Employed Physician Compensation

ADDRESSING CONCERNS ARISING UNDER
THE STARK LAW

Disclaimers

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- This presentation and the information herein is not intended to constitute legal advice or to substitute for legal counsel; the author/presenter is a compliance professional and not an attorney. As with all matters related to physician compensation arrangements seek the advice and counsel of your legal representative(s).

Objectives

- Review the Stark rule on Designated Health Services ("DHS") and compensation for referrals of these services

- Analyze compensation arrangements that may implicate the Stark rule including:
  - Identifying compensation to isolate issues associated with DHS;
  - Determining whether the arrangement encompasses incident-to compensation
Physician Self Referral Law

- Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law:
  - prohibits a physician from making referrals for certain "designated health services" (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation) unless an exception applies; and
  - prohibits the entity from filing claims with Medicare for those referred services, unless an exception applies.
  - prohibits compensation arrangements that take into account the volume or value of referrals to the DHS entity.

Stark

- Stark is a “Black and White” strict liability law
  - There does not need to be ‘intent’ to violate the law
- There are exceptions and to qualify the practice must meet all of the requirements of the exception
- Compensation arrangements
  - “... allows a physician member of a group practice to be paid a share of overall group DHS profits or a productivity bonus based upon personally performed or “incident to” services, so long as the share or bonus is not determined in a manner that is directly related to the physician’s volume or value of referrals.”

“In Incident To”

- For purposes of this discussion,
  - Incident to services provided by individuals that CANNOT be credentialed by Medicare and are not allowed to bill and be paid for their services are not considered ‘incident to’.
    - Nurses
    - Medical assistants
    - Phlebotomists
    - X-ray techs
  - Services provided ‘incident to’ by an individual that CAN be credentialed by Medicare and are allowed to bill and be paid for their services would be considered ‘incident to’.
    - Physician Assistants
    - Nurse Practitioners
    - Physical therapists
Individual Physician Compensation

- What are common methodologies used to measure physician productivity for compensation payment purposes?
  - wRVU’s
  - Percentage of collections
  - Percentage of EBITDA
  - Other compensation based on percentages of revenue generated in the practice by the physician

- How do you determine if these compensation arrangements are compensating the physician for ‘incident to’ or DHS services?

Testing Compensation Arrangements

- Identify your employed physicians
- Determine what their compensation arrangements are
  - Review contractual obligations
  - Is any part of their compensation tied to the volume or value of the business generated by the practice?
- Review actual compensation
  - What did the provider get paid?
  - How was it calculated?

Employed Physicians

- Who do you pay that could be considered a member of your group?
  - An owner,
  - An employed physician,
  - Under certain circumstances an on-call or locum tenens physician,
  - Leased physicians if IRS rules consider them to be “bona fide employees” of the group.
  - See 42 C.F.R. § 411.352(g) for expanded definitions of these categories
### Contracts

- How many do you review?
  - Large physician groups may want to start with a sample of those providers who have these compensation arrangements.
  - Smaller practices may want to review all of these arrangements.
  - The reviews should follow the same steps for each contract so the reviews remain unbiased. Any exceptions to the reviews should be adequately documented.

### Employed Physicians

- What to look for in your contracts?
  - Review for the specific compensation arrangements.
  - Some key terms to identify as problematic are:
    - Percentage of collections
    - Base plus productivity bonus
    - wRVU
    - Percentage of EBITDA
    - Percentage of gross
    - Percentage of net
    - Percentage of other

### Contract Provisions

- Percentages of any amounts tied to services provided in the practice MAY include revenue from DHS services or ‘incident to’ services.
- wRVU based compensation can also include compensation for wRVU’s generated by DHS or by services rendered ‘incident to’.
- Under the special Group Practice compensation rule, members of a “Stark defined” group can receive compensation for revenues resulting from DHS, but such compensation to the providers cannot be directly or indirectly related to the volume or value of the providers’ referrals for these services.
Review of Compensation

How was physician compensation calculated?

- Pull your financial records for the physician’s compensation
  - Original work sheets
  - Original financial reporting from your practice management system
- Identify money that was included in the compensation calculations if the compensation arrangement is a percentage contract.
- Identify CPT codes included in the wRVU calculations.
- Classify the arrangements:
  - Base plus productivity bonus
  - Productivity only

Base Plus Cash Collections Percentage

<table>
<thead>
<tr>
<th>CPT Group</th>
<th>Rendering</th>
<th>CPT Group</th>
<th>Rendering</th>
<th>CPT Group</th>
<th>Rendering</th>
<th>CPT Group</th>
<th>Rendering</th>
<th>CPT Group</th>
<th>Rendering</th>
</tr>
</thead>
<tbody>
<tr>
<td>E&amp;M (Non-productivity)</td>
<td></td>
<td>E&amp;M (Non-productivity)</td>
<td></td>
<td>E&amp;M (Non-productivity)</td>
<td></td>
<td>E&amp;M (Non-productivity)</td>
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<td>E&amp;M (Injection Admin Fees III)</td>
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<td>E&amp;M (Injection Admin Fees III)</td>
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<td>E&amp;M (Injection Admin Fees III)</td>
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<td>E&amp;M (Injection Admin Fees X)</td>
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<td>E&amp;M (Injection Admin Fees X)</td>
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<td>E&amp;M (Injection Admin Fees X)</td>
<td></td>
<td>E&amp;M (Injection Admin Fees X)</td>
<td></td>
</tr>
</tbody>
</table>

Base Plus Cash Collections Percentage

- The report does identify what money is included:
Base Plus Cash Collections Percentage

- The report does not tell you what CPT codes get mapped to these categories:

<table>
<thead>
<tr>
<th>CPT Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E&amp;M (Productivity)</td>
</tr>
<tr>
<td>11</td>
<td>Misc E&amp;M</td>
</tr>
<tr>
<td>12</td>
<td>EKG/Treadmill/Holter/Etc</td>
</tr>
<tr>
<td>2</td>
<td>Medicine (Productivity)</td>
</tr>
<tr>
<td>21</td>
<td>PQRI</td>
</tr>
<tr>
<td>3</td>
<td>Surgery (Productivity)</td>
</tr>
<tr>
<td>8</td>
<td>Lab &amp; Path</td>
</tr>
<tr>
<td>8A</td>
<td>Medicine (Non-productivity)</td>
</tr>
<tr>
<td>9</td>
<td>Supplies</td>
</tr>
</tbody>
</table>

Classification of CPT

- Have your biller or your vendor identify what codes have been included and make sure there are no DHS codes.
  - If possible work with your vendor to identify the CPT codes in your system that Medicare has designated as DHS services.
  - Agree on who will be responsible for updating the master list when Medicare updates the DHS services list.
- Use the master list in your reporting to exclude any DHS service.
- Don’t forget that the list of DHS changes every year.

Identifying ‘Incident To’ Services

- Have your biller or your vendor outline how services provided ‘incident to’ are identified in the system.
  - Rendering vs Supervising or Performing vs. Billing
  - Internal modifier for services provided by the mid-level but billed under the provider.
  - Other methods to segregate your ‘incident to’ services?
**Base Plus Cash Collections Percentage**

- For this example
  - All CPT codes mapped to the green buckets have had any CPT code associated with DHS removed.
  - When the reporting is run, only the services provided by the named provider on the report are mapped to that provider's totals. No ‘incident to’ services are mapped to this report.

**Review of Calculations**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Net Pay</th>
<th>Total Provider Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>E&amp;M (Productivity)</td>
<td>$333,000.00</td>
<td>$121,000.00</td>
<td></td>
</tr>
<tr>
<td>Medicine (Productivity)</td>
<td>$8,000.00</td>
<td>$3,000.00</td>
<td></td>
</tr>
<tr>
<td>Surgery (Productivity)</td>
<td>$3,500.00</td>
<td>$1,200.00</td>
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<tr>
<td><strong>Total</strong></td>
<td>$344,500.00</td>
<td>$125,200.00</td>
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</tbody>
</table>

Ending A/R: $16,190.00 * 36% = $5,883.85

Total estimated provider collections: $131,083.35

Salary received for five month time period: $195,000 / 12 * 6 = $97,500.00

Incentive Compensation ($131,290.04 * 55%) = $72,096.12

Percent of Base: 73.9%

Is there a problem?

- $169,596.12 paid to the physician in compensation
- $131,083.35 collected from the physicians billing

Stark is fine, no DHS, no ‘incident to’
- If the physician is employed by a hospital or a hospital affiliate, evaluate to be sure that total compensation does not exceed fair market value.
  (Independent, 3rd party FMV report is a good idea).
Cash Collections

- What’s wrong with this?

<table>
<thead>
<tr>
<th></th>
<th>Sep-13</th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>1st Qtr Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Collections</td>
<td>40,000.00</td>
<td>45,000.00</td>
<td>38,000.00</td>
<td>123,000.00</td>
</tr>
<tr>
<td>Refunds</td>
<td>1,000.00</td>
<td>150.00</td>
<td>50.00</td>
<td>1,200.00</td>
</tr>
<tr>
<td>Other Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available</td>
<td>39,000.00</td>
<td>44,850.00</td>
<td>37,950.00</td>
<td>121,800.00</td>
</tr>
<tr>
<td>Compensation available @ 47%</td>
<td>8,520.00</td>
<td>23,079.50</td>
<td>17,896.50</td>
<td>57,496.00</td>
</tr>
<tr>
<td>Less Draw Paid</td>
<td>1,000.00</td>
<td>1,000.00</td>
<td>1,000.00</td>
<td>3,000.00</td>
</tr>
<tr>
<td>Due to Physician</td>
<td>7,330.00</td>
<td>10,079.50</td>
<td>6,836.50</td>
<td>24,246.00</td>
</tr>
</tbody>
</table>

- Is all cash included from all services rendered by the practice?
  - Yes
  - Any DHS provided in the practice must be taken out of the calculations

- Is ‘incident to’ income included in the cash collections?
  - Yes
  - Cash collections from ‘incident to’ services must be taken out of the calculations.

- The cash collection sheet has a place for ‘Other income’. None is listed, but what is considered ‘other income’?

- Is the total compensation consistent with FMV?
wRVU Compensation

- Uses the total number of wRVU’s identified in the contract as included in compensation calculations and multiplies that number of wRVU’s by a conversion factor.

- Medicare conversion factor for 2014 is $35.8228³

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVUs</td>
<td>300.00</td>
<td>1,500.00</td>
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<tr>
<td>Rate</td>
<td>55.00</td>
<td>47.00</td>
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<tr>
<td>Compensation</td>
<td>16,500.00</td>
<td>70,500.00</td>
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<tr>
<td>Payroll Distributions ($25,000*3)</td>
<td>75,000.00</td>
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<tr>
<td>Bonus (Compensation-Distributions)</td>
<td>12,000.00</td>
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<tr>
<td>Total</td>
<td>87,000.00</td>
<td></td>
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</tbody>
</table>

wRVU Compensation

- You will need to determine what services are included in “Other”.

- Determine what the source of the wRVU’s are;
  - current year Medicare Fee Schedule Database
  - an agreed upon base year Medicare Fee Schedule Database specified in the contract
  - Something else

- In the “Surgical” section are wRVU’s adjusted for modifiers? (-50, -80, -52, etc.)

- How are you accounting for “Incident to” services?
wRVU Compensation

- The contract specifies that the providers' compensation is to be based on all wRVU’s generated in his practice.

- You determine the physician has a Nurse Practitioner in the clinic and her wRVU’s are also included in ‘Other’.

For Compensation Reviews

- Identify and remove any compensation paid to your providers that is potentially tied to ‘incident to’ services and DHS services.

- Explore options with your attorney on how to structure these agreements with your providers and how to fix any previous errors in compensation.

- Review your compensation models and decide which model works best for your providers and is easy(ier) for management to administer.

- Contact your attorney.

References


- 2 42 C.F.R. § 411.352(g)

- 3 Medicare CY 2014 RELATIVE VALUE UNITS PPRVU