02/06/08

OIG Reviews Relationship Between Critical Access Hospital and Hospital-based Radiologists

Robert E. Mazer
410-347-7359
remazer@ober.com

OIG Advisory Opinion No. 07-19, posted on the OIG's website on January 3, 2008, responds to an inquiry as to whether a radiology practice can prepare a written report of its interpretation of a radiology procedure for patients of a critical access hospital without charge, without violating the federal antikickback statute (FAS). As discussed below, the OIG's response reflects consideration of two important issues: (1) the relationship of Medicare payment principles to the FAS, and (2) services which hospital-based physicians can be required to provide to hospitals, without payment, consistent with the FAS.

The OIG states that the hospital had asked whether the radiology group's preparation of the written report for the hospital's medical records without charge to the hospital implicated the FAS. A footnote to the opinion indicates that the issue may have surfaced during contract negotiations. The radiologists had requested payment from the hospital for preparing the reports. In all likelihood, they asserted that providing these services for free would violate the FAS. The hospital sought confirmation from the OIG that that would not be the case.

Old Issue Revisited

As discussed most recently in our Spring 2005 *Health Law Alert* ("OIG's Supplemental Hospital CPG Looks at Hospital-based Physicians"), similar issues have been debated by hospitals and hospital-based physicians (e.g., pathologists, radiologists, and anesthesiologists) since the OIG issued a Management Advisory Report in 1991 addressing contract arrangements that potentially violate the FAS. In fact, payment for the cost of radiology report preparation is not a new issue. Approximately 15 years ago, an OIG attorney responded to an inquiry from counsel for the American College of Radiology (ACR) seeking guidance regarding hospital demands that radiologists pay the hospital for transcribing the radiologist's interpretation. The ACR attorney asserted that because the cost of transcription was part of the hospital's operating costs for which it received payment from Medicare, the hospital would be seeking a duplicate payment from the radiologists in violation of the FAS. The OIG attorney agreed, to a point. The OIG attorney indicated that the OIG would not express an opinion on how Medicare and Medicaid paid for hospital transcription costs. However,

he concluded that "[i]f a hospital demands payment from a hospital-based physician ostensibly for services that the hospital has already received reimbursement for through the prospective payment system, the [FAS] may be implicated."

OIG Analysis

In contrast to the general response to the ACR's informal inquiry, in the advisory opinion, the OIG specifically determined whether the arrangement violated FAS based on applicable Medicare payment principles. The OIG stated that, according to CMS, in order for a radiologist to receive Medicare payment for an interpretation of a radiology procedure for a hospital patient, the radiologist had to prepare a written report for the hospital's medical records. A critical access hospital was required to maintain medical records satisfying regulatory standards, but it was not required to bear the cost of preparing a report documenting the radiologist's services. Based on these Medicare principles, the OIG concluded that the radiologists' provision of written reports for hospital Medicare patients without charge to the hospital was not "remuneration" paid to the hospital. In fact, if the hospital paid the radiologists for preparing the report, the radiologists would receive double payment for the same service — one time through receipt of Medicare payment for the professional component service, and a second time from the hospital. The OIG's analysis — effectively providing for the entity that received Medicare payment for the service to bear its related cost — makes eminent sense. This is more obvious when the arrangement involves the mirror image of that addressed by the OIG — when the source of referrals or other Medicare business (e.g., hospital) attempts to shift costs for which the hospital receives Medicare payment to the recipient of its Medicare business (e.g., hospital-based physician). In those instances, the cost-shifting may violate the FAS.

The OIG recognized that while the FAS prohibits only remuneration paid for referrals or similar activities related to goods and services payable under a federal health care program, financial arrangements for services furnished to patients whose care is covered under other arrangements can result in payment of prohibited remuneration (just as a contract related to private-pay patients can result in a compensation arrangement under the federal self-referral (Stark) law). Therefore, the OIG separately addressed the issue in connection with radiology reports for hospital patients whose services were not covered by Medicare. The OIG stated that it was uncertain how other payers paid for the cost of preparing radiology reports. Therefore, unlike in the case of reports for Medicare patients, the OIG was unable to conclude that the radiologists' provision of reports for non-Medicare patients would not result in payment of remuneration to the hospital.

The OIG analyzed application of the FAS to those

arrangements based on the Supplemental Compliance Guidance (SCG) for hospitals which it had published in January 2005. See 70 Fed. Reg. 4858 (Jan. 31, 2005). The OIG had then stated that if an exclusive contract arrangement between a hospital and hospital-based physicians was consistent with fair market value, taking into account the value of the exclusivity to the physicians, then "in an appropriate context," requiring hospital-based physicians to perform "*reasonable* administrative or *limited* clinical duties directly related to the hospital-based professional services at no or a reduced charge" would not violate the FAS. 70 Fed. Reg. at 4867. The OIG concluded that the radiologists' preparation of reports appeared to be a reasonable and limited service *directly related* to their professional services that were furnished under their exclusive relationship with the hospital.

In further support of its decision that it would not impose sanctions as a result of this arrangement, the OIG made several statements that would apply arguably to many, if not most, arrangements between hospitals and hospital-based physicians. The OIG stated that the arrangement was unlikely to lead to overutilization of federally payable services or increased cost to federal programs. Additionally, the radiologists' ability to generate additional Medicare Part B billings in order to recover the cost of preparing reports for non-Medicare beneficiaries was limited by the nature of their hospital-based specialty.

Conclusion

Although the OIG expressed no opinion regarding arrangements that did not involve critical access hospitals, the analytical approach used by the OIG to determine whether the hospital or radiologists should bear the cost of report preparation should be useful to hospitals and hospital-based physicians (and potentially other physicians negotiating payment arrangements with hospitals). However, reliance on the entity that received related Medicare payments will not always lead to a clear result. The OIG had the benefit of specific advice from CMS regarding Medicare payment for the particular cost at issue. In the absence of such advice, it is sometimes difficult or impossible to determine how a particular cost — which is a component of a reimbursable health care service — is paid by Medicare.

The OIG also made clear that because other payers may use different payment principles, an analysis limited to Medicare payment principles may not be adequate. Application of the FAS to the cost of services provided to individuals who are not Medicare beneficiaries may need to be made on a different basis. The OIG relied on the supplemental CPG for hospitals. CPG statements relating to uncompensated services provided by hospital-based physicians have been subject to varying interpretation since its publication. Unfortunately, the OIG's determination sheds little light on

when services can be provided by hospital-based physicians without charge, including what services will be considered "reasonable" or "limited," and "directly related" to the physicians' professional services, and what is an "appropriate context" in which such services might be provided by hospital-based physicians on an uncompensated basis.

Ober, Kaler, Grimes & Shriver

Maryland
120 East Baltimore Street, Baltimore, MD 21202
Telephone **410-685-1120** , Fax 410-547-0699

Washington, D.C.
1401 H Street, NW, Suite 500, Washington, DC 20005
Telephone **202-408-8400** , Fax 202-408-0640

Virginia
407 North Washington Street, Suite 105, Falls Church, VA 22046
Telephone **703-237-0126** , Fax 202-408-0640