SELF-REFERRAL AND ANTI-KICKBACK LAWS IN PHYSICIAN AGREEMENTS: CHIROPRACTIC OFFICE CONTRACTS 101
By Adrienne J. Hersh, JD
ICS General Counsel

Much has been written about “self-referrals” and “kickbacks” in health care. Stated simply, health care providers may not make referrals to entities in which they have a financial interest, and they may not pay for referrals or receive “kickbacks” (commissions) for referring patients to other providers. Concerns they have a financial interest, and they may not pay for referrals or receive Stated simply, health care providers may not make referrals to entities in which

The intent of these laws is to ensure that providers who order tests and treatments for patients are not motivated by profit over professionalism.

Unfortunately, the laws are extremely complex and voluminous. Most doctors have a sense that these rules apply to contracts with physicians in the office but simply don’t know how these laws translate to their physician agreements. While it is not possible in one article to summarize all of regulations, most of their impact in the chiropractic office occurs in contracts with other physicians in the practice, either as salaried employees, independent contractors or physicians to whom the owner physician has leased office space. It is advisable to be aware of the most basic requirements and prohibitions if you participate in these types of arrangements.

Stark and Anti-Kickback Basics
The federal “Stark law,” so named for its sponsor Congressman Pete Stark, prohibits a physician from referring Medicare patients for certain health services to entities with which the physician (or immediate family member) has a financial relationship, unless an exception applies. If the referral does not fall into an exception, any payments are deemed to be overpayments and could subject the parties to treble damages and substantial fines. (Note: Stark applies to all federally funded health plans, including Medicare, Medicaid and military plans. For purposes of this article, the use of the term “Medicare” is intended to include all federally funded plans.) Sometimes the Stark law is referred to as the “self-referral” law, but that term is actually narrower that what is covered. Stark does not only apply when a physician refers to an entity in which he or she has an ownership interest. Stark can also apply when referrals are made to any entity with which the physician has a financial relationship, not necessarily ownership -- for example, a lease. The Stark law applies only to referrals made by physicians.

The anti-kickback law makes it a felony for any person to knowingly and willfully offer, pay, solicit or receive remuneration to induce referrals of Federal health care program business, unless the arrangement falls into an exception. Remuneration can be cash or in kind, but could also be discounts in services or reductions in rent. Violations of the law are punishable by a fine and up to 5 years in prison. The anti-kickback law applies to agreements between providers and any other person or entity, not only to referrals by physicians.

ALL YOUR PQRS 2014 QUESTIONS ANSWERED
By Kristen Curtis, DC
ICS Insurance Specialist

I would call 2014 the “Year of Change.” 2014 will bring a new 1500 Claim Form, new health-care laws, new ICD-10 codes and new Physician Quality Reporting System (PQRS). Recently, I have received numerous questions regarding the 2014 PQRS codes. This article will address the changes in the PQRS codes for chiropractic physicians in 2014.

1. Is PQRS mandatory?
Yes. The Patient Protection and Affordable Care Act made participating in PQRS mandatory beginning in 2015 (based on 2013 reporting). All chiropractors who are providers (Par or Non-Par) for Medicare are required to participate. If you failed to provide PQRS data to Medicare in 2013, you will see a reimbursement penalty of 1.5% in 2015. Failure to report all three measures in 2014 will result in a reimbursement penalty of 2% in 2016 and thereafter. This may not seem like much, but if you make $2,000.00 a month on Medicare visits; the penalty will cost your office $360.00 in 2015 and $480.00 in 2016 and thereafter.

Penalty Timeline
• 2015: 1.5% decrease in Medicare payments
• 2016: 2.0% decrease in Medicare payments
Payment decreases will be applied based on unsuccessful participation in PQRS two years prior.

2. Is there an incentive for participating in PQRS?
Yes. When a provider properly reports all three required PQRS measures to Medicare during the 12 month reporting period in 2014 he/she will receive a 0.5% payment bonus (this includes deductibles and co-insurance amounts). When Medicare is the secondary payer, PQRS payments are not limited to the paid Medicare portion but the entire allowed fee. Although this is not a large sum of money, you can earn extra money for something you need to be doing to avoid penalties at a later date.

3. How do I participate in PQRS?
If you are new to PQRS, you do not have to register. Start reporting the required measures for chiropractic physicians by reporting the proper G codes on your claim form. It is not hard to report.

4. What PQRS measures need to be reported by chiropractors in 2104
• Measure 131: Pain Assessment and Follow-up,
• Measure 182: Functional Outcome Assessment, and
• Measure 317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-up documented (new in 2014).

5. How often do PQRS G codes need to be reported?
Measures 131 and 182 should be reported every visit for every Medicare...Continued on Page 3

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Contracts... Continued

Commonly Used Contractual "Safe Harbors"

Under either Stark or anti-kickback laws, you must first determine whether you intend to refer patients to, or accept referrals from, the other party to the agreement. If so, the key is to make sure your contracts are structured to fit within an exception, or what the law calls “safe harbors.” For solely owned chiropractic practices where Medicare services are rendered and patients will be referred and exchanged, three exceptions to the laws are often used: lease agreements, employment agreements and personal services (independent contractor agreements). Stark permits these arrangements, but only if certain requirements are met.

Leases, of course, apply where the contracting party is simply rents space, and his or her practice is totally separate from the owner physician. Owner physicians may also hire physicians as salaried employees, or they may contract with physicians to provide services in the office.

Preliminary Consideration: Independent Contractor vs. Salaried Employee

The ICS has provided information previously about the differences between an independent contractor and a salaried employee. Members may refer to the ICS article available online, “Independent Contractor or Employee: Revised IRS Guidelines" for a list of factors that weigh in that determination. It is important to review all of the factors that comprise this assessment. In general, independent contractors have control over their work, while the employer has a greater degree of control over employees. In the case of a true independent contractor, the owner physician refers patients and the contractor takes over sole responsibility for care. In the case of an employee, the owner physician delegates patients to and retains dual responsibility for patients with the employee physician.

This article assumes the physician has reviewed the factors and come to a proper conclusion about the contractor vs. employee status of physicians with whom he or she is contracting. Generally, the Stark and anti-kickback laws are more stringent in independent contractor arrangements than for salaried employees.

Major Compliance Factors to Consider in Physician Contracts

The following elements for physician contracts are listed below. In general, they apply whether the contract is for rental, employment or independent contractor services (except where indicated otherwise):

- **A written, signed contract** - Both Stark and the anti-kickback law require signed written contracts. Contracts for salaried employees do not have to be in writing, but it is good practice.

- **A current contract** - Sometimes contracts expire or terminate of their own terms, but the parties continue to act as if the contract were still in effect. This may create a legal violation due to the absence of a written contract.

You may use automatic renewal provisions to avoid this problem; just make certain you still have options for terminating when you deem it appropriate.

- **Listing of specific services to be performed or space to be rented** – Both employment contracts and independent contractor agreements must spell out the services to be performed. Rental space should be specifically described.

- **Compensation or rent must be set in advance** – In general, compensation or the compensation formula must be set in advance and should not be adjusted retroactively. For independent contractors, the actual, total compensation (not just the compensation formula) must be set in advance. (See bullet point below regarding payments based on volume or value of referrals.)

- **Payment fair market value for services provided** – This may be one of the biggest “red flags” in evaluating whether a contract complies with anti-fraud laws. Any significant overpayments or underpayments between referring physicians may be construed as a violation to induce referrals.

- **Changes to compensation or rent during the first year** – Generally, agreements should be at least one year’s duration, and the terms should not be changed during the first year. This restriction does not apply to true employment contracts.

- **No payments based on volume or value of referrals** – Payments that are based on a volume or percentage of referral fees is another major “red flag” and a classic violation of health care laws. Rent payments under lease agreements may not be based on a percentage of revenue earned, billed, collected or otherwise attributable to the services performed by the tenant. Rental should be a flat fee based on the value of the space. Physician employees may be paid a set salary, a set fee per hour or service; a fee per patient encounter, or a percentage of charges or collections for services personally performed by the physician employee (not a percentage of referrals). In employment agreements, a base salary plus bonus is acceptable if the base salary is reasonable and the bonus is based on reaching a certain level of productivity. Productivity may not be calculated on the volume of referrals, but may be defined on any other basis that takes into account services performed personally by the physician employee, such as the employee's total patient encounters. Independent contractor agreements technically do not qualify for these alternative formulas because the anti-kickback law requires actual compensation to be set in advance for contractors. Therefore, a straight per-hour, per day or per month fee is the safest independent contractor compensation structure.

- **Arrangement must be commercially reasonable even without referrals** – Your contract must be for legitimate business reasons and must not include unnecessary services. Otherwise, the agreement could be construed as a vehicle for the payment of a disguised kickback.

Federal vs. State Laws

Both the federal government and the State of Illinois have self-referral and anti-kickback laws. The federal laws are a bit more stringent and apply only if you treat patients in federally funded plans such as Medicare. Generally, if you are in compliance with federal laws, you will also be in compliance...
Contracts... Continued

with state laws. However, many providers make the mistake of believing that if they don’t treat Medicare patients, they are exempt from all self-referral and anti-kickback laws. State law applies to all providers, regardless of their patients’ health plans or source of payment.

Illinois’s anti-kickback provision is the prohibition against fee splitting found in Section 22.2 of the Medical Practice Act. Although it is much shorter than the federal anti-kickback laws, the basic premise is similar in both: the payment of commissions to anyone (not only physicians) in any form in exchange for referrals is prohibited, unless it falls into one of the listed exceptions. The Act permits licensed health care workers to “concurrently” provide services to a patient and to divide the fees in proportion to the actual work performed and responsibility assumed by each. Thus, it would probably permit an employment agreement or contract that establishes a percentage division of fees, so long as the division is proportional to the work performed by the employer and employee. This means that the employer or owner physician must provide some services and assume some responsibility, such as general professional oversight, file review, consultation or billing review in exchange for his or her portion of the fee.

Illinois’ version of the self-referral law is found in the Health Care Worker and Self-Referral Act. It generally prohibits a health care workers from referring patients for health services to an entity outside the health care worker’s group or office practice in which the health care worker has an investment interest, unless the health care worker directly provides the services within the entity and will be personally involved in care to the patient. It is similar to the federal Stark law in that they both apply only to physicians. However, a major difference between this law and the federal Stark law is that Stark is broader and applies to any entity with which the referring physician has a “financial relationship,” not necessarily an investment interest. Therefore, if you do not accept Medicare patients, and as long as you do not violate any fee splitting provisions, you could refer patients to outside entities (for example, a physician who rents space from you) in which you do not have an investment interest.

Remember, however, that regulators will probably look to factors similar to those in the federal Stark law to determine whether the agreement violates the state fee splitting law and constitutes a kickback. For example, if a physician owner charges a tenant far less than fair market value for rent and the tenant refers large numbers of patients to the owner, the difference between the fair market rental amount and the actual, discounted rent might be considered a commission to the tenant in exchange for referring patients to the owner. The converse is also true where rent is higher than fair market value in exchange for the owner’s referral of patients to the tenant. These practices may violate state law even where the participating physicians do not treat Medicare patients.

Keeping It Simple

The self-referral and anti-kickback laws can be confounding, even to legal experts. However, keeping in mind the basic principles will simplify the issue considerably and keep you compliant at the same time: both state and federal laws prohibit physicians from accepting or paying commissions in exchange for referrals of patients, and from referring patients to certain financially related entities, unless certain conditions are met. It is possible to create straightforward employment, independent contractor and lease agreements that comply with these requirements where the parties have compliance as a priority.

PQRS... Continued

patient, who is at least 18 years old, when billing 98940, 98941and 98942. Measure 317 must be reported a minimum of once in 2014 reporting period for every Medicare patient, who is at least 18 years old, when billing 98940, 98941and 98942. All three measures must be successfully reported at least once during the 2014 reporting period. In addition, you must successfully report at least 50% of all eligible visits on all three measures to qualify for an incentive in 2014 and to avoid penalties in 2016.

6. How do I report each Measure?

Measures 131 and 182 are reported the same as they were in 2014.

G-codes for reporting Measure 131

<table>
<thead>
<tr>
<th>CODE</th>
<th>Reason</th>
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<tbody>
<tr>
<td>G8730</td>
<td>Pain assessment documented as positive utilizing a standardized tool and follow-up plan is documented. (Follow-up plan that states a planned reassessment of pain, a referral, or initial plan still in effect.)</td>
</tr>
<tr>
<td>G8731</td>
<td>Pain assessment documented as negative, no follow-up plan needed</td>
</tr>
</tbody>
</table>
| G8939 | Pain assessment documented (positive pain), follow-up plan not documented, documented that patient is not eligible for pain assessment for one of the following reasons:  
• Severe mental and/or physical incapacity where the person is unable to express self in a manner understood by others  
• Patient is in an urgent or emergent situation where delay of treatment would jeopardize patient’s health |
| G8442 | Pain assessment NOT documented as being performed, documented that the patient is not eligible for pain assessment (same reasons as G8939) |
| G8732 | No documentation of pain assessment, reason not given (pain not assessed and no documented reason of patient ineligibility) |
| G8509 | Documentation of positive pain assessment using a standardized tool; follow-up plan not documented, reason not given (pain was present but no documented follow-up plan or a reason the patient was not eligible) |

The purpose of measure 131 is for CMS to collect information on when pain assessments are conducted using a standardized tool and reassessment is planned when patient is present.

What standardized pain assessment tools can be used for measure131?

Standardized pain assessment tools include but not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

G-Codes for reporting Measure 182

<table>
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<tr>
<th>Code</th>
<th>Reason</th>
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<tbody>
<tr>
<td>G8539</td>
<td>Documentation of a functional outcome assessment using a standardized tool AND documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment (treatment plan must include goals).</td>
</tr>
</tbody>
</table>
| G8540 | Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool. Reasons:  
• The patient refuses to participate  
• The patient is unable to complete the questionnaire |
| G8541 | Functional outcome assessment using a standardized tool not documented, reason not given. |
The current JNC report outlines interventions based on BP Readings.

8. What are the recommended hypertensive reading interventions?

Activity, or Moderation in Alcohol (ETOH) Consumption.

(DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Weight Reduction, Dietary Approaches to Stop Hypertension

These changes must include one or more of the following as indicated:

Treatment of High Blood Pressure (JNC) report outlines lifestyle changes.

The Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) report outlines lifestyle changes. These changes must include one or more of the following as indicated:

Weight Reduction, Dietary Approaches to Stop Hypertension (DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol (ETOH) Consumption.

8. What are the recommended lifestyle changes?

8. What are the recommended hypertensive reading interventions?

The current JNC report outlines interventions based on BP Readings shown in the “Recommended Blood Pressure Follow Up” table (find at www. ilchiro.org/bloodpressure) and must include one or more of the following as indicated: Anti Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG).

9. How do I report the G codes on the 1500 paper claim form or electronic claim form?

On the paper claim form the G-codes are reported on line 24D. On the electronic claim form the G-codes are reported on service line 24. G codes should be reported with a zero-dollar amount. However, if your office software does not allow for this, one can use a nominal amount of $0.01.

10. How do I know if Medicare has successfully received my PQRS codes?

A N365 denial code should appear on your EOY, if you are successfully reporting PQRS codes. N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.” The N365 code is just an indicator that the quality data codes (G codes) were received; it does not guarantee the code chosen was correct or that reporting thresholds were met. The N365 code does specify that the claim will be used in calculating incentive eligibility.

What standardized functional outcome tools can be used for measure 182?

Standardized functional outcome assessment tools include but not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI) and Physical Mobility Scale (PMS). Documentation of a current functional outcome assessment must include identification of the standardized tool used.

G-Codes for reporting Measure 317
Preventive Care and Screening for High Blood Pressure

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
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<tbody>
<tr>
<td>G8783</td>
<td>Blood pressure screening provided, patient had a normal blood pressure reading, no follow-up required.</td>
</tr>
<tr>
<td>G8950</td>
<td>Blood pressure screening provided, patient had Pre-Hypertensive or Hypertensive blood pressure, follow up plan documented (see follow up table below in question 7)</td>
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</tbody>
</table>
| G8784 | Blood pressure screening not provided, patient ineligible, reason for ineligibility documented. Reasons patient is ineligible include:  
• Patient has an active diagnosis of hypertension  
• Patient refuses to participate  
• Patient care is emergent or urgent |
| G9151 | Blood pressure screening provided, patient had Pre-Hypertensive or Hypertensive blood pressure, follow up plan is not documented, patient ineligibility documented. Reasons for ineligibility see G8784. |
| G8785 | Blood pressure screening not provided, follow up plan not documented, ineligibility reason not documented. Reasons for ineligibility see G8784. |
| G8952 | Blood pressure screening provided, patient had Pre-Hypertensive or Hypertensive blood pressure, follow up plan is not documented, ineligibility reason not documented. Reasons for ineligibility see G8784. |

8. What are the recommended lifestyle changes?

8. What are the recommended hypertensive reading interventions?