become patients of the recruiting hospital.

Added flexibility for recruiting to all hospitals

Phase III amends the definition of “geographic area served by the [recruiting] hospital” enabling more physicians to qualify for hospital recruitment activities. The service area for a non-rural hospital that draws less than 75% of its inpatients from contiguous zip codes is deemed to be all contiguous zip code locations of the hospital’s patients. In addition, rural hospitals can elect to define their service area as all contiguous zip codes from which the hospital draws up to 90% of its patients, plus non-contiguous zip codes if contiguous zip codes contain less than 90% of the hospital’s patients. If the hospital includes non-contiguous zip codes under the revised regulations, it must successively add the zip codes with the highest percentage of the hospital’s patients until the 90% threshold is reached.

Phase III allows retention payments without bona fide recruitment offer

Phase III relaxes a key component of the exception for retention payments to physicians in underserved areas: the requirement that the physician have a bona fide written recruitment offer. 42 C.F.R. § 411.357(t)(1), p. 51065. Phase III now permits the recruiting hospital to pay a retention bonus based on a written employment offer or a written certification from the physician. The physician must certify: 1) receipt of a bona fide employment opportunity requiring a move of at least 25 miles and outside the hospital’s service area; 2) the identity and location of the potential employer; and 3) the economic terms of employment.

The retention payment arrangement must comply with Stark physician recruitment exception, and the payment cannot exceed the lower of 25% of the physician’s current income or the reasonable costs of recruiting a replacement.

Phase III allows “holdover” of physician services agreements

Prior to Phase III, a provider or a physician that inadvertently allowed a physician’s personal services agreement to expire automatically violated Stark. Phase III now allows a “holdover” period of the agreement for six months, if on the same terms of the original agreement. 42 C.F.R. § 411.353(f), p. 51024).

Phase III alters nature of security interest transaction

Under Phase II, if a physician sold a piece of equipment to a hospital on an installment basis and retained a security interest in the equipment to secure the hospital’s payment, he or she would have been deemed to have an ownership interest in the hospital. 42 C.F.R. § 411.357(f), p. 51027. Phase III addresses this issue by expressly stating that the security interest creates only a compensation relationship between the physician and the hospital, not an ownership relationship.

Continuing medical education (“CME”) on compliance training qualifies under exception.

Phase III revises the provision in Phase II that excluded any programs for which CME credit is available from Stark exception for compliance training provided by a hospital to physicians who practice in the hospital’s local community or service area. 42 C.F.R. § 411.357(o), p. 51061. Under Phase III, the compliance training exception now includes training programs that

offer CME credit, provided that compliance is the “primary purpose” of the CME program.

Phase III relaxes the non-monetary exception

Phase III makes two major changes to the non-monetary compensation exception. 42 C.F.R. § 411.357(m), p. 51024. Previously, non-monetary compensation up to \$300 a year (adjusted for inflation in 2007 to \$329) was accepted from Stark, but now if an entity has inadvertently provided non-monetary compensation over the allowable amount, the exception may still apply if:

- The value of the excess amount is no more than 50% of the limit; and
- The physician returns the excess compensation by the end of the calendar year in which the excess compensation was received, or within 180 days of receipt, whichever is earlier.

In addition, Phase III allows entities, without regard to the \$300 limitation, to provide one annual medical staff appreciation function (e.g., holiday party) for the entire medical staff. Gifts provided in connection with the function remain subject to the \$300 limit.

The future of physician self-referrals

Phase III was designed to reduce the regulatory burden on healthcare administration. Phase III accomplishes this by providing greater flexibility in connection with a number of exceptions, including those relating to physician recruitment and physician retention. In addition, Phase III expands the temporary noncompliance exception to include a “holdover” of a personal services arrangement for up to six months.

On the other hand, the rules are still complex, and many comments remain unaddressed. For example, this industry must continue to wait on further guidance from CMS regarding the future of “under arrangements,” “per click” and percentage compensation contracts--changes to which were proposed in the 2008 Physician Fee Schedule but not addressed in this most recent rulemaking.

What’s next? CMS is expected to launch a national Stark compliance initiative by sending detailed, mandatory financial relationship questionnaires to 500 hospitals.

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