

**STARK II PHASE III, THE RULES CHANGE AGAIN**

*By Scott P. Sandrock, Esq., Brennan Mannan & Diamond*

*On September 5, 2007, CMS issued Phase III of its final regulations, which were to respond to comments and issues that were raised after the Phase II regulations were issued in March of 2004. The new regulations have modified some prior regulations and give some guidance to changes which may be coming in the future.*

By way of background, in 1989, legislation was adopted that prohibited physicians from referring patients for laboratory services to business entities in which the physicians had a financial interest. The regulations, named after Representative Pete Stark who introduced the legislation, became known as the "Stark" regulations, which went into effect in 1992. Since that time, the regulations and restrictions have been expanded to prohibit referrals by physicians to entities for services in a growing list of categories known as "Designated Health Services" (DHS). Currently, DHS prohibitions, in addition to laboratory services, includes physical therapy and occupational therapy services, radiology services, radiation therapy services and supplies, durable medical equipment, parenteral and enteral nutrients and supplies, home health services, outpatient prescription drugs, prosthetics, orthotics and prosthetic devices, and outpatient hospitalization services. The Stark rules make an absolute prohibition against referrals for DHS unless the physician satisfies one of the specific exceptions described in the regulations.

Phase III has modified and, in most cases, further restricted the applicable exemptions frequently used in planning business arrangements. A number of the key components of Phase III include:

**Group Practice.** Under the prior interpretations, a medical practice could hire an outside group to provide services within the group practice and meet the specific exception. For example, a group may contract with a radiology group to interpret readings of diagnostic images. The new rules restrict this provision to provide that the group practice may still engage a physician as an independent contractor, but the contract must be with a specific physician, not a group, and the services must be provided at the offices of the contracting group.

**DME.** CMS notes in Phase III that in its view, with the limited exception of braces and other things necessary to leave the  
*(Continued on page 10)*



*Specializing in Healthcare Law –*

**BRENNAN, MANNA & DIAMOND offers business strategies and legal solutions to healthcare facilities and physicians**

Knowledge makes all the difference! While other firms claim they do healthcare law, BRENNAN, MANNA & DIAMOND has developed one of the largest healthcare practices in the region.

This focus allows BM&D to provide innovative, business-oriented solutions to healthcare facilities and physicians. Our attorneys serve as business and strategic advisors to our healthcare clients.

From the development of centers of excellence and physician-owned ambulatory surgery centers to expediting mergers, affiliations and acquisitions, our depth and breadth of experience provides you with a firm structure for business growth.

While you focus on patient care, you need specialists who focus on your business. Call BRENNAN, MANNA & DIAMOND.

**THE BM&D HEALTHCARE AND HOSPITAL GROUP**

- |                      |                      |
|----------------------|----------------------|
| Jack Diamond         | Randal C. Fairbanks  |
| M. Mark Bajalia      | Dr. Bradley S. Feuer |
| David L. Brennan     | Mathew A. Heinle     |
| Richard W. Burke     | Frank A. Lettieri    |
| Jason A. Butterworth | Scott P. Sandrock    |
| John N. Childs       | Frank T. Sossi       |
| Lisa M. Clark        | George F. Voinovich  |
| L. Joe Davis, Jr.    |                      |

Call Scott Sandrock  
Healthcare Group Attorney  
at 330-253-5060

**BRENNAN MANNA & DIAMOND**  
ATTORNEYS & COUNSELORS AT LAW

330-253-5060 ■ www.bmdllc.com

**"We're Pro Business."**

BUSINESS STRATEGIES AND LEGAL SOLUTIONS FOR THE HEALTHCARE INDUSTRY

*(Continued from page 9)*

medical office, that CMS believes that there are few if any circumstances where a physician could personally furnish DME under the rules, and CMS doubts that a physician would qualify under that exception. CMS further notes that CPAP equipment is deemed to be DME and it would not qualify under the in-office ancillary services exception.

**Productivity Bonus.** In the past, the rules and most advisors discouraged physicians from having any productivity bonuses paid from revenue generated from ancillary services at a medical practice in relation to the referrals made by the physician for those ancillary services. For example, a physician who may refer a patient for diagnostic tests at an MRI located within the medical office, should generally not be paid a portion of the MRI revenue in relation to referrals made for MRI services. CMS reiterates that position, but did modify in Phase III its position on “incident to” services directly related to professional services of the physician. For example, if a physician referred a patient for physical therapy to a PT Department within the medical practice, the physician could receive productivity bonuses related to profits generated from the PT services, provided that the PT services were under the direction of the physician and were a part of his professional services for that patient.

**Shared Facilities.** In some areas, physicians have shared facilities such as a time share pathology laboratory or a time share imaging facility. CMS in Phase III takes the position that any per use or per click arrangement is unlikely to satisfy the supervision requirements and will not meet the in-office ancillary services exception. In the view of CMS, a “block lease” or other pre-set time shares may be still permissible provided they are carefully structured in their operation.

**Physician Recruiting Exception.** Perhaps the area of greatest change deals with the rules on physician recruitment. The Phase III rules have been relaxed in this area. Under the old rules, the provision prohibited groups from imposing any non-compete or other similar restrictions on the recruited physician. The Phase III rules do permit practice restrictions, provided they are not “unreasonable.” The rules further expand the costs that can be supported by a recruiting hospital. For example, to replace a retiring physician in an under-served health area, existing costs may be covered in addition to new costs. Phase III now condones the payment of “retention payments” to physicians in an under-served area to retain the physician services in certain circumstances.

**Professional Courtesy.** Under the Phase II rules, a provider who wanted to extend professional courtesy was required to provide written notice to all insurance plans that the practice would waive or reduce co-pay or deductible payments. Phase III rules have eliminated that requirement.

**Hospital Physician Relations.** The Rules currently provide that hospitals can provide non-monetary compensation to staff physicians up to \$300 (adjusted for inflation). This rule frequently created problems when the hospital wanted to have an annual appreciation dinner plus provide some CME programs for their medical staff. The Phase III rules exempt the value of the annual staff appreciation function from the limited amount, and further exempt the value of any compliance training that the hospital may offer to its medical staff.

**Changes on the Horizon.** In addition to the changes outlined in Phase III, CMS has signaled some additional changes in the regulations that may be announced in the future. While these comments are not law, they do give insight to planning issues for the near future. Areas that CMS has noted for future emphasis include:

**Independent Diagnostic Testing.** CMS continues to express its concerns regarding the financial impact of the growing numbers of independent diagnostic testing facilities. While currently these services are lawful, provided they are properly structured, CMS indicates that it may modify its position on those rules in the future.

**Under Arrangements.** Joint ventures can be created between hospitals and physicians to provide expanded new services for patients in a community. These joint ventures permit some revenue sharing between the hospital and the physicians managing those specialized facilities and services. These arrangements are currently exempt from the prohibitions outlined under Stark. CMS in its comments suggests that it wants to review those joint ventures and may issue rules in the future regarding such programs.

The Phase III rules and CMS comments on future consideration for changes in the rules present some significant challenges for physicians. There are still numerous situations that permit physicians to enhance delivery of services for patients, in cost effective and convenient circumstances for the patients. While the government rules may complicate the structure, with careful planning, we believe that physicians can and should continue to be pro-active in their business plans to adapt to the business side of medicine.

If you would like a copy of the Phase III rules or have any questions concerning these matters, please contact: Scott P. Sandrock, Phone: 330-253-4367 or [spsandrock@bmdllc.com](mailto:spsandrock@bmdllc.com).

