

FAQ Results

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Question What does the physician referral law prohibit?

#1501:

Answers: The physician referral law (section 1877 of the Social Security Act) prohibits a physician from referring patients to an entity for a designated health service (DHS), if the physician or a member of his or her immediate family has a financial relationship with the entity, unless an exception applies. (The exceptions are specified in 42 CFR Part 411, Subpart J.) The law also prohibits an entity from presenting a claim to Medicare or to any person or other entity for DHS provided under a prohibited referral. No Medicare payment may be made for DHS rendered as a result of a prohibited referral, and an entity must timely refund any amounts collected for DHS performed under a prohibited referral. Civil money penalties and other remedies may also apply under some circumstances. Additional information is available at www.cms.hhs.gov/PhysicianSelfReferral/01_overview.asp#TopOfPage

Question My hospital has physician recruiting contracts that predate the Stark Phase II interim final regulations. Do these contracts need to comply with the new regulations?

#3163:

Answers: Yes, all recruiting arrangements must comply with the new regulations as of July 26, 2004. Each financial relationship with a physician must be evaluated for compliance with the Stark law based on its specific facts and circumstances. However, we are mindful of the concerns raised by the question and can offer the following observations. First, the Stark law is a self-implementing statute that went into full force and effect on January 1, 1992 with respect to referrals for clinical lab services and January 1, 1995 with respect to referrals for other designated health services. Accordingly, parties have had a legal obligation to comply with the statute since those effective dates. In the absence of final regulations for a particular exception, parties must have complied with a reasonable interpretation of the statute. Second, the Phase II regulation, including the new exception at § 411.357(e)(4) for certain joint recruitment arrangements, goes into full force and effect on July 26, 2004. Thus, a hospital-funded recruitment arrangement in which the recruited physician is subject to a restriction against competing with the group will not comply with the new joint recruiting exception in the Phase II regulations. Parties should document that any non-compete clause is void and will not be enforced. Third, continuing obligations (i.e., obligations for which performance is not yet required or is not yet complete) under a pre-existing recruitment arrangement must comply with the Phase II regulations as of July 26, 2004. For example, past payments under an income guarantee need not be recalculated so long as, at the time they were paid, the arrangement complied with a reasonable interpretation of the statute. Finally, in addition to the Stark law, all recruitment arrangements are also subject to the Federal anti-kickback statute

located at section 1128B(b) of the Social Security Act (42 U.S.C.1320a-7b(b)), which may prohibit recruitment arrangements even if they do not violate the Stark law. Inquiries with respect to that statute should be directed to the Office of Inspector General. Additional information on the Stark law and regulations is available at: Stark law and regulations

Question #3224: Are dialysis facilities required to limit compensation for medical director services to the amount allowed under the fair market value “safe harbor” provision in the Stark Phase II interim final regulations?

Answers: No. In an effort to address public concerns about how to determine fair market value for medical director compensation, the Stark Phase II regulations provide a “safe harbor” under the definition of “fair market value” at §411.351 for hourly payments to physicians that are calculated using one of two specified methodologies. However, use of the safe harbored methodologies is strictly voluntary. Parties may use other appropriate methodologies to determine whether compensation is fair market value. DHS entities that choose to use either of the two safe harbor methodologies will be assured that their compensation rates will be deemed fair market value for purposes of the Stark law. For more information on the safe harbor methodologies, see the Phase II preamble discussion at 69 Fed. Reg. 16092 and the definition of “fair market value” at 42 C.F.R. § 411.351.

Question #8807: Do implanted brachytherapy sources qualify for the exception for implants furnished by an Ambulatory Surgical Center (ASC)?

Answers: Yes, we are interpreting 42 C.F.R. § 411.355(f) to include implanted brachytherapy sources.

Question #8883: Can you please provide some examples of organizations, providers, or other entities that are NOT “physician organizations” as defined at 42 C.F.R. §411.351?

Answers: The following are examples of organizations, providers, or other entities that are NOT physician organizations. This list is illustrative, not exclusive: · Hospitals and other Part A providers of services · Federally qualified health centers · A single legal entity (that does not satisfy the requirements of a group practice for purposes of §411.352) that encompasses (that is, operates) a faculty practice plan AND either a medical school or hospital, or both · A medical school that does not operate a faculty practice plan but employs physicians to provide clinical and academic services

Question #8879: What is a “physician practice” within the definition of “physician organization” at 42 C.F.R. §411.351?

Answers: A “physician practice” is a medical practice comprised of two or more physicians organized to provide patient care services (regardless of its legal form or ownership). For example, a “physician practice” may be a group of physicians that practice together but do not meet all of the requirements of §411.352 for “group practices” for purposes of satisfying the requirements of the physician services and in-office ancillary services exceptions. We note that the provision of patient care services by employed or contracted physicians does not automatically cause an entity to become or be considered a “physician practice” (and, thus, a “physician organization”). For example, a hospital, which, in general terms, is an institution that provides medical, surgical, or psychiatric care and treatment for the sick or the injured, is not considered a “physician practice” or “physician organization” even though it employs or contracts with two or more physicians to provide patient care services to its inpatients and outpatients.

Question #8890: There are two references in the Phase III preamble (72 FR 51033, 51045) that appear to prohibit referrals for ancillary services provided in office space and using equipment that is

leased other than in a block lease arrangement. May a group practice provide and bill for ancillary services provided in shared office space using shared equipment if the supervision requirement for the particular service is satisfied by a “member” of the group and the arrangement otherwise complies with Medicare coverage and reimbursement regulations?

Answers: Yes. Services that qualify for the in-office ancillary exception in §411.355(b) must satisfy performance, location, and billing requirements. In order to satisfy §411.355(b)(1), a service must be furnished personally by: (i) the referring physician, (ii) a physician who is a member of the same group practice as the referring physician; or (iii) an individual who is supervised by the referring physician or, if the referring physician is in a group practice, by another “physician in the group practice.” A “physician in the group practice” is defined at §411.351 to include both a “member” of the group practice as well as an independent contractor during the time the independent contractor is performing services in the group practice’s facilities. Assuming that the location and billing requirements in §411.355(b) are satisfied, in-office ancillary services supervised by a member of the group practice would not be subject to the referral prohibition.

Question #8881: If a hospital (or other Part A provider) directly employs or contracts with physicians to provide physician services to hospital patients, does that make the hospital (or other Part A provider) a “physician organization”?

Answers: A hospital (or other Part A provider) is not considered to be a “physician organization” simply because it has employment or contractual arrangements with physicians for the provision of patient care services.

Question #8886: Does the Phase III “stand in the shoes” “grandfathering” provision apply to an arrangement that, as of September 5, 2007, did not meet the definition of an “indirect compensation arrangement” (and was not directly between a physician and a DHS entity) but would have satisfied the requirements of the exception for indirect compensation arrangements in 42 C.F.R. §411.357(p) if it had been applicable?

Answers: No. The only arrangements that qualify for the “grandfathering” provision in §411.354(c)(3)(ii) are those that, as of September 5, 2007, both (1) met the definition of an “indirect compensation arrangement set forth in §411.354; and (2) satisfied the requirements of the exception for indirect compensation arrangements in §411.357(p). If an arrangement satisfies both of these criteria, it need not be amended during its original term or the current renewal term (that is, the renewal term the arrangement is in as of September 5, 2007) to comply with the requirements of another exception. (See 72 FR 51028.)

Question #8884: Is the exception for physician recruitment in 42 C.F.R. §411.357(e) available to a hospital that wants to recruit a resident it has trained? Assume that the resident already resides in the geographic area served by the hospital (as defined in §411.357(e)(2)).

Answers: The exception in §411.357(e)(3) may be available to the hospital for the provision of recruitment assistance to the resident upon completion of the residency. When all of the requirements of §411.357(e) are satisfied, the exception protects remuneration provided by a hospital to a physician to induce the physician to relocate his or her medical practice into the geographic area served by the hospital in order to become a member of the hospital’s medical staff. In the case of a resident, the resident need not relocate a medical practice, provided that the resident establishes his or medical practice in the geographic area served by the recruiting hospital. However, the resident must become a member of the hospital’s medical staff. 1. Resident is not a member of the organized medical staff. To the extent that, during his or her residency, the resident is not considered to be part of the hospital’s organized medical staff, the exception in §411.357(e) would be available to the hospital. CMS recognizes that, often, residents do not join the organized medical staff of

the training hospital until their training is complete and they are able to practice without supervision. Having “privileges” or “permission” to provide patient care services only under the supervision of an attending physician (in the case of residents) is not necessarily the same as “being a member of the medical staff.” We note that this discussion is limited to residents and any activities that occur within the scope of their training programs. If a resident moonlights, he or she may be a member of the organized medical staff of the hospital at which he or she moonlights. Of course, as always, all of the requirements of an exception must be satisfied in order for remuneration to comply with the physician self-referral rules. 2. Resident is a member of the organized medical staff, but such membership is coterminous with his or her employment with the training hospital. If the resident’s privileges terminate (for example, pursuant to a provision in the medical staff bylaws or the resident’s employment contract) at the end of his or her residency and the physician (formerly the “resident”) is not considered a member of the medical staff upon the completion of the residency, the hospital may use the exception at §411.357(e) to provide a recruitment payment to the physician, provided that all of the requirements of the exception are satisfied at the time of the arrangement. We caution that this answer is contingent upon: (1) the coterminous nature of the medical staff membership having been established prior to the parties entering into the recruitment arrangement; and (2) consideration provided by either party pursuant to the recruitment arrangement not occurring until after the termination of the physician’s medical staff membership as a resident.

Question Is a staffing company a “physician organization”?

#8882:

Answers: A staffing company that does not directly provide and bill for patient care services, but merely facilitates the provision of physicians to hospitals and other health care providers, is not a “physician organization” as defined at 42 C.F.R. §411.351.

Question Must a physician who “stands in the shoes” of his or her physician organization (as defined at 42 C.F.R. §411.351) become a signatory to a written agreement between the physician organization and a DHS entity in order to satisfy the requirements of a direct compensation arrangement exception?

#8885:

Answers: No. For purposes of satisfying the requirements of an exception to the physician self-referral prohibition, we consider a physician who is standing in the shoes of his or her physician organization to have signed the written agreement when the authorized signatory of the physician organization has signed the agreement.

Question Do the provisions regarding termination/amendment of leases apply to personal services arrangements?

#8889:

Answers: Yes. As stated in the Phase III final rule, “a personal service contract can be amended in the same manner as an office space or equipment lease” (72 FR 51047). The provisions regarding termination/amendment of office space and equipment leases (see 72 FR 51044) apply to personal service arrangements.

Question Consider the following facts. A physician group practice (Group Practice 1) has a written contractual agreement with another physician group practice (Group Practice 2) for the services of a physician in Group Practice 2. Group Practice 1 would bill Medicare for the services of the physician (Physician A) as Group Practice 1 services. Must Physician A sign a contractual agreement directly with Group Practice 1 in order to be considered a “physician in the group practice” with respect to Group Practice 1 (so as to permit Group Practice 1 to bill for the services provided to its patients by Physician A)?

#8888:

Answers: In order to be considered a “physician in the group practice,” as defined at 42 C.F.R. §411.351, 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. Under the specific factual scenario described, Physician A may either sign an agreement directly with Group Practice 1 or sign the agreement between Group Practice 1 and Group Practice 2. If the latter option is selected, the written agreement between Group Practice 1 and Group Practice 2 must identify Physician A by name and also identify the services that he or she is to perform for Group Practice 1.

Question #8887: Is physician ownership a prerequisite for meeting the definition of “physician organization” or “physician practice”? In other words, must all “physician organizations” or “physician practices” have at least one physician owner?

Answers: No. Physician ownership is not determinative as to whether an entity (regardless of its legal form, for example, limited liability company, professional corporation, etc.) is a “physician organization.” We note that 42 C.F.R. §411.352 states that, with respect to a group practice (which is a “physician organization”), the single legal entity that is the group practice may be organized by any party or parties, including, but not limited to, physicians, health care facilities, or other persons or entities. Likewise, physician ownership is not determinative as to whether an entity (regardless of its legal form, for example, limited liability company, professional corporation, etc.) is a “physician practice.”

Question #8880: Is a federally qualified health center a “physician organization”?

Answers: No. A federally qualified health center (as defined at 42 C.F.R. §405.2401(b)) is not a “physician organization” as defined at §411.351. Federally qualified health centers are subject to the conditions for coverage at 42 C.F.R. Part 491. These regulations require, among other things, that the federally qualified health center have written policies and procedures, disclosure of certain information to patients, minimum staffing composition and levels, and that the federally qualified health center provides medical emergency procedures as a first response to common life-threatening injuries and acute illness. Federally qualified health centers may share some characteristics with physician medical practices. However, federally qualified health centers typically are not structured as physician medical practices in the traditional sense, nor are physician medical practices required to meet the same conditions for coverage as federally qualified health centers.