

If the Stark law will not protect your private practice, what will?

I can tell you from personal experience that the Stark law does not protect a physical therapist in private practice (PTPP) from losing their clinic to physicians. A part of my family's practice is a large outpatient clinic, which we have had for 47 years. We are in the process of losing it to the primary referral source, a group of orthopedic surgeons. They want the income from owning their own physical therapy clinic, and under our current laws this is legal.

Historically, there has been a tremendous misconception that the Stark law was the perfect solution to eliminate physician owned physical therapy services (POPTS). In reality, Stark I and II never prevented physicians from owning and providing physical therapy services in their offices. The physicians have always been able to have a POPTS situation if they met the defined exceptions. The main exceptions that have to be met include: 1) the therapy must be performed as in-office ancillary; 2) the physician must have direct supervision of these services; and 3) the physician must bill these services under his or her billing number. So if the Stark law does not save our practice from POPTS, what can we do?

THE STARK LAW

In order to address this issue, a brief overview of the Stark law and its progression would be beneficial. In 1989, Section 1877 of the Social Security Act, Stark I, was enacted and it "prohibited physicians from referring certain designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship—unless an exception applied."¹ At that time, the only DHS that Stark I addressed were referrals for clinical laboratory services. It was not until 1993 that 10 additional DHS prohibitions were added, including physical therapy. Our profession assumed that this would eliminate POPTS. Unfortunately, the ambiguity of the law was the only protection that was provided. This ambiguity arose from the fact that when the Health Care Financing Administration (HCFA) published the final rules in 1995, they applied only to the clinical laboratory services and did not address the other 10 DHS listed in 1993 and 1994. As a result of this ambiguity, and the large fiscal penalties for violators, many physicians sold their physical therapy practices in the 1990s.

Finally, in January 1998, HCFA published a proposed rule (63 FR 1659) that revised the regulations to address the 10 other DHS, which included physical therapy. This revision is known as Stark II. The general impression from the therapy world was that the Stark II regulations actually weakened rather than improved the effectiveness of the law. With Stark II, some of the ambiguity of the law was resolved and physicians started to reenter the physical therapy market. As a result of Stark II, Congress began to hear from constituents that HCFA was being invasive and unfair. This pressure led HCFA to change the regulations by "substantial broadening of the in-office ancillary services exception by easing the criteria for qualifying as a group practice and conforming the supervision requirements to HCFA coverage and payment policies for the specific services. . . . We are dropping the requirements that an in-office ancillary service be supervised under strict 'direct supervision' standards of the 'incident to' billing rules in favor of requiring the level of supervision that is mandated under Medicare payment and coverage rules applicable to particular DHS."² Again, there was a delay in publishing the final rules and regulations of Stark II. The regulations would be split into two phases. Phase I was not published until January 2001, and became effective in February 2002. As a profession, many of us believe that the continued changing of the rules and regulations has a direct impact on the consumer.

QUESTIONS RAISED

The government will always attempt to protect the consumer. In its 2003 Work Plan, the Office of Inspector General (OIG) published that it "will evaluate the conditions under which physicians bill 'incident-to' services and supplies." The Centers for Medicare & Medicaid Services (CMS, formerly HCFA) states in the Federal Register its concern for "unfair competition" regarding a physician's ability to provide in-office ancillary services and be reimbursed for them.² Some would argue that the physician's ability to own a physical therapy practice is an antitrust issue. Antitrust needs to be examined as more physicians take ancillary services in-office to compensate for lost revenue.

The question has been raised whether physicians have an unfair competitive advantage over a PTPP if they have POPTS. Does this setting adversely affect a patient's choice? In a POPTS setting, antitrust and patient choice have to become immediate concerns, since the majority of physical therapy services occur under the physician referral model. Congress expressed concern over the antitrust and patient choice issues to HCFA in 1989. HCFA believed that it had addressed these concerns through the Antikickback Statute and Section 1877 of the Social Security Act (Stark I law). However, there is some contradiction, as HCFA also acknowledged that "a patient's choice can be affected when physicians steer patients to less convenient, lower quality, or more expensive providers of health care, just because the physicians are sharing profits with, or receiving remuneration from, the providers."³ It becomes apparent that further legislation should be passed to specifically rectify the antitrust and patient choice issues.

Through the efforts of the American Physical Therapy Association (APTA) and its Private Practice Section (PPS-APTA), these questions continue to be raised to HCFA. In 1998, HCFA reported in the Federal Register's Comments section that several studies define "The Problems Associated with Physician Self-referrals." In June 1998, the OIG reported that "patients of referring physicians who owned or invested in independent laboratories received 45% more laboratory services than all Medicare patients in general." In 1991, HCFA cited the Florida Cost Containment Board, which analyzed the effects of joint ventures. "The Board found that doctor owned clinical laboratories, diagnostic imaging centers, and physical therapy and rehabilitation centers performed more procedures on a per-patient basis and charged higher prices than non-doctor affiliated facilities."³ The antitrust and patient choice issues are a reality for PTPPs.



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In late 1999 and early 2000, the American Medical Association (AMA) and some legislators worked fervently to eliminate the Stark law completely. This was stopped through the efforts of APTA, PPS-APTA, and their grass roots. As a consolation to the AMA for not eliminating Stark, HCFA once again loosened the Stark law in Phase I of the regulations. As a profession, we will have the scenario of POPTS as long as we have to function under our current physician/therapist model. Our challenge as a profession must be to get out and inform the public about their choices. How many of us have spent money to educate the public that they have the right to ask their doctor if a licensed therapist is providing the service in the doctor's office? Have we marketed to the consumer to try our services rather than the physician's current recommendation? Are we educating the insurance carriers that they could be paying for a nonprofessional to provide therapy services in a physician's office? Are we participating in APTA's grassroots efforts to lobby Congress to have CMS put a distinction on HCFA 1500 forms for the therapy services provided in the physician's office? This would enable CMS to track expenses and attribute them to the type of provider setting.

ALTERNATIVES

It is obvious that the Stark law does not prevent a POPTS situation. What alternatives do we then have as a profession? In its 2020 Vision Statement, APTA and its House of Delegates outlined a plan for our profession. Several components of the plan include "Direct Access under Medicare" and "Physician Status" for physical therapists. As PTPPs, we must be involved with the APTA House of Delegates so that we can affect legislation through one of the most powerful lobbying efforts in Washington, DC. We must be involved with the state and federal political action committees to support those legislators who support our profession. In doing this, we will be able to continue to meet with federal and state legislators and educate them on PT issues. There are processes out there, and we need to make them work to our advantage.

In addition to political involvement, there are other models to be considered. I am not advocating certain models, but offer them for discussion:

- Joint ventures where the private practitioner is the majority owner in the practice. Some will respond that this would be fine for the PT partner but unfair to the other PTPPs in town.
- CORFs that allow physicians to be employed by the therapists.
- Physical therapy achieving Professional Corporation (PC) status. Peter J. McMenamin, PT, has recently published a series of articles in Impact promoting the fight to make PTPPs have a PC status. This is a function at the state level, but it would prevent non-PTs from owning a practice just as other professional organizations, such as those for physicians, lawyers, and accountants, have this function to protect them.
- Partnership models for real estate and occupational medicine where the physician and therapist share in equal revenue.
- PTs employing physicians rather than being employed by physicians, in states where it is allowed. Occupational medicine, in some states, allows a PT to own the business and employ a physician as an independent contractor.
- In the 35 states that have some form of direct access, we must continue to fund the state PACs and work for more equal legislation. We cannot allow the PAC funds to slow because our state has obtained direct access.
- Educate our staff, hold each other to high standards, and inform State Boards about abuse or malpractice that occurs.
- Volunteer time to take students in our clinics for clinical rotations and visit the classrooms to educate them on POPTS before they are employed.

CONCLUSION

We have many opportunities at our fingertips as the political landscape of medicine continues to drastically change. Stark II will most likely not become more restrictive. If you review the General Comments Regarding the January 1998 Proposed Rule and Responses section of the Federal Register, you can see the power of the AMA. The majority of the questions that HCFA addresses appear to be from physicians. APTA and PPS-APTA were able to pose some questions, but we have to increase support for them to be able to compete with the AMA. Physicians were able to get their Congressional leaders' attention, which made a difference for them. APTA has a growing PAC fund and a respected reputation in Washington. The Stark law has never protected us from POPTS and most likely never will. It is time for us as physical therapists to grow our membership in APTA and grow our PAC and grassroots efforts to make the system work for us and eliminate POPTS. ®

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References

1. Federal Register Rules and Regulations. Washington, DC: Department of Health and Human Services; August 14, 1995;60(156):41915.
2. Federal Register Rules and Regulations. Washington, DC: Department of Health and Human Services; January 4, 2001;66(3):859, 860.
3. Federal Register Rules and Regulations. Washington, DC: Department of Health and Human Services; January 9, 1998;63(6):1662.