Complying with the Stark Law Across Multiple Center Locations

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Urgent message: The "in office ancillary services exception" to the Stark law enables urgent care centers to offer a range of services in-house, but complications arise when the urgent care operation consists of multiple locations.

Urgent care centers are almost certainly familiar with the Stark law, a federal conflict-of-interest statute designed to help curb physician self-referral. It is a particularly exacting regulation, but there are numerous exceptions that may help healthcare providers avoid liability—the common federal exception Stark In-Office Ancillary Services Exception (IOASE) being one. This exception is designed to protect the in-office provision of certain designated health services (DHS) that are truly ancillary to the medical services being provided by the physician to his group's patients. Meeting this exception, however, can prove challenging for owners who operate multiple centers.

Stark Casts a Wide Net

The federal Stark law (42 USC § 1395nn), which applies to Medicare and Medicaid, 1) prohibits a physician from making referrals for (ie, ordering) certain DHS payable by Medicare or Medicaid to an entity that the physician, or an immediate family member of the physician, has an investment/ownership interest in or a compensation arrangement with, and 2) prohibits the filing of claims for those referred services unless the arrangement satisfies a statutory exception. Compensation arrangements also include employment and contractor relationships.

Despite frequent misunderstanding by operators, urgent care centers are subject to the Stark law just like any other medical practice or facility comprised of physicians. The DHS rendered by them includes x-rays, laboratory testing, and, sometimes, the provision of durable medical equipment.

State Stark law equivalents, known as Physician Self-Referral Prohibitions, often apply to all payors, including insurance and patient private pay payments, where similar designated services are involved. Intent is irrelevant; the Stark law is strict liability. In other words, it essentially assumes that arrangements that do not meet the exception criteria are too dangerous to be permitted (regardless of what the parties intended); ie, expensive for payers and contrary to patient interest because the physician is profiting from his own referral of specialty services.

It is therefore critical for an urgent care center to be in strict compliance with a Stark law exception. Most states' exceptions to the law mirror those of the federal law; though the federal government has more quickly and often enacted exceptions which the states could not keep up with. Accordingly, many attorneys are comfortable that state authorities will not necessarily pursue action if compliance with the federal law exception criteria can be achieved. However, mere technical violations can be fodder for insurance companies seeking to recoup reimbursement, which can be powerful leverage when accompanied by the threat of the criminal violation becoming a part of the public record.

The Contours and Limits of the 'Separation' Strategy

Most urgent care providers will be familiar with the IOASE, and likely have received counsel regarding how to maintain compliance with the Stark law exception. Often, however, owners utilize the time-honored "legal protection" practice of setting up separate sites under a different entity for each location, each having a separate tax identification number. This is for the legitimate purpose of insulating assets of one center from any manner of lawsuits, as well as payer recoupments (offsets or refunds) attributable to another center. It also serves the perceived goal of reducing the collection "footprint" to minimize

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appearing on the radar of payers as a larger player (though this assumption neglects that payers can cross-reference physician owner provider numbers).

Some owners also separate the entities to minimize personnel for each location, to avoid higher employee benefit-related costs, or to fall short of the imposition of certain labor laws. Additionally, separate tax IDs allow for localized and discrete collateralization of bank lending. Regardless of the incentive, however, most non-healthcare attorneys and clients view separation as a best practice without realizing that it causes strict violation of the Stark law.

The primary challenge facing centers seeking to comply with the IOASE is meeting what is known in common parlance as the *75% test*, which comes in two parts. An important factor in applying this test is that the government does not look to the location of the patient care services; but rather, it conducts the calculations based on the distinct operating entity identity (ie, its tax ID).

The first part, which is particularly germane to the analysis when operating out of multiple tax IDs, measures the total amount of "patient care services" rendered by physicians who are owners and W-2 employees under that particular tax ID. The government's bright-line rule does not distinguish its analysis on whether the physician is working part-time or full-time for the center. Essentially, the test looks at how much time that physician works for that particular tax ID compared with the amount of time he works under a different tax ID. This is measured by both the amount of time billed through the tax ID and the time involved in clinical oversight (for example, in the urgent care context, medical directorship services) of that tax ID.

The phrase *patient care services* is specifically defined to include any task(s) performed by a physician in the group practice that addresses the medical needs of specific patients or patients in general, regardless of whether they involve direct patient encounters or generally benefit a particular practice. For example, patient care services can include services such as consulting with and supervising other physicians, or time spent training staff members, arranging for equipment, or performing certain administrative or management tasks.

First Test

To conduct the first test, a calculation is performed for each physician based on the time he dedicates to the single tax ID in relation to his dedication of time and billing to other tax IDs. The percentage calculated for each physician-owner and employee is added up, with the collective percentage amount divided by the total number of owners and employees attributable to that tax ID. The resulting average percentage must equal at least 75%.

For example, if a physician practices 40 hours per week in total and spends 30 hours per week on patient care services for a specific group, the physician has spent 75% of his time providing patient care services for the group (30/40).

""A group must demonstrate compliance by measuring patient care services by provable substantiating metrics."

As further illustration, if one physician practices through a tax ID for a total of 50 out of her 60 hours worked per week, another physician practices through the same group for a total of 15 out of his 15 work hours per week (ie, he works exclusively for the group on a part-time basis, having no outside work obligation), and another physician practices for 30 of her 50 hours worked per week, then the first 75% test is satisfied (50/60 + 15/15 + 30/50 = 83 1/3% + 100% + 60%; then, dividing the total %s by three physicians results in 81.11%, which is greater than 75%).

If you have physicians cycling through different locations with discrete entity tax IDs, then their percentage will approach 10% to 20% (or even less), bringing the number down to an average below 75% and failing the Stark law bright-line objective test. For example, 100% plus 20% divided by two physicians is only 60%. The challenge becomes exacerbated when you have an owner who spends perhaps only 10% of her time across a number of separate professional entities serving in a medical director capacity, if at all.

Obviously, a crystal ball is not available to measure compliance in advance for a given year. Nevertheless, a group must be able to demonstrate compliance by measuring patient care services by provable substantiating metrics: 1) the total time each member spends on patient care services documented by any reasonable means (eg, time cards, appointment schedules, practice management software reports); or 2) any alternative measure that is reasonable, fixed in advance of the performance of the services being measured, uniformly applied over time, verifiable, and documented. If it cannot be proven, it never happened.

Independent contractors (who are paid on a 1099 basis), however, are not counted at all for purposes of the first part of the 75% test. This has led those seeking to comply to believe that they can simply classify physicians who cycle through their locations on a part-time basis as contractors, to avoid diluting the 75% average calculation above. Urgent care centers have predominately done this by accident, however, as many emergency physicians are used to classification as contractors, and

expect it. Similarly, part-time providers who occasionally work a shift or cover a center on a relatively limited basis prefer this classification. Additionally, owners may prefer avoiding the costs associated with W-2 categorization. This accident or strategy, depending on perspective, is flawed at its inception.

Second Test

The second so-called 75% test measures whether members (ie, employees and owners) of the group personally conduct no less than 75% of the physician-patient encounters of the group. It is designed to prohibit a group practice from utilizing a disproportionately significant number of independent contractor physicians. The Centers for Medicare and Medicaid Services' (CMS') regulatory commentary (but not statutory or regulatory text) provides that the encounters are measured per capita, and not by a metric based upon time. The term "physician-patient encounters" is not specifically defined under the Stark law or regulations, but would imply a direct encounter between the physician and patient.

Combining multiple locations into a single tax ID, or, alternatively, combining regionally contiguous locations into a single tax ID may be the only answer to satisfying the first test, as distinct operating entities cannot always practically meet the 75% test within the four corners of their operation. The second part of the test is rather obvious as to the best approach: making physicians W-2 employees.

Conclusion

In addition to the above-referenced tests, there are other criteria of the IOASE which must be met, but those are easier to accomplish in the context of a unified entity under a single tax ID and in an urgent care setting. We also note that the above scenario and challenges could even be present within a single location—for example, a primary care or orthopedic practice with the same owner as the urgent care center is co-located in the center. It is accordingly critical that bona fide efforts be made to analyze existing corporate structure and physician relationships, and to achieve precautionary compliance. ■