



The Stark Reality

Physician Arrangements in the Crosshairs

By Marguerite A. Massett, Esq.

A recent spike in federal attention to physician financial arrangements suggests that physician self-referral prohibitions, the federal Stark laws, may be the compliance issue *du jour* for physicians. Two federal departments, Health and Human Services (HHS) and the Department of Justice (DOJ), have recently focused their enforcement arsenal on physician noncompliance with Stark and the related anti-kickback and false claims issues that can follow. Although some may be frustrated by this apparent “assume the worst” attitude of federal regulators, physicians are well advised, in light of this recent activity, to channel their energy into a more productive endeavor — focusing compliance plans on the areas of newfound interest to the enforcement agencies.

Two recent unrelated developments can be viewed as “carrot” and “stick” alternatives to enforcement. First, on April 24, 2006, HHS Inspector General Daniel Levinson issued an open letter lauding the benefits of voluntary self-disclosure by physicians and other providers of federal regulatory violations. The letter indicated that penalties can be limited, exclusion avoided and more manageable compliance requirements secured, in return for hospitals and doctors voluntarily acknowledging and correcting Stark and anti-kickback violations. Less than a month later, after the DOJ’s second failed attempt to win criminal convictions against Alvarado Hospital and two former senior executives based in part on alleged Stark and anti-kickback violations, Inspector

General Levinson announced that he was unilaterally moving to exclude the hospital from the Medicare program. In other words, following DOJ’s failure to convict the hospital and its executives of crimes, HHS issued its own cash flow–related death sentence. Taken together, the message from the Inspector General appears clear: “Come to us voluntarily, or we’ll come after you.”

In the Alvarado Hospital case, the alleged violations involved Alvarado’s recruitment of more than 100 physicians into practices that already operated in the hospital’s service area. Alvarado asserted that, in each case, there was community need for the specialty practiced by the recruited physician. The problem, however, as alleged by the DOJ and, ultimately, Inspector General Levinson,

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was that the financial support for the recruited physicians was actually intended to benefit the practices into which they were being recruited — practices that were responsible for considerable inpatient and outpatient referrals to the hospital. During the course of the lawsuit, one hospital executive pled guilty to receiving payments from the practices for facilitating their selection as “host” to the recruited physicians, adding to the impression that the recruitment arrangements benefited the practices themselves as opposed to simply offsetting costs associated with the newly recruited physicians.

Inspector General Levinson’s letter encouraging voluntary disclosure of possible Stark and kickback problems gained new prominence following the announcement of his intention to exclude Alvarado Hospital from Medicare. According to the letter, self-disclosure of wrongdoing offers the benefits of limited penalties and lessened compliance-related mandates, both of which are normally imposed as part of an HHS settle-

ment agreement. But what does a physician do when he or she has nothing to disclose, not having violated any law, but is merely concerned that an innocent transaction might be scrutinized as the next poster child for the “stick” approach to enforcement?

To determine how to respond appropriately and effectively, one must look to the basics of the applicable laws. The federal Stark laws prohibit physicians who have a financial relationship with a health care facility or provider from referring Medicare or Medicaid patients to that facility or provider for certain designated services unless an exception applies. Billing for services provided as a result of a prohibited referral may be considered a federal false claim, subjecting the facility or provider to possible criminal and civil penalties. In addition, the referring physician and the facility or provider receiving the referral may find themselves charged with violating anti-kickback laws. Although the intent of the parties is critical to a determination of whether or not a criminal violation of the anti-

kickback laws has occurred, Stark violations do not require nefarious intentions. Simply referring patients in situations where referrals are prohibited violates the law, regardless of the reason or “intent” behind the referral.

In view of recent events, physicians should familiarize themselves not only with the various Stark exceptions, but also with the guidance and “safe harbors” that have been issued relative to the anti-kickback laws. For instance, financial transactions between physicians and facilities or providers to which they refer patients that (i) reflect fair market value compensation for goods or services rendered, and (ii) would be financially reasonable, even if no referrals of patients were involved, can usually withstand Stark and anti-kickback scrutiny. Physicians should maintain documentation confirming that financial details of their transactions are commercially reasonable, regardless of any patient referrals between the parties. In addition, in light of the significant attention being paid to hospital support for physician recruitment, scrupulous efforts must be made to document that funds from the hospital are used solely and exclusively to cover costs associated with the recruited physician, including salary, and not to offset any component of overhead that the host practice would have borne even if the recruited physician had not joined the practice.

The best defense against finding oneself on the wrong side of federal enforcement officials as they focus on physician financial transactions is to maintain detailed financial records. Contemporaneous documentation can help deflect adverse inferences and avoid the “stick” approach to physician compliance lapses.

Mrs. Marguerite A. Massett, J.D., a partner with Hancock & Estabrook, LLP, has diverse legal experience in health care operations, insurance, reimbursement and public policy. She also advises clients on health care–related compliance issues, such as antitrust, fraud and abuse, and governmental enforcement actions. Previously, Mrs. Massett served as general counsel to a multihospital health care system, and as in-house counsel to a national managed health care corporation. In addition, she has served as a public policy advocate in Washington, DC, specializing in health care delivery and financing issues. Mrs. Massett is admitted to practice in New York and Connecticut. ■



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