

Stark law college



**ASSIGN  
BUSTER**

CONTENTS Introduction 1 History of Stark Law2 Key Concepts3 General Prohibition Under Stark Law3 Financial Relationships4 Exceptions4 Stark Law vs. Anti-kickback Statutes4 Enforcement of Stark Law5 Compliance with Stark Law6 Examples of Problems6 Compliance Plan7 Risk of Not Making Repayments8 Physician Recruitment9 Conclusion10 References11

Introduction On July 17, 2003 a California Grand Jury filed an indictment against Barry Weinbaum; Tenet Healthsystem Hospitals, Inc.

; and Alvarado Hospital Medical Center, Inc. stating the defendants “ did knowingly and intentionally conspire with each other and others... to commit offenses against the United States” by soliciting and receiving remunerations and offering and paying remunerations (US v. Weinbaum, Tenet Healthsystem Hospital Inc. and Alvarado Hospital Medical Center, Inc. ).

Monday, February 13, 2006: Iowa Methodist Hospital Settles Fraud Claim.

“ An Iowa lawsuit alleging that Iowa Methodist Hospital pressured physicians to use specific pacemakers in order to get rebates from the manufacturer has been settled...” (MedLaw). Both of these cases are examples of the enforcement of Stark Law and Anti-kickback statutes. The regulations were designed to “ curb fraud and abuse and excessive spending in governmental health care programs” (Brooks). Stark Law or the self referral law prohibits physician from referring Medicare patients for certain health care services to entities with which the physicians or their immediate family members have a financial relationship.

The financial relationship can be either an ownership interest or a compensation arrangement (HHS News). The federal anti-kickback statutes

makes it a crime to knowingly solicit, receive, offer or pay any remuneration in exchange for referrals for which payment may be made under a federal health care program such as Medicare or Medicaid (Sarraille). The purpose of the anti-kickback statute is to ensure that the medical referral decision is made with the patient's best interest in mind, and to prevent inflation of the cost of medical treatment by the payment of referral fees and the referral of patients for care they do not need (US v. Weinbaum et. al ).

The physician self-referral laws and regulations were implemented to close loopholes in financial relationships between physicians and entities to which they referred. Various studies and research has been conducted which supports a correlation between increased utilization of services to those entities to which the physician had financial ties (Brooks). History of Stark Law In the late 1980's Representative Fortney " Pete" Stark lead the movement in Congress to address self-referrals by physicians. In 1989, the original Stark law known as " Stark I" was enacted by Congress. This law, section 1887 (a) of the Social Security act prohibited physician referrals under Medicare for clinical laboratory services when the referring physician has a financial relationship with the lab unless certain regulatory exceptions are met.

The Omnibus Budget Reconciliation Act of 1993 expanded the prohibited referrals to 10 additional designated health services and encompassed Medicaid. The expansion of the law became known as " Stark II. " The additional services are as follows: 1. Physical Therapy 2. Occupational Therapy 3. Radiology (including MRI, CT scans, and ultrasound services) 4.

Radiation Therapy services and supplies 5. Durable Medical Equipment and supplies 6. Parental and enteral nutrients, equipment and supplies 7. Prosthetics, orthotics and prosthetic devices and supplies 8.

Home Health services 9. Outpatient prescription drugs 10. Inpatient and outpatient hospital services The Balanced Budget Refinement Act of 1999 added coordinated care plans offered by Medicare + Choice organization to the exception covering services furnished by certain prepaid health plans. Implementing regulations for the 1989 law were issued in 1995. In January 1998, the Health Care Financing Administration (HCFA) proposed implementing regulations for Stark II. At this time the statute was interpreted conservatively so as to produce a broad prohibition and narrow exceptions.

As a result of the proposed regulations, HCFA received nearly 13, 000 public comments stating the statute was too conservative; unclear and intruded into the physician's office practice. Therefore the implementation process was split into two phases to provide guidance. Phase I addresses the general prohibitions, the definitions of the various designated health services and the major exceptions. Phase II will address the preamble or regulations of physician recruitment. Key Concepts General Prohibition under Stark Law The basic physician self-referral prohibition as established in Section 1877(a) of the Social Security Act is: A physician cannot refer patients to an entity for the furnishing of designated health services if there is a financial relationship between the referring physician or an immediate family member of the referring physician and the entity unless the financial relationship fits within one of the specific exceptions in the statute or regulations. This applies to physicians who refer Medicare and Medicaid patients.

The law also prohibits an entity such as a hospital from billing for services that were provided as result of a prohibited referral. Financial Relationships When referrals are being made the question of a financial relationship must be asked. The Stark law applies to both a physician's financial relationship with his medical practice to which he makes referrals, and to a physician's director or indirect financial relationship with outside entities such as hospitals to which the physician refers. The relationship may be with the physician himself or a member of the physician's immediate family. Financial interest includes ownership and compensation such as: independent contractor arrangements, consulting fees or payments for rental of equipment or space. Exceptions Many of the Stark exceptions were made in response to public comments received on Stark I.

Several of the exceptions require that any compensation involved be calculated in a manner that does not take into account the volume or value of referrals between the parties. In-office ancillary services exception and referrals for physician services within the group exception are two of the most notable exceptions. Although only part of the Stark statute and several exceptions have been interpreted in the regulations all of it is currently in effect (Gosfield, 2004). Stark Law vs. Anti-kickback Statutes One of the major misunderstandings about the Stark statute is that it is the same as the anti-kickback statute. " They are not the same law; they have a very different scope and are in two different titles of the Social Security Act" (Ibid.

. The anti-kick back law provides both criminal and civil penalties for individuals and entities that knowingly offer, pay, solicit or receive bribes or kickbacks or other remuneration in order to induce business reimbursable by

Medicare, Medicaid or other governmental programs (Maruca, 2000). Stark law can be distinguished from anti-kickback law in a number of ways. First, the anti-kickback law applies to all services covered under the governmental programs; not just the list of designated health services listed in Stark law. The anti-kickback law provides for civil as well as criminal penalties, while the Stark law provides only civil penalties. The anti-kickback law covers all individuals or entities guilty of prohibited conduct, where the Stark law covers only physicians.

The “ safe harbors” under the anti-kickback law are optional, unlike the Stark exceptions which are mandatory. Finally, the anti-kickback law requires a showing of intent to violate the law. In 1985, the Third Circuit Case of the United States v. Greber held that “ if one purpose of an arrangement is to induce a referral of government reimbursable business, then the arrangement is unlawful regardless of whether the arrangement has other lawful purposes. ” As in most cases, proof of intent is one of the government’s most difficult obstacles in bringing a successful anti-kickback case.

Even though there are all of these differences between Stark law and anti-kickback law, in every situation where the Stark statute applies, the anti-kickback statute applies too. Enforcement of Stark Law Stark II is enforced in conjunction with other federal laws including the anti-kickback statute. Enforcement of the Stark law has kicked into high gear. ” (AISHealth) Stark II presently provides for civil money penalties not to exceed \$100, 000 for each “ arrangement or scheme” that a person knows or should know has a principal purpose to violate the statute.

Additionally, the government may withhold payments for prohibited referrals or seek to recoup past payments. (Gordon) Given the significant financial impact of a violation of Stark II, physicians and other providers who received referrals from physicians for designated health services should review their current financial relationships to ensure compliance. Compliance with Stark Law Hospitals and physicians alike need to review their physician contracts for potential Stark Law violations and consider what steps to take when violations are uncovered. There are two major challenges faced by hospitals today in order to become compliant with Stark Law. The first is cleaning up common contractual violations. Second, is avoiding the danger inherent in not returning money stemming from illegal financial relationships.

Providers are being encouraged to use the Office of Inspector General's Self Disclosure Protocol to bring Stark violations to the government's attention. Providers who resolve Stark or kickback liability through the Self – Disclosure Protocol will receive “ good settlement terms, paying ‘ near the lower end’ of the Civil Monetary Penalty fines and penalties they would face in a regular enforcement action. ” (AISHealth) Examples of Problems Organizations may discover the following when they review for Stark compliance: 1. Expired Contracts. 2.

Financial relationships where no contract ever existed. 3. The parties modify the financial terms without putting the modifications in writing. 4. The terms were modified during the first year of the financial arrangement (some Stark exceptions require the terms to be in place for one year).

5. The agreement incorrectly describes the service (a medical director agreement calls for a physician to work 100 hours per year and the physician only works 80 hours in a year). 6. The hospital gives a gift or benefit to a doctor that exceeds Stark's \$322 de minimis exception. This exception allows hospitals to give small gifts totaling no more than \$322.

0 a year to referral sources without triggering a financial relationship for Stark purposes. Compliance Plan The best plan in determining compliance with Stark Law is in evaluating a relationship or transaction. The following questions should be asked when evaluating the relationship. Does the relationship involve a physician? For Medicare purposes, a physician is not limited to MDs and DOs but also includes dentists, podiatrists, optometrists and chiropractors. Referrals made by a facility such as a Skilled Nursing Facility to whom a physician has made a referral can also fall into this category.

Is there a prohibited referral for a Designated Health Service? A referral is any request for medical or related service or for a plan of care. The Designated Health Services were previously discussed. HCFA has interpreted the Designated Health Services categories broadly but changes are anticipated in the final version of Stark. Is there a direct or indirect financial relationship with the entity providing the service? The relationship may be with the physician or a member of the physician's immediate family. Does an exception apply? A few of the exceptions have already been discussed.

Generally the exceptions share a number of characteristics including, the requirement that payments or other benefits to a physician must be



consistent with the fair market value of the items or services provided; the payments cannot vary with the volume or value of referrals for designated health services; the arrangements must be in writing and continue for a term of at least one year? Risk of Not Making Repayments What should be done if these violations are found? Does the provider just correct the problem and move on, or do they have an obligation to repay the government for any moneys illegally collected, even if in error. Government officials maintain that under the Social Security Act, it's a felony for providers to knowingly fail to disclose that they have money that belongs to the government once they become aware they were not entitled to receive it (42 USC Sect 1320 a-7b(a) (3)). Relationships and arrangements which are determined to violate the self-referral and anti-kickback rules should be modified or terminated as soon as possible. The Office of the Inspector General emphasizes that only fraudulent activity needs to be disclosed to enforcement agencies. Therefore it is up to the practitioner to determine whether the potential violation rises to the level of disclosable fraud or should be treated as an innocent error. The practitioner needs to keep in mind that a violation disclosed on his own is likely to be treated more leniently than one that is brought to the attention of the government by an outside party or government audit.

Physician Recruitment With all the apparent restrictions the question becomes how do hospitals recruit physicians? “ The final regulations allow a hospital to recruit a physician to relocate his medical practice to a geographic area served by the hospital in order to become a member of the hospital's medical staff by paying the physician finance incentives” (Koch,

2004). However there are specific limitations that must be occur. 1. The arrangement is set out in writing and signed by both parties. 2.

The arrangement is not conditioned on the physician's referral of patients to the hospital. 3. The hospital does not determine the amount of remuneration to the physician based on volume or value of any actual or anticipated referrals by the physician or other business generated between the parties. 4. The physician is allowed to establish staff privileges at any other hospital and to refer business to any other entity.

When it comes to recruitment and physician contracts, two major clarifications must be addressed. First, the only costs to the physicians' group that can be picked up by the hospital as part of the subsidy for recruitment are incremental costs," says Michael F. Anthony, Esq. These are costs to the group that would not otherwise be incurred without the new financial arrangement (Epstein, 2004).

The second clarification prohibits a physicians' group or hospital from imposing a no compete clause to physicians in their employment contracts. It is the hope that " CMS considers a grandfather clause for previous contracts. If not, it will be of concern to many individuals who have to restructure contracts in order to meet the new regulations," Jerry Weissman, vice president of medical staff development for Community Health Systems. The final regulations allow the recruitment of residents and new physicians who already reside in the hospital's service area as long as they have been in medical practice for less than one year. Recruitment strategies need to include that a community need exists and then recruit physicians.

Conclusion After a long period of ambiguity, it is believed that the healthcare industry has generally welcomed the arrival of Stark II. A Stark II audit in any facility will provide a better understanding of the regulation and as well as prevent a provider from having to pay large penalties for not reporting items that were in violation of the regulations. Malpractice cases, reduction in physician payments and the decrease in healthcare providers have increased requests from physicians to enter into financial relationships with the hospitals that would fall under the Stark II regulations. Hospitals must understand and be prepared to enter into these financial relationships. However, the final regulations will have a significant impact on the way certain physician financial relationships are analyzed under the Stark law.

References United States District Court, Southern District of California, July 2002 Grand Jury; United States of America v. Barry Weinbaum, Tenet Healthsystem Hospitals, Inc. , Alvarado Hospital Medical Center, Inc. Retrieved July 29, 2006, from the World Wide Web: [www.findlaw.com](http://www.findlaw.com)

[http://www.medlaw.com/healthlaw/fraud/5\\_2/iowa-methodist-hospital-s.html](http://www.medlaw.com/healthlaw/fraud/5_2/iowa-methodist-hospital-s.html). Brooks, Cheryl. Compliance with Stark II Phase II: A Hospital

Perspective. Unpublished, Mary Rutan Hospital; Bellefontaine, Ohio The U. S. House of Representatives. HHS Issues Final Rule Addressing Physician Self-Referrals. Retrieved July 29, 2006, from the World Wide Web: <http://www.house.gov>

gov/stark/webarchives/Stark2/Stark2info.html Sarraille, A. , Kahaner, E. , & Spencer, A. Reducing Anti-kickback Risks. Focus on ASCS.

Retrieved July 29, 2006, from the World Wide Web. Thallner, Karl (May, 2001) Stark II and Physicians' Outside Relationships [Electronic Version]. Physician's News Digest. Retrieved July 29, 2006, from World Wide Web: <http://www.physiciansnews.com/law/501thallner.html>

Gosfield, Alice (February, 2004) The Stark Truth About the Stark Law: Part II [Electronic Version]. Family Practice Management. Retrieved July 29, 2006, from World Wide Web: <http://www.aafp.org/fpm/20040200/41thes.html>

Maruca, William (December, 2000) Compliance and Relationships among Providers [Electronic Version]. Physician's News Digest. Retrieved July 29, 2006, from World Wide Web: <http://www.physiciansnews.com/law/1200maruca.html>

Pressure Mounts on Hospitals to Reduce Risks of Stark Law Violations (July 3, 2006). AIS Business News of the Week. Retrieved July 29, 2006, from the World Wide Web: <http://www.aishealth.com/Bnow/070506c.html>

Summary of Key Aspects of Final Stark II Rule. AIS Compliance. Retrieved July 7, 2006, from the World Wide Web: <http://www.aishealth.com/Compliance/HCFAs/StarkII.html>

Epstein, Deborah (July, 2004) Stark II Clarifications Bring Sweeping Changes to Recruiting and Referral, MD Options. Retrieved July 29, 2006, from the World Wide Web: <http://www.mdoptions.com/cgi-bin/article.html>

<https://assignbuster.com/stark-law-2849-words-college/>

cgi? article\_id= 1623 The U. S. House of Representatives. Letter on the recent Regulations on Stark II / The Physician Self- Referral Laws.

(January 17, 2000). Retrieved July 29, 2006, from the World Wide Web:  
<http://www.house.gov/stark/webarchives/stark2/stark2.html> Koch, Susan  
(Summer, 2004) Stark II Phase II Adds Clarity to Physician Recruitment Arrangements, [Electronic Version] Health Brief. Retrieved July 29, 2006 from the World Wide Web.