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Forming Physician Supergroups: Structural and Regulatory Challenges

Entity Structure, Governance, Reimbursement, Federal and State Stark Laws, Anti-Markup Rule

WEDNESDAY, JANUARY 13, 2021

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

Rachel B. Goodman, Senior Counsel, **Foley & Lardner**, Tampa, FL

Hannah E. Zaitlin, Senior Counsel, **Foley & Lardner**, Boston, MA

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SO YOU WANT TO BE A SUPER GROUP? HOW DO YOU GET THERE AND THEN WHAT?

Rachel B. Goodman
Foley & Lardner, LLP

Hannah E. Zaitlin
Foley & Lardner, LLP

This presentation and outline are limited to a discussion of general principles and should not be interpreted to express legal advice applicable in specific circumstances

Overview

In light of the constantly changing health care environment and increased government scrutiny enforcement actions, this session will:

- utilize a hypothetical scenario to look at the movement towards the formation of Super Groups;*
- explore the process from a regulatory, operational, and business vantage point; and
- provide an overview of the key regulatory compliance issues related to patient referrals and the performance of ancillary services within Super Groups.

* We use the term “Super Group” to refer to the combination of group practices that have joined together under one legal entity to realize cost savings and efficiencies of scale

Overview

This session will focus on the following topics:

- Overview of Physician Consolidation
- Structural Challenges and Options
- Regulatory Compliance Issues

Hypothetical Scenario

Three (3) physicians (Drs. Moe, Larry, and Curly) are owners and employees of an orthopedic group practice ("Orthos-R-Us"). The group also employs three (3) other part-time physicians. The group has three (3) offices, each of which includes x-rays, and currently offers physical therapy at one (1) location. The practice is interested in adding a magnetic resonance imaging (MRI) machine in one (1) of its offices because the physicians often order MRI scans for their patients, including Medicare patients. However, the physicians remain concerned as to sufficient volume to make the MRI profitable. The physicians are also interested in contracting with a radiologist (Dr. Adams) as an independent contractor to interpret the MRI images. Dr. Adams is willing to do the reads, but wants to do them from his own office on a limited part-time basis as an independent contractor.

Hypothetical Scenario

Dr. Harpo owns and operates a five (5) physician group of neurologists and neurosurgeons in the same area. The group has two (2) offices, one of which is in the same building as one of the offices of Orthos-R-Us. Dr. Harpo and Dr. Moe, long time friends and colleagues, meet for dinner one night and discuss the possibility of coming together as a single group. Dr. Harpo also points out that there is a brand new MRI office which had opened in their shared building, but the owner had hit the lotto and was looking to exit. Dr. Harpo indicated that his group's MRI volume, while impressive, would not justify an MRI alone but, perhaps together, the two (2) groups could support it.

Hypothetical Scenario

Dr. Harpo and Dr. Moe also agreed that they would speak to their good friend, Dr. Zhivago, a pain management specialist who owns a group of eight (8) physicians (including Dr. Zhivago), six of which are part-time physicians, who specialize in pain management. When they approach Dr. Zhivago, he is very interested and suggests they consider an in-office lab that, among other things, can provide quantitative urine analysis for drug screening. The lab could be expanded to include other services.

Benefits of Consolidation

- Increase clinical practice quality and efficiencies, improve care coordination, and reduce healthcare costs through clinical transformation;
- Clinical integration and delivery strategies to initiate value based delivery models and bundled payment arrangements;
- Improve ability to negotiate and align – yes, ALIGN—with health plans;
- Develop, own and offer ancillary services and business lines, including diagnostic imaging, clinical laboratory and pathology, and accumulation and processing of practice data for pharma and payor usage;
- Hiring of executive and specialized management expertise;
- Economies of scale (e.g. insurance, employee benefits, staffing, operations)
- Improved access to capital to upgrade infrastructure and office technology;
- Investment in compliance, risk management and billing/collection resources;
- Improved lifestyle standards and better on-call coverage sharing;
- Promote recruiting efforts and assists the creation of a viable exit strategy or succession plan; and
- Internal Referrals – Groups can guide internal referrals to both other MDs in the group as well as ancillary providers.

Pitfalls of Standing Still

- It is increasingly more difficult to operate in the private physician practice environment as a solo provider or small practice group.
- Reimbursement from insurance companies and payors are declining, and are typically slow to arrive, while the cost to provide clinical services and care to patients is increasing. This places significant financial pressure on many professional practices.
- Hospitals, providers of all types, and health plans have consolidated and evolved into sophisticated businesses with substantial financial and technological resources to meet the rapidly evolving healthcare environment.
- As a result, professional practices face increased competition from hospitals, health systems and other clinical service providers.

Structural Considerations of Operating in the Physician Practice World

Unified Business Establishment of a Super Group

- One way that a physician practice may deal with the identified challenges is to consolidate with other similarly situated practices and form a “Super Group.”
- This Super Group can either be an existing or newly formed entity (the “Consolidated Entity”) that would facilitate the consolidation of identified medical practices (“Practices”) through the merger, consolidation, acquisition or lease of each Practice's fixed assets (and staff) by the Consolidated Entity (a “Consolidation”).
- Substantial consideration must be given to the corporate, tax, and regulatory elements and consequences, and to the operational and technological factors to develop and create the Consolidated Entity in the most effective form.
- Lengthy delays in reimbursement must be avoided during the Consolidation ramp up.
- Depending upon the form of the Consolidation, the physicians who own the Practices (the “Participating Physicians”) will receive an equity interest in the Consolidated Entity in the form of either an exchange or a purchase of such equity.

Due Diligence Concerns

Due diligence must be undertaken by each Practice to review and analyze the following items with respect to each other Practice:

a) clinical delivery initiatives, i.e., do the Practices share the same vision concerning the management and delivery of clinical services, and the willingness to implement cutting edge clinical transformation strategies;

b) integration of operating systems, billing systems, and electronic medical records;

c) staffing, human resources, payroll processing and payment, and accounts payable;

d) current managed care issues, including, without limitation, participation versus non-participation, and whether the reimbursement rates secured by a Practice may be available for use by the other Practices/specialities once the consolidation occurs;

e) insurance (general liability, professional liability, property, directors and officers, and errors and omissions, and other necessary protections);

f) employment benefit plans; and

g) pension and retirement plans.

Governance of Consolidated Entity

The Consolidated Entity must operate as one unified, integrated, centralized business for purposes of governance and management, and should include, without limitation:

a) centralized decision-making by a managerial body that maintains effective control over the Consolidated Entity's affairs and business operations, and compensation; and

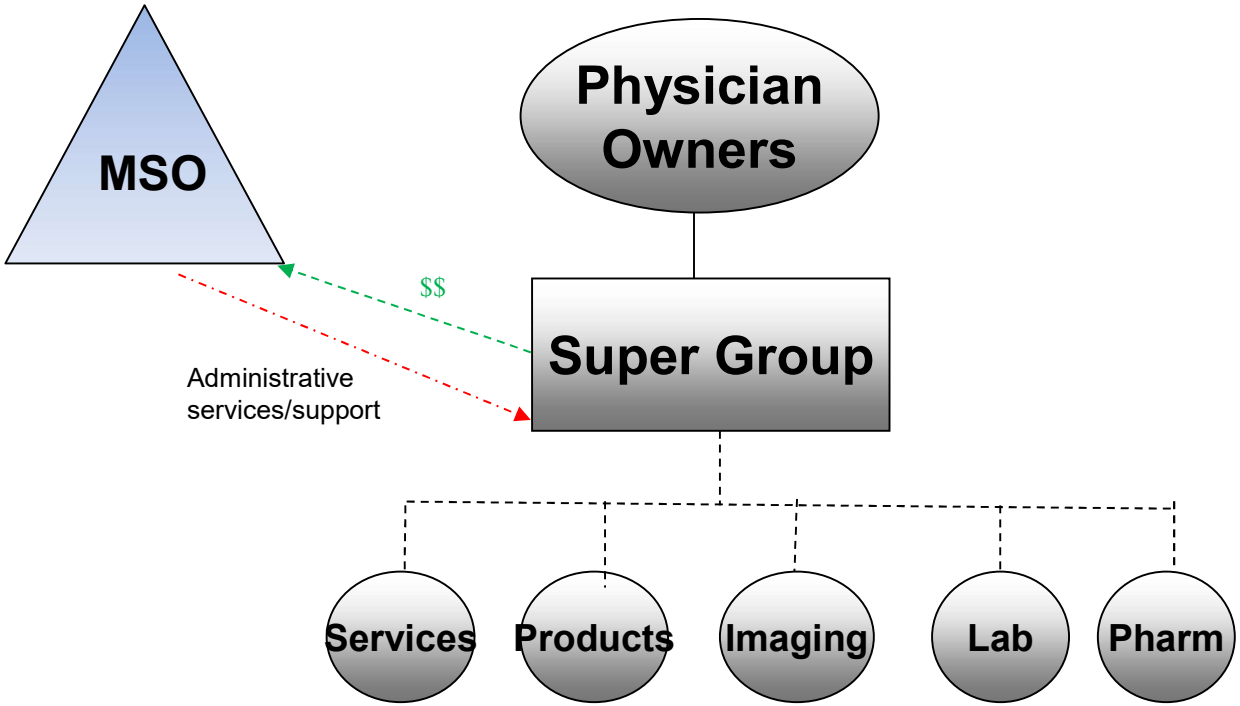
b) Consolidated billing, accounting and financial reporting.

The Consolidated Entity's managerial body (the “Board”) must possess the authority to establish the overall business policy and direction of the Consolidated Entity and will ordinarily consist of representatives designated by each Practice (and then, following the consolidation, by the Divisions). CANNOT BE A SHAM. Essential to Stark compliance.

Consolidated Entity Operated As One Business Division or Multiple Divisions

- The Consolidated Entity's business can be operated as either a single business division or through multiple separate divisions (each a “Division”).
- In the event that the multiple division model is chosen, operational decisions internal to a specific Division that do not affect the Consolidated Entity as a whole can be reserved to such Division and its Participating Physicians, subject to the review (for, among other things, compliance with applicable law) and final approval by the Consolidated Entity's Board.
- Shared Expenses/ Division Expenses

Fully Integrated Super Group (i.e., one division)



- Stark Law – In-office ancillary services and employment exceptions
  - Medicare DHS revenue cannot be directly allocated based on referrals, but note recent changes to Stark that may impact
- Anti-Kickback Statute – Employment safe harbors

Governance
- Democratic vs. founders reserve powers
- Part-timers

Compensation
- Equal or productivity
- By specialty
- Profit centers?
- Revenue/expense allocation

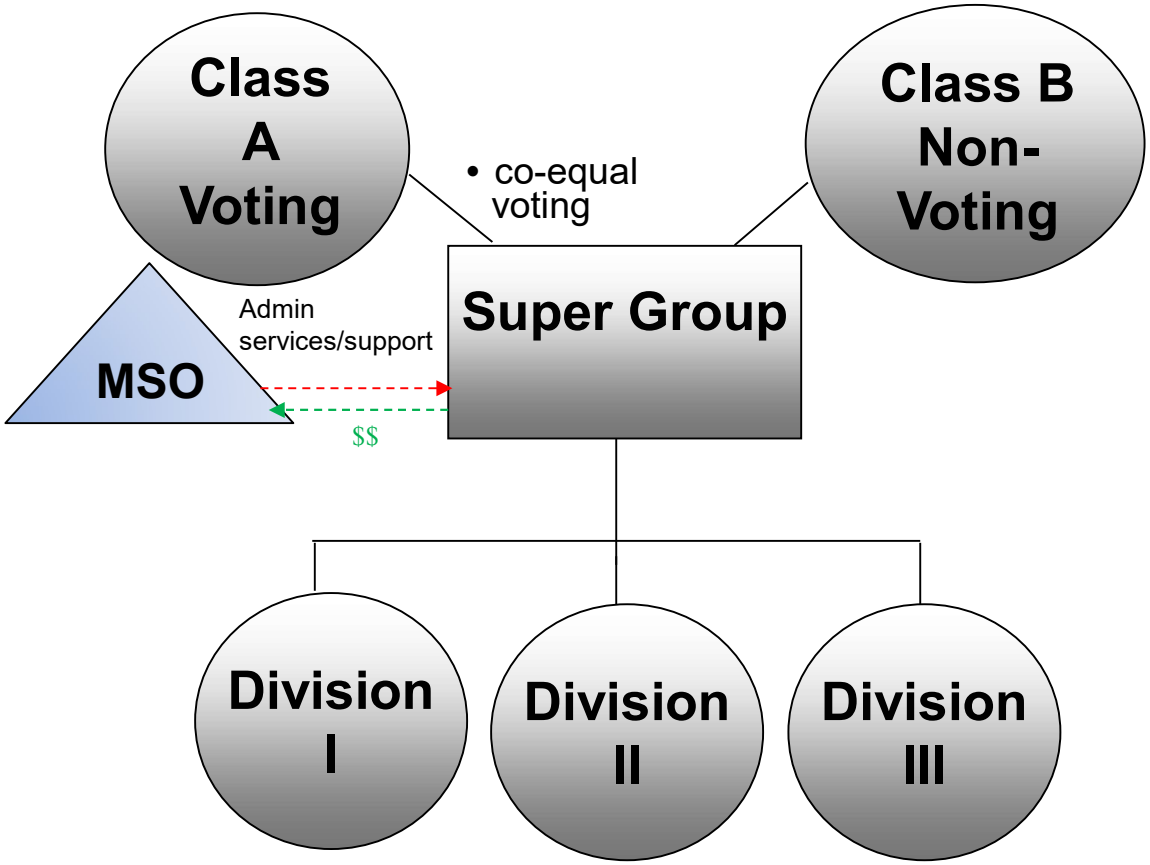
Buy-In/Buy-Out
- Transfer events
- Cross purchase vs. redemption
- Liquidation value vs. goodwill
- Succession planning

Restrictive Covenants

Principal Obstacles to Full Consolidation

A. Shared governance
B. Shared economics
C. Change of brand identity
D. Different cultures
E. Different IT platforms (and recent IT investments)
F. Different billing arrangements
G. Different debt profiles
H. Different payment contracts/rates
I. Different salary and benefit structures
J. Different buy-sell arrangements
K. Trust?

Group Practice Without Walls



- Stark Law – In-office ancillary services and employment exceptions
  - Medicare DHS revenue cannot be directly allocated based on referrals
- Anti-Kickback Statute – Employment safe harbors

Owners
- Each Owner receives 1
- Class A Unit; Class B Units based on relative value of contributed practice

Owner Actions
- Supermajority voting

Board
- Representative of constituent interests
- Central authority

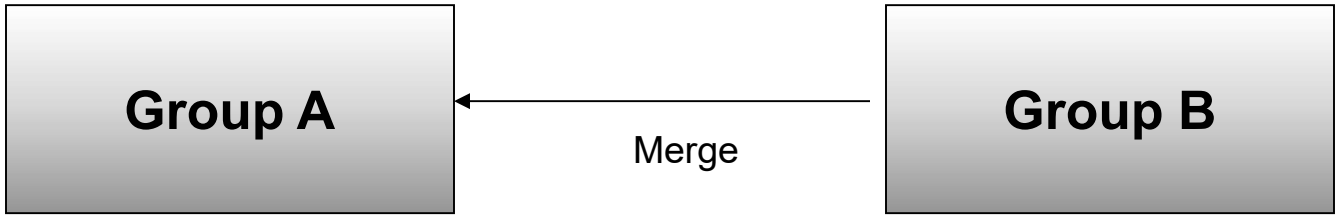
Board Voting
- Routine-majority
- Major Actions – supermajority

Divisions
- Profit center accounting
- Delegated authority for day-to-day operations
- Cross-indemnity for divisional deficits?
- Commitment window and unwind rights?

Transactional Structure Options

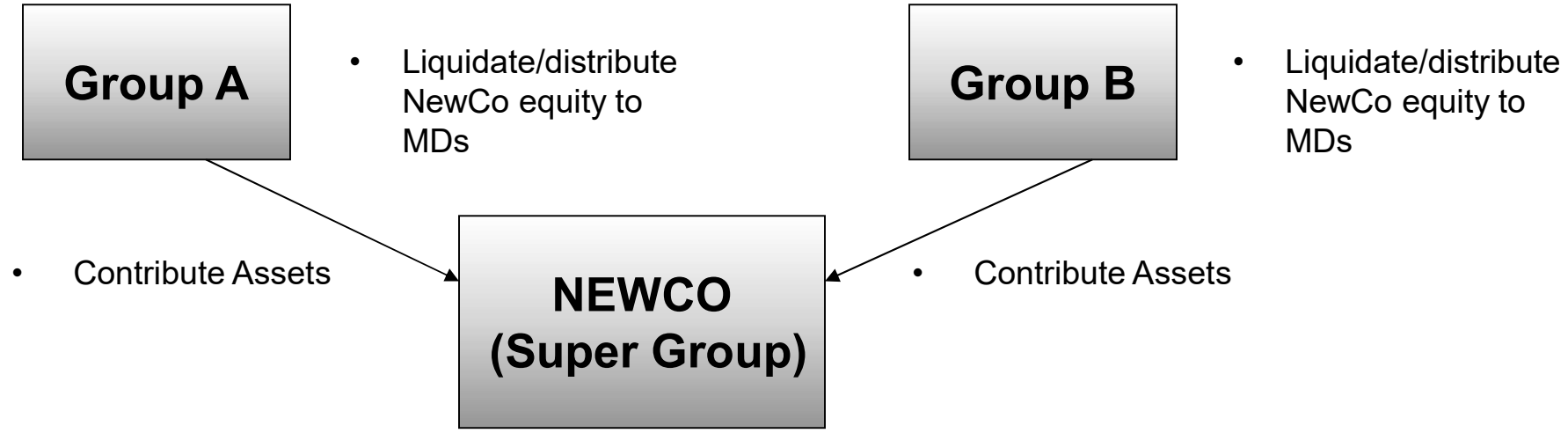
A. Merger
B. Asset Contribution
C. Asset Sale

Practice Merger



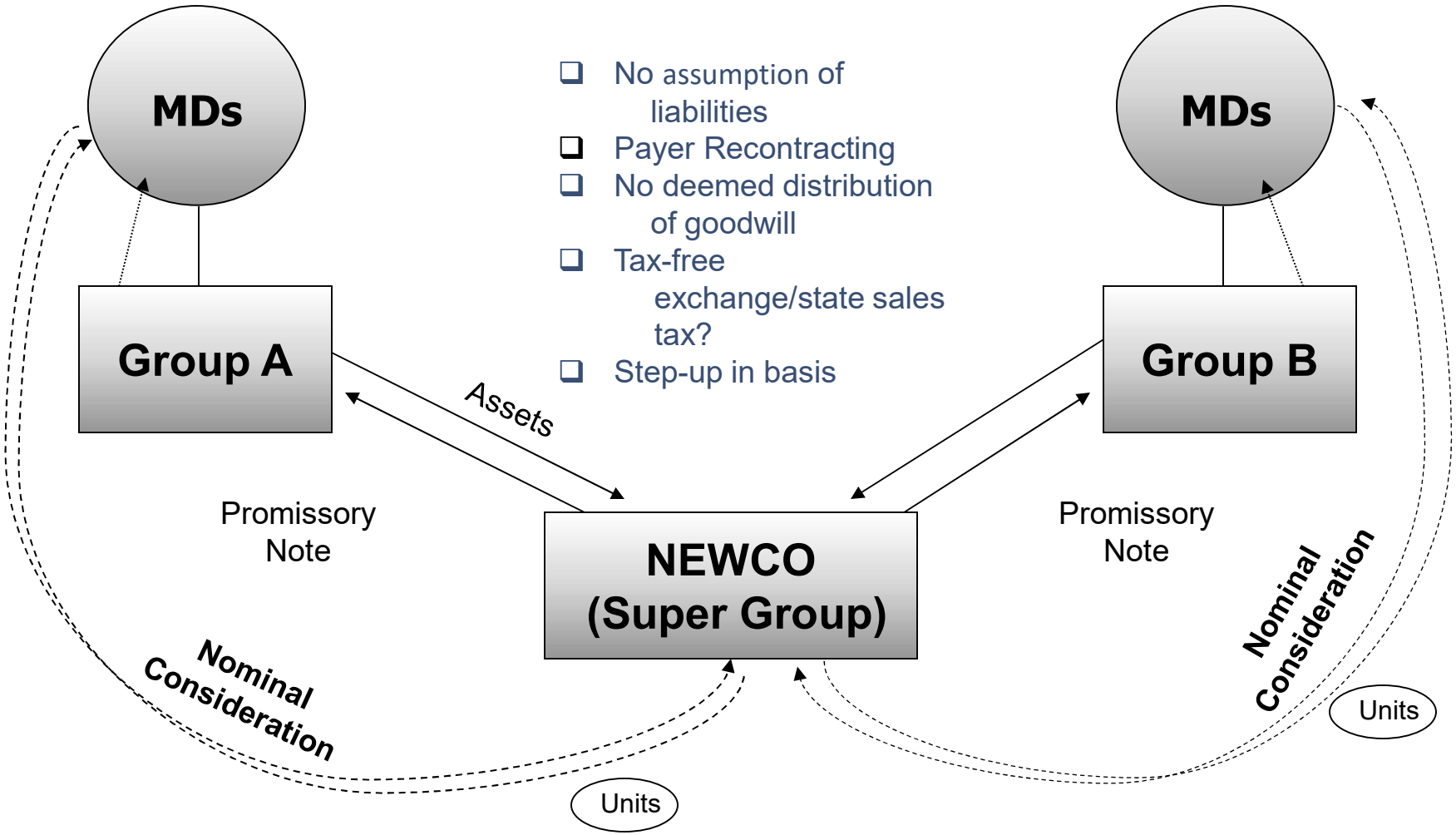
- Liabilities assumed
- Group A/B contracts retained
  - Group A provider numbers; Group B physicians re-credentialed on Group A provider numbers
- Tax-free reorganization
- No goodwill issue
- Carry-over basis in assets

Asset Contribution



- No assumption of liabilities
- Payer re-contracting/re-credentialing
- Tax-Free contributions
- No deemed distribution of goodwill?
- Carry-over basis in assets

Asset Sale



- No assumption of liabilities
- Payer Recontracting
- No deemed distribution of goodwill
- Tax-free exchange/state sales tax?
- Step-up in basis

Will There be Internal Referrals and/or Ancillary Designated Health Services ("DHS") Included?

- If YES – The Super Group must meet the definition of a "Group Practice" under the Federal Stark Law (and other relevant State laws)

- This is a **KEY CONSIDERATION** in consolidation.

- One often hears of meeting the "Group Practice" definition under Stark because it is a definition that allows you to meet certain "global" exceptions.

Federal Anti-Referral Proscription ("Stark Law")

- The Stark Law provides that a physician may not make a referral to an entity with which the physician (or an immediate family member of a physician) has a financial relationship with for the furnishing of designated health services ("DHS") for which payment is made by the Medicare Program. 42 U.S.C. §1395nn(a)(1).
  - Violation of the Stark Law results in claims denials and knowing violations potentially subject the Consolidated Entity and the Participating Physicians to civil monetary penalties, refund of payment related to such referrals, exclusion from federal healthcare program participation, and false claims liability exposure.

Stark Self-Referral Laws

- Penalties/Sanctions
  - Denial of payment.
  - Refunds to beneficiaries of co-pays.
  - *Civil money penalty of up to $15,000 for each bill or claim for a service person knows or should know is for a service for which payment may not be made under the statue.
  - *Civil money penalty of up to $100,000 for each arrangement or scheme which the physician or entity knows or should know has a principal purpose of ensuring referrals which, if directly made, would be in violation of the statue.
  - *Exclusion from the Medicare, Medicaid and/or other federally funded health care programs.

** For knowing violations*

Stark "Group Practice" Definition

- A "group practice" must contain two (2) or more "member" physicians, legally organized as a single entity, and operating primarily for the purpose of being a physician group practice.
- A "member" of a group practice generally includes (a) a physician with a direct ownership interest in the practice; or (b) a full or part time physician-employee of the practice.
- Operational requirements must be satisfied to qualify as a "group practice" for purposes of the Stark Law:

“Group Practice” Definition

a) Each of the members of the practice must provide substantially the full range of patient care services that he or she routinely provides using the group's resources, such as office space, facilities, equipment and personnel;

b) Substantially all (at least 75%) of the patient care services of the members must be provided through the group, billed under the group's billing number, and any reimbursement received must be treated as receipts of the group
   - Patient care services can be measured by various means, as specified by the regulations
   - Exception for group practice that is located solely in a HPSA, and for other group practice services rendered in a HPSA do not count against the group

c) Members of the group practice must personally conduct no less than 75% of the physician-patient encounters of the group practice (stated differently no more than 25% of a group practice's patient encounters can be performed by independent contractors

“Group Practice” Definition

d) The group practice must operate as a unified business, meaning that it has (i) centralized decision-making by a body representing the practice that maintains control over the group practice's assets and liabilities, and (ii) consolidated billing, accounting, and financial reporting.

e) The overhead expenses of, and income from, the group practice must be distributed according to methods that are determined prior to receipt of payment for the services; and

f) No member may receive, directly or indirectly, compensation based on the volume or value of the physician's DHS referrals, except through a permitted profit sharing or productivity bonus arrangement (as further provided in the regulations).

Distribution of DHS Profits – Special Rule for Productivity Bonuses and Profit Shares

- A physician in a group practice may be paid a share of overall profits of the group, provided that the share is not determined in any manner that is directly related to the volume/value of DHS.
  - "Overall profits" means the group's entire profits derived from DHS payable by Medicare/Medicaid OR the profits derived from DHS payable by Medicare/Medicaid of any component of the group practice that consists of at least 5 MDs.
- A physician in the group may be paid a productivity bonus based on services s/he has personally performed or services "incident to" such personally performed services, provided that the share is not determined in any manner that is directly related to the volume/value of DHS.
- *But note that these rules are being modified in January 2022.

Comparison of Compensation under the Group Practice Definition and Other Exceptions

Group Practice Definition

FMV Not required

Prohibition is on the Direct Taking into Account the Volume or Value of Referrals of DHS

Employee and PSA Exceptions

FMV Required

Prohibition is on the *Direct or Indirect* Taking into Account the Volume or Value of Referrals of DHS (and for the PSA Exception, the prohibition extends to "other business generated")

So Which Stark Exception Do I Aim For?

In-Office Ancillary Services ("IOAS")	Employee/PSA
Must meet "group practice" definition in order to use IOAS	Can use Employee exception for employed docs and PSA Exception for independent contractor docs regardless of whether practice meets "group practice" definition
More flexibility in compensation methodology (but most DME is not covered by exception)	Less flexibility, **but IOAS will not protect referrals to a hospital or other entity outside group, and if there is an indirect compensation arrangement, the indirect comp exception must be met (!).** This exception requires FMV and prohibits the direct or indirect taking into account the volume or value of referrals of DHS or other business generated

U.S. ex rel. Bookwalter v. UPMC

On September 17, 2019 the 3rd Circuit found that physicians who received a bonus if their RVUs exceeded a certain level met the "aggregate compensation" element of the definition of "indirect compensation arrangement:

The court reasoned that although the physicians' procedures performed at the hospital were "personally performed services" and thus not "referrals," inpatient and outpatient hospital services are DHS; and (3) therefore, because the physicians received productivity bonuses after reaching a certain level of RVUs, all else being equal, the more procedures the physicians referred to the hospitals, the more RVUs they accumulated and the higher their aggregate compensation.

The court also found that the first element (unbroken chain of financial relationships) and third element (knowledge or deemed knowledge that the aggregate compensation was met) were also satisfied

The court found that the allegations that the physicians were paid above FMV are at least plausible.

Back to Our Hypo: Orthopedic Group “Orthos-R-Us"

- 3 owners/employees (Drs. Moe, Larry and Curly)
- 3 part-time employees (2 of which work nowhere else; one who works 50% for Orthos-R-Us and 50% elsewhere)
- 3 offices
  - Imaging services at each office currently
  - PT services at one location
- Wants an MRI
- Wants Dr. Adams to do the MRI reads (and he wants to do them part-time in his own office).

Back to Our Hypo: Dr. Harpo's Neuro Group "Duck Soup Neurology and Neurosurgery"

- Dr. Harpo is owner and employee
- 4 other full-time employees: Drs. Groucho, Chico, Gummo and Zeppo
- 2 offices
  - Some ancillary services including imaging (e.g., Dopplers)
  - 1 office is in the same building as Ortho-R-Us
- MRIs done in the same building that is for sale.

Back to Our Hypo: Dr. Zhivago's Pain Management Practice

- 2 physician owners and employees
- 6 other physician employees (part-time)
- Time spent on behalf of the Practice:
  - 2 physician employees – 75%
  - 2 physician employees – 50%
  - 2 physician employees – 25%
- Wants an in-office lab to do qualitative urine test analysis for drug screening

So Are We a “Group Practice”?

- Ortho-R-Us?
- Duck Soup Neurology and Neurosurgery Practice?
- Pain Management Practice?

- ***WHAT ABOUT AS A SUPER GROUP?***

Applying the Test to See If We Meet the Definition of a "Group Practice"

- Do we have 2 or more physicians legally organized as a single entity for the purpose of being a physician group practice?
- Does the practice operate as a unified business?
- Are overhead expenses of (and income of) the practice distributed according to methods that are determined prior to receipt of payment?
- Does each member provides substantially the full range of patient care services that s/he routinely provides using the group's resources?

Applying the Test to See If We Meet the Definition of a "Group Practice" (con't)

- Are substantially all of the services of the members provided through the group, billed under the group's billing number, and reimbursement is treated as receipts of the group?
  - Basically, do members of the practice personally conduct no less than 75% of the physician-patient encounters of the group practice?
- Does any member receive (directly or indirectly) compensation based on the volume or value of his/her DHS referrals (except through permitted profit sharing or productivity bonus arrangement)?

PHYSICIAN	PERCENTAGE (FTE)	PERCENTAGE (PTE)
Dr. Moe (Ortho-R-Us)	100	
Dr. Larry (Ortho-R-Us)	100	
Dr. Curly (Ortho-R-Us)	100	
MD #1 (Ortho-R-Us)		100
MD #2 (Ortho-R-Us)		100
MD #3 (Ortho-R-Us)		50
Dr. Harpo (Duck Soup Neuro)	100	
Dr. Groucho (Duck Soup Neuro	100	
Dr. Chico (Duck Soup Neuro)	100	
Dr. Zeppo (Duck Soup Neuro)	100	
Dr. Gummo (Duck Soup Neuro)	100	
Dr. Zhivago (Pain Mgmt.)	100	
MD #1 (Pain Mgmt.)	100	
MD #2 (Pain Mgmt.)		75
MD #3 (Pain Mgmt.)		50
MD #4 (Pain Mgmt.)		50
MD #5 (Pain Mgmnt)		25
MD #6 (Pain Mgmt.)		25
MD #7 (Pain Mgmt.)		75

Is it a “Group Practice?”

Orthos-R-Us

5 @ 100% and 1@ 50% =

91.6% ➔ ***PASS***

Duck Soup Neuro.

5 @ 100%

100% ➔ ***PASS***

Pain Mgmt.

2@ 100%

2@ 75%

2 @50%

2@ 25%

500 / 8 = 62.5% ➔ ***FAIL***

COMBINED AS A SUPER GROUP

12@100%

2@ 75%

3 @ 50%

2 @25%

1550/ 19 = 81.58 ➔ ***PASS***

In-Office Ancillary Services Exception

- 3 Questions to Ask
  - ***WHO*** provides the DHS?
  - ***WHERE*** is the DHS performed?
  - ***HOW*** is the DHS billed?

In-Office Ancillary Services Exception – Who May Furnish/Supervise DHS

- Referring MD;
- MD who is a member of the same group practice as the referring MD; or
- Individuals supervised by the referring MD or another MD in the same group practice.
- "Member of the same group practice" includes:
  - MD with a direct/indirect ownership or investment interest in the practice
  - F/T or P/T physician employee
  - Locum tenens MD
  - Physician who provides on-call services for other members
- Independent contractors/leased MDs are not "members" of a group practice.

In-Office Ancillary Services Exception – Who May Furnish/Supervise DHS

- Independent contractors can be "physicians in the group practice" and supervise the performance of DHS for purposes of the IOAS exception
  - In order to be considered a "physician in the group practice," an independent contractor physician must furnish patient care services for the group practice under a contractual arrangement directly with the group practice to provide services to the group practice's patients in the group practice's facilities.
  - If the I/C physician is supplied to a Group Practice by another group practice or a physician staffing company, the physicians must either (1) sign an agreement directly with Group Practice, or sign the agreement between Group Practice and the other group practice or the staffing company (e.g., a joinder addendum)
  - If the latter option is selected, the written agreement between Group Practice 1and the other group or staffing company must identify the Physician by name and also identify the services that he or she is to perform for Group Practice.

In-Office Ancillary Services Exception – Where DHS May Be Furnished

- Same building OR Centralized Building

- "Same building" in which the referring MD (or another group practice member) furnishes physician services unrelated to the furnishing of the DHS
  - 3 scenarios (full-time/part-time)
  - Structure with a single street address (some exclusions)

In-Office Ancillary Services Exception – When Furnished in "Centralized Building"

- Includes all or part of a building that owned or leased on full-time basis (24/7) by group practice, and used exclusively by the group practice (includes mobile vehicles, vans, trailers)

- Block leases do not qualify as centralized location for purposes of the In-Office Ancillary Services Exception.

In-Office Ancillary Services Exception – How DHS Must Be Billed

- By the MD performing or supervising the DHS
- By the group practice of which the MD is a member, employee or independent contractor under the practice billing number
- By an entity that is wholly owned by the MD or group practice
- By an independent 3rd party acting as a billing agent

And Remember . . . They Want Dr. Adams to Do the Radiology Reads

- Part-time employee versus 1099
- Would do the reads in his own office or at a group location
- Federal Anti-Markup Rule may be implicated!
  - Applies to all diagnostics tests (not just DHS)

The Anti-Mark-Up Rule

The Anti-Mark-Up Rule Applies Only if the Physician Performing the TC or PC of the Diagnostic Test Does Not "Share a Practice" With the Ordering Physician

Alternative 1 – "Shared Services" Test. If the performing physician, who is the physician that supervises the TC or performs the PC or both, furnishes substantially all (at least 75%) of his or her professional services through the billing physician or other supplier, the TC and/or the PC, as applicable, will not be subject to the anti-markup payment limitation.

Alternative 2 – "Site of Service" Test. If the arrangement does not meet the "Shared Services" test, the physician supervising the TC and/or performing the PC will be deemed to share a practice with the billing entity if the physician supervises the test and/or performs the PC in the office of the billing physician or other supplier."

Anti-Mark-Up Rule

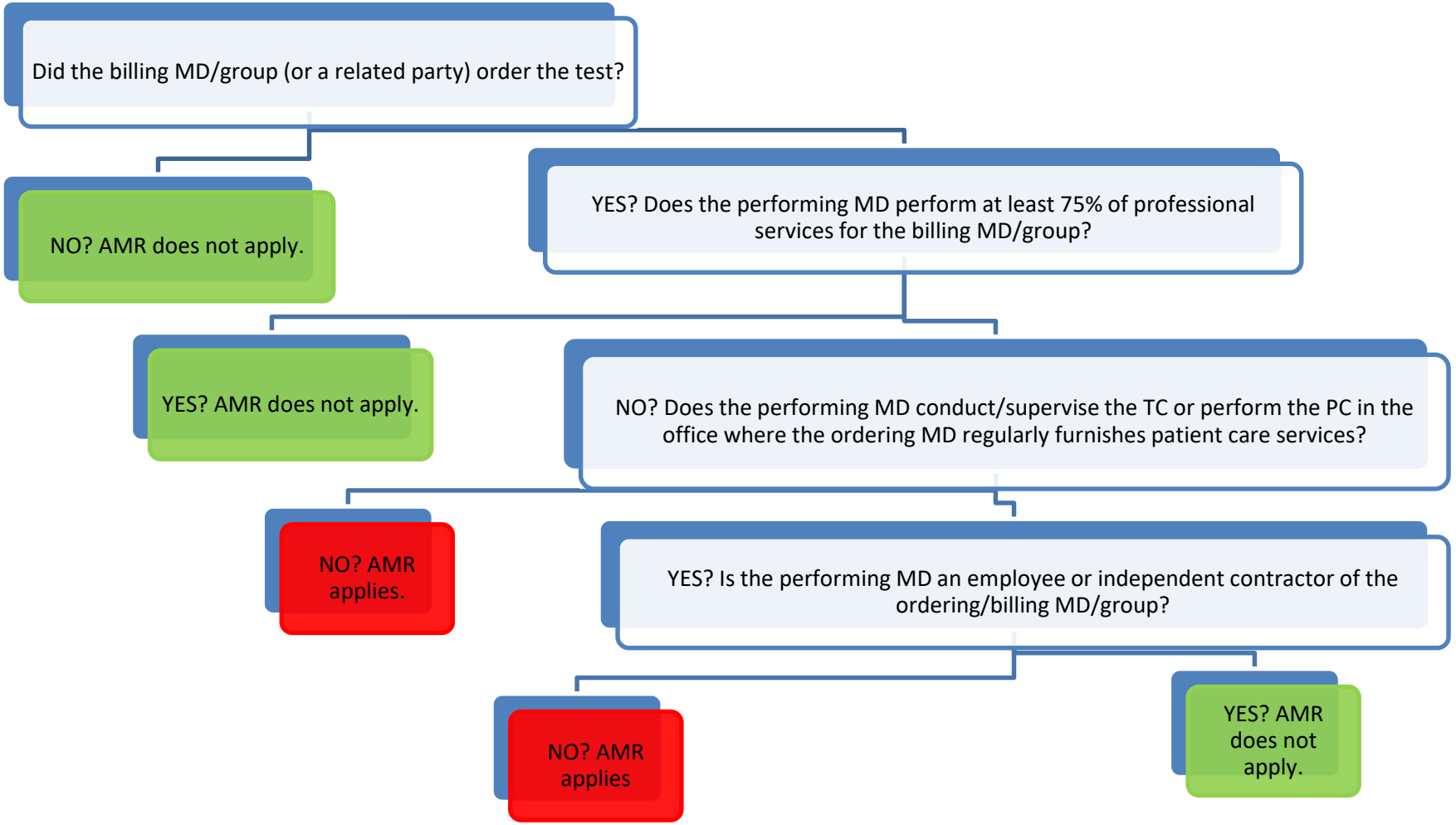
- “Office of the billing physician or other supplier” means any medical office space in which the ordering physician or other ordering supplier regularly furnishes patient care (which may include space where the billing physician or other supplier furnishes diagnostic testing) if the space is located in the same building in which the ordering physician or other ordering supplier regularly furnishes patient care.
- If the billing physician/supplier is a "physician organization", such as medical group, the term "office" means space in which the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally.

Anti-Mark-Up Rule

If the Anti-Markup Rule applies, then Medicare will pay the billing physician or other suppliers (less applicable deductibles and co-insurance) for the TC or PC billed by the billing physician at the lowest of:

1. the performing supplier's net charge to the billing physician or other supplier; or
2. the billing physician's or other supplier's actual charge; or
3. the fee schedule amount for the test that would be allowed if the performing supplier billed directly. (42 CFR §414.50(a)(1))

Global billing is not allowed if the AMR applies to the TC or PC. Section 10.1.1.2 of the Medicare Claims Processing Manual.


Did the billing MD/group (or a related party) order the test?
NO? AMR does not apply.
YES? Does the performing MD perform at least 75% of professional services for the billing MD/group?
YES? AMR does not apply.
NO? Does the performing MD conduct/supervise the TC or perform the PC in the office where the ordering MD regularly furnishes patient care services?
NO? AMR applies.
YES? Is the performing MD an employee or independent contractor of the ordering/billing MD/group?
NO? AMR applies
YES? AMR does not apply.

Intersection Between Anti-Mark-Up Rule and Stark

- If the Anti-Markup Rule applies, the billing supplier will not be an "entity" under Stark for the TC and/or the PC, as applicable
  - Billing supplier is carved out of the definition of "entity" where the AMR applies because there is no incentive for overutilization
- The payment limitation has to apply for the exception to the definition of entity to kick in – it is not enough that the rule be implicated
- The exception to the definition of "entity" is useful where the IOAS would not apply, e.g., a part-time mobile imaging arrangement
  - Parties could manufacture a failure to avoid the payment limitation

Additional Concerns Related to Other Services

- Physical Therapy
  - Supervision rules/ Incident-to rules
- Laboratory services
  - Recall our Hypo: They are considering setting up an in-office lab* for drug screening tests….
    - Need to consider Federal Stark Law, whether the Anti-Markup Rule is implicated, etc.
    - And don't forget relevant State law – licensure, etc.

* Note that CMS requires (through sub-regulatory guidance only) that physician-owned labs service only patients of the physician office; if it will service other patients it must enroll as an independent lab and obtain a separate CLIA certificate.

Finally …

- Consider tax consequences of transaction

- Although it would be unusual for the antitrust laws to be implicated, if a combination of groups would result in a dominant share of the local market, competent anti-trust counsel should be consulted prior to entering the deal.

CONTACT INFORMATION

Rachel B. Goodman
Senior Counsel
Foley & Lardner LLP
100 North Tampa Street
Suite 2700
Tampa, FL 33602
Phone: (813) 225-4158
RGoodman@foley.com

Hannah E. Zaitlin
Senior Counsel
Foley & Lardner LLP
111 Huntington Avenue
Boston, MA 02199
Phone: (617) 502-3253
HZaitlin@foley.com