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'Grass-roots effort' sparks hope for Stark reform

Physician groups attempt end-run around HCFA's final Stark II regulations

With final regulations on Stark II still on hold, five years after the law was passed, two major physician practice groups are attempting an end-run around the Health Care Financing Administration by taking the case for reform directly to Congress.

The Englewood, CO-based Medical Group Management Association (MGMA) and the Arlington, VA-based American Medical Group Association have launched what they call a "grass-roots effort" to strip out the controversial compensation arrangement provision of the law and to get clarification from Congress on how Stark II defines the term "group practice."

The physician groups claim they've never opposed the intent of the self-referral laws — "to prohibit abusive joint ventures that lead to overutilization of certain services." They say the lobbying push is necessary because "the complexity of the statute makes education of the physician, administration of and compliance with the regulation, as well as enforcement practically impossible," according to a letter sent April 15 to leaders of the Senate Finance Committee, House Ways and Means Committee, and the House Commerce Committee. **(To read the requested changes described in the letter, see page 3.)**

"The Stark law was actually intended to simplify things — and of course it has hardly done that," explains **Edward Kornreich**, JD, a health care

*See **Stark II**, page 2*

FTC continues crackdown on physician anti-trust

Last month's anti-trust settlement between a Nevada physicians' group and the Federal Trade Commission (FTC) underscores the need for physicians to better understand how they are — and aren't — allowed to communicate with one another under federal law, experts say. **(For more information on the Nevada case, see *Physician's Compliance Hotline*, April 12, 1999, page 1.)**

"The federal government doesn't like doctors grouping together in a shell in order to jack up

*See **Physician anti-trust**, page 4*

Physician beats the rap in federal mail fraud case

In a rare court victory against federal prosecutors, psychiatrist Anthony F. Valdez, MD, of El Paso, TX, has successfully defended charges that he defrauded a number of private health insurance companies by submitting claims for services he never provided.

Some experts are encouraged that the Valdez verdict could prompt more defendants to fight in court rather than simply pay to settle charges, as is more common. Others, however, note that the Valdez case is part of a troubling trend in which federal prosecutors pursue charges against physicians even when the alleged fraud doesn't concern Medicare.

"The government is becoming more and more aggressive in bringing health care fraud cases to court," says **Frederick Robinson**, JD, of the law firm Fulbright & Jaworski in Washington, DC. "Five years ago, no prosecutor would have touched this particular case." In addition to the fact that no federal

*See **Valdez case**, page 3*

INSIDE:

Stark II

Continued from page 1

specialist with Proskauer Rose in New York City. "The law has become so complicated that it is essentially unworkable."

The physician groups' plan is to attach a rider amending the Stark II laws to a budget reconciliation bill or other piece of legislation by the end of the current term. And so far, Congressional support for Stark II reform has been strong, says **Anders Gilberg**, government affairs field representative at MGMA's Washington, DC, office. "We've met with a number of legislators, and virtually all of them have indicated that their constituents and groups in their district are telling them this is a problem," Gilberg says. "They do want to address this issue."

So far, however, the proposed changes have drawn only silence from the law's author, Rep. Fortney "Pete" Stark (D-CA). While Stark has reviewed the requests, representatives from his office won't release any public comment on them before meeting with the groups directly.

Gilberg says that while there's little support for repealing Stark II altogether, "there's a lot of interest in refining it and cleaning it up." So why not wait until the Health Care Financing Administration issues its final regulations, probably sometime in 2001? Gilberg says that HCFA itself may be confused about what the Stark II regulations mean. The confusing nature of the proposed rules only reflects the vagueness of the law itself, particular with regard to how the law defines group practices and financial relationships between certain entities, Gilberg says.

Kornreich notes that HCFA's intent in defining "group practice" has been to distinguish between sham practices and legitimate practices. The problem is that the agency's definition criteria so far have been highly subjective. At one point, the agency floated the idea of requiring that a certain number of physicians be based in each office. "They wanted to avoid group practices without walls, but they eventually recognized that definition wasn't workable," Kornreich says. Even so, Kornreich maintains that "the only way you can clarify the meaning is to use very objective criteria. We just don't have those criteria yet."

The physician groups particularly want the "compensation arrangement" section of the law removed because such arrangements have grown so complex that the law is simply unable to adequately address them all, Gilberg says. Besides, he says, "virtually all of those arrangements are already covered under the anti-kickback statute. It's not like you won't have a body of fraud law out there to address payment for referrals."

Gilberg cautions, however, that just because a good possibility exists that Stark could change, don't assume your practice can afford to ignore the proposed regulations. While it's true that HCFA hasn't taken enforcement action yet, the agency

A Stark time line

1989: Original "Stark I" legislation passed, dealing with physician self-referrals to clinical laboratories.

1994: "Stark II" legislation expands the existing law to include a myriad of prohibited "designated services" commonly provided in physician offices, such as X-ray, ultrasound, physical therapy, and chemotherapy.

1995: "Stark II" amendments included in the Balanced Budget Act of 1995. Physician groups supported the amendments, designed to clarify certain issues in the law, but President Clinton vetoed the bill to which they were attached.

1998: The Health Care Financing Administration publishes proposed rules Jan. 9, 1998, for implementation of Stark II. HCFA indicates it could take "a few years" to issue final regulations. ■

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Editor: **Russell Underwood** (803) 781-5153 (russ.underwood@medec.com)
Executive Editor: **Susan Hasty** (404) 262-5456 (susan.hasty@medec.com)
Publisher: **Brenda L. Mooney** (404) 262-5403 (brenda.mooney@medec.com)

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Stark II

Continued from page 2

doesn't have to wait for the final regulations to launch a crackdown. After all, the law has been on the books since 1995. "Historically speaking, when HCFA does begin to enforce a law, it can go back all the way to the year the law was passed and look at all of your billing transactions potentially as false claims," Gilberg says. "We're very concerned that people are operating in a vacuum out there, and that when HCFA does start to go after people, they could be liable for all their billings back to 1995." ■

Physician groups lay out their case for Stark reform

In their letter to Congressional leaders, officials at the Englewood, CO-based Medical Group Management Association (MGMA) and the Arlington, VA-based American Medical Group Association, requested that the following specific changes be made to the Stark II self-referral laws, according to Anders Gilberg, government affairs field representative at MGMA:

"1. That Congress remove the 'compensation arrangement' provision of the law. Section 1877 of the Social Security Act prohibits certain referrals where a physician has a financial relationship with the entity to which a patient is referred. 'Financial relationship' is defined as either 'an ownership or investment in the entity' or a 'compensation arrangement.' When applied to the practice of medicine for medical groups, the inclusion of this prohibition as it relates to compensation arrangements is extremely confusing and unworkable.

"2. That Congress clarify the definition of 'group practice' to ensure that HCFA follows the intent of the statute. This is the only place in the entire Medicare statute in which the term 'group practice' is defined. Thus, it is very important that the definition be clear and capable of fair and uniform application to the broad spectrum of physician group practices."

The groups' two main concerns with the existing definition are as follows:

♦ "Compensation Test: The compensation test within the definition of group practice highlights the unfairness with which the statute and proposed regulations treat physicians practicing in different settings. For example, using the law's 'in-office ancillary exception,' a single specialty group of internists would be able to retain 100% of the compensation derived from the provision of designated health services. The same physicians practicing in a multi-specialty setting, however, would be required to bring those same revenues up to the level of the entire group and share them as 'profits' with all members of the multispecialty practice.

♦ "Other Standards: The law currently authorizes the Secretary to add by regulation and without limitation, any other standards to the definition of 'group practice,' above and beyond those detailed in the legislation. This open-ended delegation defeats any kind of regulatory certainty for group practices and invites regulatory intrusion into the basic structure and operation of thousands of private practices throughout the country." ■

Valdez case

Continued from page 1

money was involved, Robinson notes that the amount of money in dispute was fairly small — about $37,000 in claims, less than 1% of Valdez's practice.

Even so, the Federal Bureau of Investigation, working on a tip from a former girlfriend of Valdez and corroborating testimony from a former office manager at the practice, charged Valdez with one count of conspiracy to commit mail fraud and six counts of mail fraud, which carry a maximum penalty of five years each. Realistically, if convicted, Valdez probably would have faced two to three years in a prison and a fine as high as $250,000.

Robinson, who represented Valdez in the case, believes the government took such an active role in prosecuting a non-Medicare fraud case because it had already invested a lot of time in pursuing Valdez. "I believe they originally thought there might have been Medicare and Medicaid fraud going on," he says. "They spent a lot of time investigating that, but at the end of the day they didn't have anything related to federal health care programs. [They went forward anyway because] I think it's difficult for the government to give up a multiyear investigation without charging something."

The government's principle witness in the case was a former office manager, who claimed that she

Valdez case

Continued from page 3

and the doctor had conspired to submit fraudulent bills to private insurance companies. Before the government's investigation began, however, Valdez had already reported her to the local police department for embezzling more than $50,000 from the practice. The defense argued that she had slipped improper claims into the stack of claims Valdez signed each week, then siphoned off the money when it came in from the payers.

For his part, Valdez maintains that, although he personally signed each claim form, he often signed 150 forms in a 10-minute period each week and that he didn't review their contents. Since the case was criminal rather than civil, prosecutors couldn't argue that his failure to review the bills constituted reckless disregard. Even if they had, Robinson says, "It's still an issue of what's reasonable under the circumstances. I don't think it's reasonable that a doctor should have to double-check all the work of the people on his staff. If he has to do that, why bother hiring staff?"

Even so, Robinson says the Valdez case highlights the need for even smaller physician practices to have compliance programs that include at least the following elements:

- Implement a policy of conducting background checks on new hires. At a minimum, check references. Also perform a criminal background check, and consult the Office of Inspector General's Medicare exclusion list, which is updated regularly and posted on the Internet.
- Send staff with billing responsibilities to Medicare-sponsored billing seminars.
- Maintain subscriptions to appropriate Medicare newsletters.
- Have an outside auditor review billing annually to weed out anything inappropriate. ■

Physician anti-trust

Continued from page 1

health care costs," says **Reed Tinsley**, CPA, an accountant with Horne CPA Group in Houston. "If physicians get angry and try to deal with managed care as a group, the government will preclude them from collectively discussing contract issues. That means you have to disseminate information to each physician individually."

Tinsley says there are many cases — settled and pending — in which an independent practice association-appointed "messenger" tells payers that failure to adhere to his physicians' terms will result in all physicians terminating their agreement with the payer. "That means they could damage the payer significantly," says Tinsley. "Through market power and size, the IPA can get what it wants."

While that may seem to be the purpose of banding together in an IPA, the government doesn't like it, Tinsley says. The upshot is that physicians in messenger-model IPAs can't discuss pricing jointly. They can't collude to terminate or damage a provider network. They can't have a meeting and vote to terminate a contract, and they can't correspond together or post messages that all members can read on an electronic bulletin board that espouse ideas like, "We won't accept this contract unless we get X amount." Each person has to make a decision individually, he adds.

In looking at messenger-model IPAs — and Tinsley says the FTC will look at virtually all such agreements — the commission will determine whether the messenger facilitates collective decision making by network providers, rather than independent unilateral decisions. Specifically, it will look at whether the agent:

- coordinates the providers' responses to a particular proposal;
- disseminates to network providers the views or intentions of other network providers as to the proposal;
- expresses an opinion on the terms offered;
- collectively negotiates for the providers;
- decides whether to convey an offer based on the agent's judgment about the attractiveness of the prices or price-related terms.

If the agent engages in such activities, the arrangement may amount to an illegal price-fixing agreement, like the one alleged in Nevada.

Tinsley, says all the anti-trust activity and scrutiny by the FTC shouldn't discourage physicians from forming such groups. Along with the cost benefits that can accrue to members, he says, payers prefer working with groups rather than individuals. And there shouldn't be any reason to fear the FTC looking at your IPA as long as there are firewalls created to separate each participating practice, and each participating practice makes contracting decisions on its own. ■