The Stark Law and Productivity-Based Compensation in Group Practices

When a group practice bases physician compensation on productivity, it can potentially run afoul of the self-referral law. Here's an overview of that law and what it means for how you can—and can't—determine physician compensation in a group practice.

The Physician Self-Referral Law

In the 1980s, former Rep. Pete Stark Jr. (D-Calif.) advanced legislation to curb unnecessary Medicare expenditure. The resulting self-referral law—also known as the Stark law—prohibited physicians from referring testing services to laboratories in which they have a financial interest. The goal was to remove financial incentives for ordering unnecessary tests. Over the years, the law became much more expansive and convoluted, and the most recent changes went into effect on Jan. 1, 2022.

What does the law restrict? The physician self-referral law applies to designated health services (DHS) that Medicare or Medicaid pay for. It bans a physician from referring such services to entities with whom he or she (or an immediate family member) has a financial relationship (based on ownership or compensation). The law also prohibits the entity from submitting claims for such services. However, the law does provide some exceptions to these restrictions.

Which entities are subject to the law? The self-referral law defines *entity* broadly, ranging from solo practices or practices of multiple physicians to limited liability companies, foundations, and nonprofit corporations. (Note: This article only applies to group practices.)

Examples of physicians referring to their own practice. Suppose, for example, a physician orders a diagnostic test or treatment to be furnished by the practice. Under the law, this would be considered a self-referral if the service is a DHS.

Designated Health Services in the Ophthalmic Practice

CMS has categorized 12 items or services as DHS, including durable medical equipment and clinical laboratory services.

Types of DHS that apply to ophthalmology practice. The DHS that impact ophthalmology include radiology and certain other imaging services, clinical labs, and outpatient prescription drugs.

Watch for these codes. Effective Jan. 1, 2022, the list of CPT and HCPCS codes designated as DHS that are most applicable to the ophthalmic practice include the following:

- 76510-76519: These codes apply to ophthalmic ultrasound; A-Scan, B-Scan
- 92132-92134: These codes apply to OCT of the anterior segment, optic nerve, and retina
- 92227-92229: These codes apply to imaging of the retina for detection or monitoring, with review and report by clinical staff or interpretation and report by physician or other qualified health professional or point of care automated analysis (artificial intelligence)
- 0330T: *Tear film imaging, unilateral or bilateral, with interpretation and report*
- 83516: *Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method* (used for the InflammaDry test)
- 83861: *Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity* (used for the

Online Resources

The physician self-referral law is complex and very easy to violate unless you take time to understand the many ways that it applies to your practice. Some useful primers are available:

- CMS has a wealth of information: www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.
- CMS training modules on fraud, waste, and abuse include useful guidance on the self-referral law: www.cms.gov/Outreach-and-Education/MLN/WBT/MedicareFraudandAbuse/FraudandAbuse/story.html.
- The Office of the Inspector General provides some training resources: https://oig.hhs.gov/compliance/physician-education/.

BY **JOY WOODKE, COE, OCS, OCSR,** ACADEMY DIRECTOR OF CODING AND REIMBURSEMENT, AND **ALLISON W. SHUREN, JD.**

TearLab diagnostic test)

- HCPCS codes for outpatient prescription drugs, such as J0178 for Eylea (aflibercept) or J0585 for Botox (botulinum toxin)

For these DHS services, group practices must be careful in how they compensate physicians, as discussed below.

Download the full list of CMS codes. Each January, CMS updates the list of CPT and HCPCS codes that it uses to flag DHS. Make sure that your practice is using the most current list, which you can download at www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral.

Group Practices: Productivity-Based Compensation

Can physicians' compensation be based on referrals of DHS to their group practice? One issue that creates confusion is whether a physician in a group practice may be compensated based on the volume or value of his or her referrals, including DHS referrals, to the practice. Yes—it is OK to factor in DHS referrals as long as the physician personally performs the DHS or the DHS is furnished incident to the physician's treatment plan, performed by a non-physician practitioner (NPP; e.g., a physician assistant). Note: personally performs means just that; if the physician ancillary personnel perform the DHS, that wouldn't count. You also should be careful, as discussed below, about including a service's technical component when calculating compensation. Furthermore, this discussion applies to compensation; profit distributions would need to be analyzed separately.

Example. A separately reimbursed Medicare Part B drug, such as anti-VEGF therapy, is a DHS. If a physician personally administers the drug, the productivity formula may include the administered drug's HCPCS code as a factor.

Professional versus technical components. Reimbursement for some DHS services can be broken down into a professional component, which covers the review and interpretation of a test, and a technical component (TC), which covers the performance of a test. Most ophthalmologists generally do not personally perform the TC of diagnostic tests or clinical labs. Unless they do, the TC of a DHS should not be included when calculating productivity-based compensation.

An exception for group practices that have a low volume of DHS. In the unlikely event that a group practice's annual revenue from DHS is less than 5% of practice revenue and no physician's compensation contains more than 5% from DHS revenue, the practice has flexibility with the compensation model. While the 5% threshold sounds straightforward, it can get tricky, and you should consult with your health care attorney for guidance.

How to stay current. Review the list of DHS-related CPT and HCPCS codes, identify all services on that list that are relevant to your practice, consider any exemptions, and confirm that your current compensation model is in compliance with the physician self-referral law.

Compliance in Practice

Suppose a group practice sets each physician's compensation as, for example, 40% of that individual's net collections. In calculating those collections, the practice should take note of these two two caveats:

- If a physician referred a DHS to the practice but didn't personally perform or interpret that service, exclude the payment for that DHS from that individual's net collections.
- If a physician performed only the professional component of a DHS, exclude payment for the service's TC from that individual's net collections.

What happens to the excluded payments for the TCs? They can be pooled and disbursed as overall profit through a formula that is compliant with physician self-referral law. For example, the money could be distributed based on percentage of ownership, per capita, or by total days worked.

Practice operating agreements, physician employment agreements, and independent contractor agreements with other physicians or facilities should all be reviewed by an attorney who specializes in Stark Law to confirm compliance with DHS and compensation formulas.

You Realize You're Not in Compliance. What Next?

Suppose your practice submits claims to Medicare, but you then realize that the claims were ineligible for payment due to noncompliance with the physician self-referral law. What next? If your Medicare Administrative Contractor (MAC) pays you for those services, that would be considered an overpayment. You have 60 days to repay a known overpayment to the MAC. You can start by submitting a Self-Referral Disclosure to CMS. There are several benefits to following the Self-Referral Disclosure Protocol (SRDP), including the possibility of an extended timeline for making the repayment. Prior to making an SRDP submission, consult with an attorney about any actual or potential violations that your practice might have made, find out whether an SRDP should be submitted, and confirm that it was successful. Be sure to follow SRDP's special instructions. (Learn more about the SRDP at www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self_Referral_Disclosure_Protocol.)

Ms. Shuren is a partner at Arnold & Porter.
Financial disclosures: Arnold & Porter: PS.
See the disclosures key, page 8.

MORE ONLINE. For the regulatory definition of a group practice, see this article at aao.org/eyenet.

ADVOCACY WORKS

Thanks to intense Academy lobbying more than 20 years ago, the set of eyeglasses or contact lenses covered by Medicare furnished to patients following cataract surgery have long been exempt from the (Stark) prohibition on referrals.

Academy advocacy never stops. For the latest updates, check your email each Thursday for *Washington Report Express.*