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Endovascular Fellow TODAY

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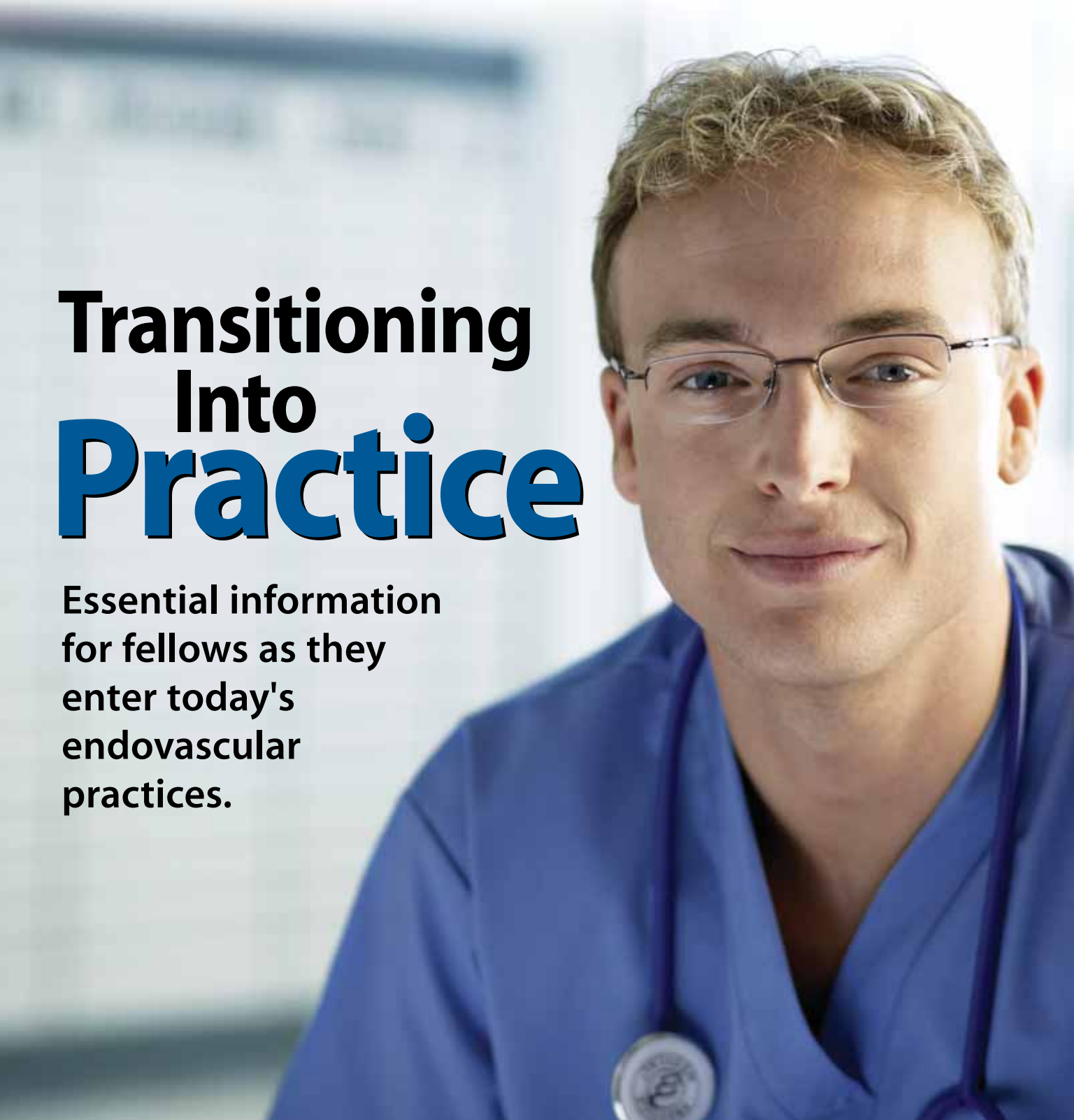

Transitioning Into Practice

Essential information for fellows as they enter today's endovascular practices.

Transitioning Into Practice

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With the support of Medtronic Vascular (Santa Rosa, CA), *Endovascular Today* is proud to present this special issue designed specifically for fellows entering endovascular practices. In addition, you will begin receiving a free subscription to our monthly publication, *Endovascular Today*, compliments of the publisher and Medtronic.

As you enter your practice, you will find yourself in an exciting period of endovascular history, filled with unique challenges and substantial opportunities for success both personally and professionally. Accordingly, we have asked five experts to provide articles on specific topics we believe are of paramount importance to physicians as they make this transition.

First, Ali Azizzadeh, MD, FACS, offers step-by-step tips for you to consider before you finish your fellowship, while securing a job and setting up your new practice. He stresses the value of gaining diverse experience and collaborating among physicians. Next, Colleen Johnson, MD, describes how best to build community contacts when establishing your new practice. She describes the sources you can use to discern the local landscape and to locate physicians and potential referral specialities. Also, she guides you through community interaction with advice on speaking opportunities and volunteer service.

Terrell J. Isselhard, JD, is an attorney specializing in providing counsel to physicians. His contribution to this special edition presents a comprehensive discussion of physician employment agreements and how to make sure yours will suit your specific needs before you sign it. Medtronic's senior reimbursement manager, Alex Au-Yeung, lends his expertise on the often-confusing subject of physician coding and reimbursement. He provides sample coding tables, lists diagnosis codes that you will likely require, and reminds you what questions to ask when coding. Finally, Blair A. Keagy, MD, covers three legal constraints that may affect your practice: the Anti-Kickback Act, the Stark Law, and the False Claims Act. The case reports he provides describe the cases that led to these laws.

We hope this special edition of *Endovascular Today* provides helpful and practical information as you launch your career, and we look forward to hearing from you. ■

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Before You Leave Your Fellowship

Advice to consider when beginning your practice.

BY ALI AZIZZADEH, MD, FACS

The conclusion of your training is a very exciting time in your professional life. After many grueling years of medical school, residency, and fellowship training, you can finally start your career. It is also a period of major transition; you will begin the independent practice of medicine. Whether starting a solo practice, joining an existing group, or entering academic medicine, you will be faced with new challenges on a daily basis. Consider the following tips to help you make the transition.

BEFORE FINISHING YOUR FELLOWSHIP

Gain Diverse Experience

Do as many cases with as many different attending physicians as you can. There is no substitute for experience. As you have figured out by now, there are often different ways to perform the same procedure. Different practitioners, even in the same practice, may approach various clinical situations somewhat differently. You are the product of the surgeons who train you. You want to have as many solutions to a particular problem as possible. When you are doing a case in the middle of the night and plan A does not work, you need to have a plan B. In addition, do not forget to scrub in on the rare cases, even if you are not particularly interested in them. You may consider scrubbing in for a mesenteric bypass or a thoracic outlet decompression procedure rather than doing another carotid endarterectomy.

Thoroughly Understand Vascular Ultrasound

The vascular lab is the cornerstone of any successful vascular surgery practice. Naturally, any physician who cares for vascular patients needs to be able to read and interpret ultrasound studies. This becomes even more important if you are planning to set up a new vascular lab. Your ultrasound technician will often refer to you for guidance and direction. It is very helpful to have a solid knowledge base of performing and interpreting ultrasound studies. It is also beneficial to learn about the business aspects of running a vascular lab. This has traditionally been a major source of income for physicians. Finally, ultrasound is a major component of the specialty board examinations that you will be taking.

Read Regularly

You may feel stretched for time during your fellowship, but it is important to dedicate some time for reading. Select a vascular textbook, and set aside time in your schedule on a weekly basis to educate yourself on a chosen topic. It is also a good habit to read about cases the night before. You can supplement your basic reading by keeping up with the current literature. You will become much busier once you enter clinical practice. Keep in mind that your board examinations are just a few months away.

Collect Reference Material

The practice setting that you enter may be very different from the institution at which you received your training. Some of the information you may want to collect for later reference may include operative notes, data sheets, pathway orders, diagrams, computer logs, and follow-up protocols. This is especially important if you are entering solo practice. It is a good idea to keep a sample operative note on common procedures, especially if you are not dictating them as a fellow. You may want to obtain a few PowerPoint presentations from your professors on common topics. This will be very useful when you are invited to give talks as a new physician in your local hospital.

Find a Job

If this is your last year of training, you have probably found a job by now. For those of you still looking, your program director and faculty are probably a good starting point. Many good jobs are never advertised. Some senior physicians tend to call the program directors they know when they are ready to hire a new partner. The society Web site is filled with an abundant number of open positions. A good job should match your qualifications and needs. Make sure you do your homework on the practice before the interview.

The Interview

Above all, be yourself. You want to be hired for who you are. Be confident without being arrogant. Be honest about your experience. Find out about the history of the practice. Look for red flags. If some of the associates have left, find out why. Sometimes, you can even try contacting the former associates yourself. Look into the political landscape of the practice. What are the referral patterns? Who are the competing groups and what are their specialties? Who performs the endovascular procedures? Will you have access to an endovascular suite? Other issues you may want to inquire about are overhead, benefits, and call schedule.

The Contract

An academic institution may offer you a two-page appointment letter with little room for negotiation, although a private practice group may present you with a 20-page document detailing every aspect of the employment. It is very important for you to understand the content of the contract. It is advisable to seek professional help from a legal counsel. The information contained in the contract includes length of employment, salary, partnership track, and termination. When negotiating a salary, the AAMC faculty survey is a useful resource. Benefits including insurance (health, disability, and malpractice), vacation, and retirement plans (401[k]) should also be discussed. Noncompete clauses tend to favor the employer. If you are required to sign one, your lawyer may be able to help you negotiate the details of this clause.

YOUR FIRST JOB

Before You Get There

There are certain steps that must be taken as soon as you sign your contract. First, if you are moving out of state, you need to apply for a state medical license. Depending on the location, this may take months. Next, you need to apply for credentials at all the hospitals in which your group practices. They may also ask you to complete additional applications for insurance companies and other care plans. Taking care of this ahead of time will enable you to start practicing when you arrive. The hospital may also contact you regarding operative preference cards and other resources you may require. The attending surgeons at your training institution are a good resource for understanding these issues.

Setting Up Your Practice

The amount of work you have to do is highly variable and depends on the type of practice you are entering. If you enter a group practice, it is likely that a well-developed structure is already in place. On the other hand, if you start a solo practice, you have your work cut out for you. The building blocks of a modern endovascular practice include office space, support staff, vascular lab, operating room capital equipment, and endovascular supplies. If you are the first vascular surgeon entering practice in a community hospital, it would be advisable to obtain a strong written commitment from the administration regarding all the above elements. The minimal capital equipment needed to start a program includes a mobile C-arm, a motorized fluoroscopy table, and a power injector. An endovascular inventory, depending on the supplies kept in house, can range from $150,000 to more than $1,000,000. Consider contacting the local industry representatives to help create your initial inventory.

Getting Started

The three As of building a practice are available, affable, and able. I have listed available first because that often seems to be the most important factor. As a new physician in the hospital, you will be closely watched by your partners, peers, and staff. Remember, there is only one chance for a first impression. Start out with cases that you are comfortable doing (Figure 1). For example, it

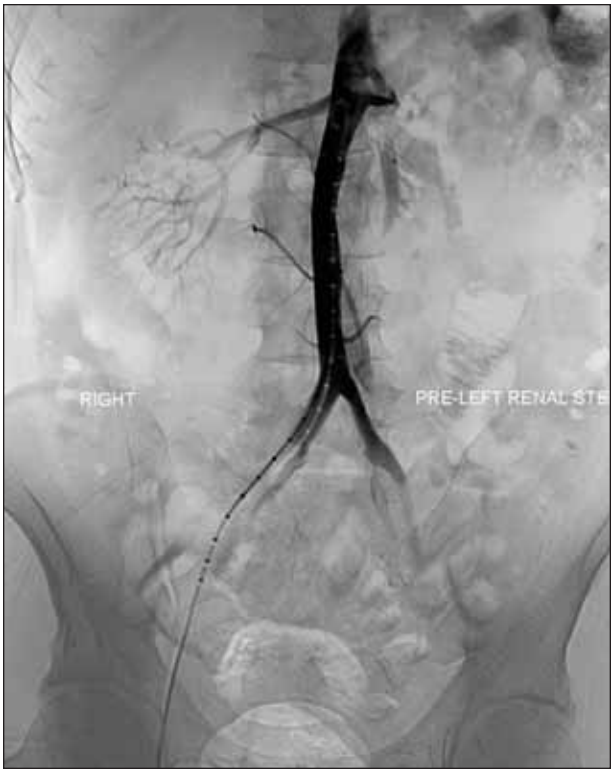

Figure 1. Abdominal aortogram in a patient with a type B aortic dissection extending into the left renal artery. Be judicious in selecting your cases early on.

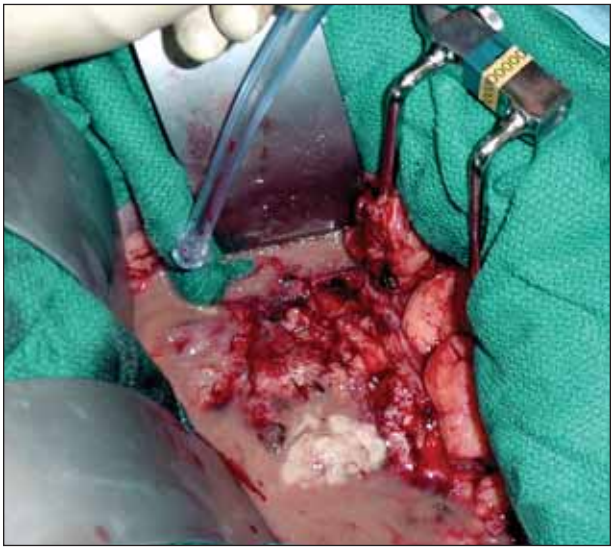

Figure 2. Ruptured mycotic abdominal aortic aneurysm. Ask your colleagues for advice and assistance when you encounter unusual cases.

would not be advisable to repair a thoracoabdominal aneurysm in your first week of practice. When you encounter difficult situations, be very liberal in obtaining advice and assistance from colleagues with more experience (Figure 2). This will not be considered a sign of weakness. Remember, they have all been in this situation before. As you gain more experience and confidence, you will be able to take on the most challenging cases without a problem.

Collaborate

Today, a growing number of physicians from different specialties are performing endovascular procedures. The often-blurry specialty lines have all but disappeared. Depending on your institution, vascular surgeons, cardiologists, and interventional radiologists are in competition for the same patient population. Neurologists, nephrologists, neurosurgeons, and cardiothoracic surgeons have started acquiring catheter skills. Regardless of your specialty and skill set, you will require the services of some of your competitors. It is advisable to maintain a cordial relationship with all of them. This will foster a collegial environment and ultimately improve patient care. It will also enable them to approach you in times of need.

Communicate

Communication is a key habit in running a successful practice. Preferences vary among referring physicians. Initially, however, it is reasonable to call or write a letter to the primary provider outlining your diagnosis and plan. If you perform a procedure, it is also customary to send a follow-up letter and enclose a copy of your operative notes for their files. Enclosing copies of before and after angiograms can often help educate the primary physicians about your procedures. This will also help them remember you when they encounter a similar patient in the future. Do not forget the importance of communicating with your partners and peers. For example, if you admit a partner's long-time patient over the weekend, it would be useful to update him or her expeditiously.

You have invested a great amount of time, energy, and resources to complete your training. This is a very exciting era in vascular surgery. Endovascular therapy has revolutionized our treatments for vascular disease. Newer technologies are being developed at a rapid pace, and the future appears even more promising. I wish you the best of luck as you embark upon your career. ■

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Building a Successful Practice

Community interaction is integral to gain referrals when establishing a new practice.

BY COLLEEN JOHNSON, MD

As the ink dries on the signature line of your contract, the work of building a practice begins. By learning the local landscape, introducing yourself to and becoming part of the community, and maintaining a professional and welcoming appearance, you can successfully institute your new practice.

LEARN THE LOCAL LANDSCAPE

It is imperative to identify local physicians and determine their interactions with one another. This investigative process begins at the medical staff offices of hospitals where you are seeking privileges (Table 1). These physicians are likely to be encountered on a daily basis and are your potential sources of inpatient referrals; your interactions with these physicians in the hospital will ideally translate to outpatient referrals.

Information from local and state medical societies will help you expand your lists of referring physicians. Local medical societies will likely have similar information as the medical staff offices. Occasionally, physicians will have only courtesy privileges at one institution or not have admitting privileges at any hospital. State medical societies will provide information regarding those physicians outside of the immediate area. When contacting the state medical society, it is helpful to provide a geographic radius or the zip codes of surrounding cities. If your practice is in a larger city, it may be wise to choose a smaller radius than if you are moving to a primarily rural or tertiary care environment.

The Internet can also be a resource when building a referral base. The American Medical Association Web site can be searched to identify physicians within a geographic area.[1] It is also helpful to register with the American Medical Association and state and local medical societies because patients and physicians often look to these organizations for information. The final listing of physicians can be cross-referenced with the local phone book. This ensures that any physician not registered with either the hospital or a medical society is not overlooked.

TABLE 1. FINDING PHYSICIANS

- Hospital medical staff offices
- Local medical society
- State medical society
- American Medical Association (www.ama-assn.org)
- American Osteopathic Association (www.osteopathic.org)
- WebMD physician directory (www.doctor.webmd.com)
- Phone book

TABLE 2. POTENTIAL REFERRAL SPECIALTIES

• Family practice	• Rheumatology
• Internal medicine	• Hospitalists
• Nephrology	• Obstetricians
• Neurology	• Dermatologists
• Podiatrists	• Wound clinics

The lists can be sorted and culled according to specialties (Table 2). Isolate those physicians who are more likely to be sources of patient referrals. Primary care physicians, internists, family medicine physicians, and nephrologists are logical choices. However, limiting the search to these primary care specialties excludes some potentially fruitful relationships. Neurologists are often the first to evaluate and formulate a treatment plan for acute stroke patients. Early interactions with neurologists can result in multiple referrals to evaluate and treat carotid disease. In addition, fibromuscular dysplasia and many of the more uncommon arteritises have cerebral manifestations. By interacting with neurologists, you are more likely to be at the forefront of their consciousness when they encounter these unusual patients. Rheumatologists are often overlooked as potential referral sources. They will refer patients for temporal

artery biopsies and for complications of Takayasu's and giant cell arteritis.

Another often-overlooked referral source is nurse practitioners. Many are either practicing independently in the hospital setting or within a large primary care group. Other nurse practitioners may be operating large wound care clinics. Acknowledging their role in patient care and offering to evaluate their patients can go a long way when building a practice.

> "It is important to establish a reputation as a competent surgeon and interventionist before pushing the envelope."

As new physicians embark on the process of starting a practice, much of the focus is placed on building an arterial practice. Venous disease is often viewed as less prestigious, or frivolous and cosmetic. Obstetricians evaluate and treat many women who develop venous varicosities during pregnancy. Dermatologists find venous disease during annual skin evaluations. Women make the overwhelming majority of medical care decisions for families, and each family frequently has at least two parents who are aging and will likely need vascular intervention. A positive experience in the vein clinic can generate many new patient referrals to an arterial practice.

INTRODUCTIONS TO THE COMMUNITY

Opening the front door to an office building does not guarantee a waiting room full of patients. While you have probably done some reconnaissance work during the interview process, your work continues well after the contracts have been signed. It is essential to learn the local political scene.

Industry representatives can play an instrumental role. Ask the local medical device representatives which physicians perform the majority of vascular surgery and the bulk of the endovascular interventions. It is important to gain an understanding of why you were recruited and the specific skills you are expected to bring to the community. By identifying a specific need or niche to fill, you can establish a referral toehold.

As your role becomes defined, it is time to make yourself known to local physicians. A short letter of introduction, sent 1 to 2 months before your anticipated date of arrival, is an ideal way to start the process. In this letter, briefly state your educational background and training. Discuss procedures you may be able to offer that are not currently available. It is important to be humble in this initial communication. Speak in generalities, and do not claim to perform procedures that you hope to add to your armamentarium in the future. If thoracic endografting is not part of your training, do not discuss this in your letter to community physicians. A template letter to encourage primary care physician referrals to vascular surgeons is available from the Society for Vascular Surgery Web site.[2] At the conclusion of the letter, include the date your office will begin to accept referrals and new patients. Include the phone number where your office can be reached. It is reasonable to have your office open at least 2 weeks before you anticipate seeing your first patient. The letter should be printed on good-quality paper. If you are joining a group practice, use the group's letterhead. If you are beginning a solo practice, it is a good time to consider designing your own letterhead or logo. This will be your first introduction to the community, and although it does not need to be handwritten on linen paper, it should be cleanly formatted and well-written. It is effective to follow the initial letter with a short announcement that the practice has officially begun accepting new patients to your care. A postcard with a photo and a statement that you are now accepting patients can be sent to the same physicians.

Once your start date has been set, it is important that someone is always available to answer the phone calls. Your office staff will interact with referring physicians before you start seeing patients. Before this start date, all office staff should be educated on how you would like the phone answered. They should also know what information will be needed at this initial phone call and any testing that you may require before the visit. A pleasant interaction during the initial phone call goes a long way to continued referrals. Office staffs have a large say in directing patient referrals. If the process to refer a patient is cumbersome and the office staff displeasing, it is unlikely that another referral will be made.

Another effective way of introducing yourself to both physicians and the community alike is through the local papers. A small advertisement with a photo, a statement of your clinical interests, and the office location and phone number can be lucrative. Newspaper advertising can be expensive, but the return on your investment is excellent.

The days of driving to each referring physician, introducing yourself, and having a cup of coffee are gone. Although it may be reasonable to visit a few physicians who are likely to refer a large volume of patients, it is often easier to have them come to you. A cocktail party or open house provides an excellent opportunity to shake

hands and let people interact with you on a social level. This event should not require professional party planners or rival a Hollywood red carpet event; a simple, informal affair is sufficient to allow you and your future partners to discuss the role within the community that you expect to fill and how you can evaluate and treat their patients.

KEEPING UP APPEARANCES

Because appointments are easy to get and physicians are apt to try and help new physicians, referrals will come in at the beginning. To keep new patients coming through the front door, it is important to stay in the forefront of the community consciousness.

Local medical societies meet regularly and are frequently looking for speakers. Approach the local medical society president and offer to speak at an upcoming meeting. These venues allow you to explain the rationale behind your approach to common vascular surgical problems. It also permits you to impart unique approaches to these problems and how you can treat these patients. When selecting a topic to present, it is important to speak about diseases you are comfortable discussing. Do not discuss thoracic debranching procedures in conjunction with thoracic aortic endografting, but rather carotid artery disease, peripheral arterial disease, aneurysmal disease, or venous disease. Although these procedures may be cutting-edge and sexy, these are not the cases you want to launch your career. It is important to establish a reputation as a competent surgeon and interventionist before pushing the envelope.

It is also important to acknowledge local competition. If someone else in the community does a similar procedure, emphasize unique approaches that you may offer or additional services you can provide. In addition, be humble. Presenting an arrogant façade does not endear you to physicians who have been practicing in the community for years. Their methods may be antiquated, but by presenting a distinctive approach in a collegial manner, it is possible that many people will come around to your way of thinking.

Divisional or departmental hospital meetings provide additional opportunities to speak. The department of surgery meeting may not be as worthwhile as the internal medicine meetings. Approaching the department chiefs and asking simply to introduce yourself to their group can be very beneficial. Often, these meetings are poorly attended, but that provides a more intimate setting for you to meet these physicians. By appearing at these venues, it demonstrates your commitment to establishing a practice and your desire to form a working relationship with them.

Many hospitals provide a grand rounds forum for hospital-wide education. Arranging to speak at one of these forums may not provide direct physician-to-physician contact, but instead may allow you to educate hospital personnel. Nursing staff, respiratory staff, and other ancillary personnel are also potential referral sources. The opinion of these individuals is often sought when deciding whether to consult another physician. Nurses can easily prompt referrals with statements such as, "Dr. Johnson spoke about this last week. What do you think about a vascular consult?" Never underestimate the power of a nurse's suggestion.

> "Through community involvement, potential patients begin to see you as more human and much more like them."

One final speaking opportunity that can result in countless referrals are the infamous "rubber chicken" dinners. These are often sponsored by local philanthropic societies and community organizations. Although the venue may not be glamorous, the attendees are interested and genuinely grateful for your time. Make sure the presentation is appropriate for the audience, which may not necessarily be interested in the basic science of vascular disease, but rather how it may affect their lives and what they can do about it. At the conclusion of the talk, leave time for questions. Do not be surprised by the questions asked. Although the audience may not relate directly to the topic you discussed, if these people get the impression that you care about them, they are likely to refer a friend or solicit their primary care physician for a referral.

COMMUNITY INVOLVEMENT

Community involvement is mandatory for any physician starting a new practice. Becoming involved with various community organizations gives an impression that you are there to improve the community and not just to make money. By giving back to the community, you will get more in return than you ever imagined. Involving yourself in a new community need not be a daunting task. Many churches have groups that provide various services for the congregation or the community. Most cities have very active community service organizations. Simply reading the paper or watching the local news can help you identify local service organizations, which are always looking for help. By calling and asking about becoming involved, you will be surprised at how easy involvement can be. Social clubs and country clubs are often viewed as elitist; however, these organizations provide an opportunity to interact with a wide variety of people outside the medical community who have an array of political and social agendas. Becoming an active member

of such a group can open a variety of doors to committees and organizations with which you may not otherwise be involved.

Often the easiest ways to become involved is through children's activities such as sports, dancing, and music, which provide excellent networking opportunities. Becoming a head coach may not be possible due to the unpredictability of your work schedule, but you can volunteer to assist. Attend games and practices. Learning the names of team members and cheering from the stands is an excellent way of being involved.

Through community involvement, potential patients begin to see you as more human and much more like them. Referring physicians begin to see that you are there to be a part of the community and help improve the local environment. The perception becomes that you are here for the duration and not just passing through to the next career stepping stone elsewhere. As your visibility in the community improves, you will begin to see your referrals increase. It is important to remember that signing up is not sufficient—it is imperative to put forth a sense of commitment and reliability. Keep the commitments you have made. Arrive on time to meetings and events. Be more than a name on a roster.

Patients and physicians alike extrapolate behavior from these events to your clinical practice. Being aggressive or belligerent at community events reflects poorly on your practice, and people will think twice before making an appointment. Everything you do and say reflects back to your clinical practice.

CONCLUSION

It is easy to sign a contract, but it is much more difficult to establish a practice that encourages patient referrals. By taking the initiative to step to the front of the local medical community and the community at large, you will encourage patient referrals. Once the patient flow begins, it is important to provide them with a positive experience. Keeping a full waiting room requires maintaining relationships with referring physicians and the lay community. ■

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1. American Medical Association Website. Available at: http://www.ama-assn.org. Accessed January 20, 2007.
2. Potential Resources. VascularWeb. Available at: http://www.vascularweb.org/_CONTRIBUTION_PAGES/Practice_Issues/index.html. Accessed January 20, 2007.

Physician Employment Agreements in the 21st Century

Critical elements you should consider to help ensure that your agreement suits your specific needs.

BY TERRELL J. ISSELHARD, JD

One of the more perplexing issues physicians confront as they transition from fellowship to practice is their employment agreement. These agreements can vary from an informal offer and acceptance conveyed over a phone call to a complex written contract the size of a small novel. This article addresses the question of when a written employment agreement is appropriate, the advantages and disadvantages of entering into a comprehensive employment agreement, and several provisions critical to providing physicians with the legal protection necessary in their employment relationship.

LIMITATIONS OF ANALYSIS

This article is intended to familiarize the reader with several of the pertinent issues they may choose to address in their employment agreements. It is not a review of all legal issues that will impact your respective agreement. In the US, employment agreements are governed by the law of the state with the most significant "contacts" with the contracting parties. In this context, "contacts" refers to the state where the contracted employment is to take place, but (as with most legal rules) there are exceptions. A physician may agree to work for a practice with offices in two neighboring states that have conflicting laws regarding the relevant provisions of the employment agreement. Because it is not possible to provide a dissertation on the employment laws of all 50 states within the context of this article, I strongly recommend that any physician preparing to enter into an employment agreement meet with an attorney familiar with the employment laws in the state governing your contract.

WHEN IS AN EMPLOYMENT AGREEMENT APPROPRIATE?

Under the law in many states, an employee hired without an agreement is considered to be an "employee at will," meaning that the employer can fire the employee without cause, notice, or compensation (aside from compensation already earned) at any time. Although various federal and state statutes protect employees from age, sex, racial, and disability discrimination in the workplace, unless there is a verbal or written agreement to the contrary, an employee working for a business organization has no additional legal rights concerning dismissal.

Therefore, the first issue to address is whether it is in an employee's best interest to have a written agreement. The most obvious benefit of a written employment agreement is evidence of the terms of employment (see Table 1 for a list of the terms that are likely to be addressed). Although a verbal employment agreement is valid and enforceable, the parties may subsequently dispute the exact nature of those terms, and the only evidence of the details will be the parties' own conflicting testimony. A written agreement can address a wide range of terms and provide the employee with certainty regarding his or her position at the practice. On the other hand, the ambiguity of a verbal agreement has advantages: some terms contained in a written agreement (such as a noncompete agreement) may be against the best interest of the employee. An employee who is planning on a short stay at a particular medical facility before moving to another job in the same geographic area may prefer a verbal agreement, trading a degree of uncertainty regarding the specific terms of employment for the freedom to change jobs.

TABLE 1. TERMS TO BE NEGOTIATED IN AN EMPLOYMENT AGREEMENT

- Salary
- Profit sharing
- Partnership track
- Vacation, personal, and sick days
- Length of employment: Does the agreement automatically renew each year, or do the parties renegotiate the terms on an annual basis?
- Termination: Does the employer need to demonstrate gross negligence or malfeasance on the employee's behalf? Are warnings required? Is notice required? Is there compensation for involuntary termination?
- Malpractice insurance (during and after employment)
- Health insurance
- Disability insurance
- 401(k) plans
- Any other fringe benefit programs you wish to incorporate

NONCOMPETE AGREEMENTS

A medical practice that has an existing patient base may wish to restrict a new hire from competing with the practice when the employee terminates employment. It is not a question of if but when the employee will terminate. In every employee/employer relationship, the employee will ultimately terminate employment, whether due to death, disability, termination (voluntary or involuntarily), retirement, or finding another job.

Enforceability

The enforceability of restrictive covenants presents an excellent example regarding the disparity of the states' treatment of employment agreements. In some states, restrictive covenants are enforceable; in other states, the courts deem these covenants contrary to public policy and unenforceable. A third group of states will enforce such covenants subject to certain limits. In these states, the restriction must be limited as to time (often 1 to 2 years) and to a geographical area that bears a significant relationship to the actual business interests of the medical group. For example, a vascular surgeon in central Illinois whose practice serves a 50-mile radius of his office may be able to enforce a restrictive covenant that covers that 50-mile radius for a 2- or 3-year period. On the other hand, a surgeon working within the Chicago city limits may only be able to enforce such a covenant within a 3- to 5-mile radius, and a surgeon leaving that practice may only lose hospital staff privileges at one or two hospitals.

In addition to the limitations on enforceability, these agreements often face other stumbling blocks. Most states provide that any ambiguity in an agreement should be construed against the party who drafted the agreement (usually the employer). In addition, a restrictive covenant may not be enforced if the employer has materially breached the employment agreement, (ie, not paid compensation or kept other promises, such as setting up a promised 401[k] plan). If an employer has failed to meet its contractual obligations, the employee can argue that the restriction would be unfair to enforce. It is critical therefore that an employer strictly honor its promises if it wants to enforce a restrictive covenant. Finally, if an employee wants to break a restrictive covenant, he or she should seek legal counsel first to determine whether the state honors such agreements and whether the employer has met all of its contractual obligations.

Damages for Breach of Restrictive Covenant Not to Compete

Depending on how the restrictive covenant is drafted, the consequences of such a breach may be monetary damages, an injunction, or both. Monetary damages are generally a dollar award determined by the court or mediator to compensate the employer for lost revenue caused by the breach of agreement. An injunction would prohibit the terminated party from establishing a competing medical practice. Some parties agree in the employment contract to "liquidated damages," which represent the sum that the parties estimate that the employer would likely suffer if the employee were to breach the restrictive covenant. These liquidated damages are generally upheld (in those states that enforce restrictive covenants) so long as it is not perceived as a punitive amount. I recommend liquidated damages to my clients because these provisions reduce the likelihood of future court proceedings regarding the actual business loss incurred by the employer.

To Sign or Not to Sign?

When I represent employers, I encourage them to have a restrictive covenant to protect their patient base. It is unfair for a junior physician to move into a community, be introduced to the patient base and be financially supported by the established medical practice, and then leave the medical practice and significantly damage it by taking a large number of patients. When I represent an employee joining a medical practice, I advise him or her to not enter into an employment agreement with a restrictive covenant unless he or she clearly intends to honor it or unless the restrictive covenant has a prearranged liquidated damages provision, which will allow him or her to "buy out" of the restriction (Table 2). The costs to both parties in any litigation to enforce or breach the restrictive covenant are time consuming, costly, and uncertain because courts are reluctant to enforce such restrictions.

TABLE 2. RESTRICTIVE COVENANTS: ITEMS TO CONSIDER

- Avoid if possible
- Limit geographic range and time
- Consider liquidated damages

MALPRACTICE INSURANCE

Deciding who pays the cost of professional liability insurance for the employee upon the employee's termination is probably the most critical and controversial provision in current employment agreements. The rising cost of malpractice insurance and the grim possibility of exposing your personal assets to a judgment makes this both a costly and essential area of negotiation.

Before analyzing the contractual issues, it is essential to understand a few basic concepts regarding medical malpractice insurance policies. Coverage of a physician under a malpractice insurance policy is triggered by events described in your insurance policy. There are two types of policies that have two very different triggers (Table 3).

Occurrence Policies

These policies cover acts of malpractice that occurred during the policy year, regardless of when the patient or physician is first notified of the alleged malpractice.

Claims-Made Policies

These policies cover acts of malpractice when the claim is reported during that policy year, even if the malpractice occurred years before. This is an important distinction. If the physician is covered by an occurrence policy, he or she is covered for malpractice that occurred during the policy year, even if the malpractice does not manifest itself for years after the policy expires. Under the more prevalent claims-made policy, if the malpractice occurs in 2006, but no claim is made until 2008, the policy that was in effect in 2006 would not provide coverage. A physician under a claims-made policy who terminated employment at the end of 2006 would need to carry insurance to cover those claims that may arise from malpractice that occurred during 2006, but that does not result in a claim until years later.

Tail Policy Coverage

The most common situation I encounter in negotiating employment agreements is whether the employer or the employee is responsible for purchasing the tail coverage for the professional liability coverage after termination of employment. A tail policy covers any lawsuit filed after termination of employment that relates to activities performed by the physician while an employee of the medical practice. Many years ago, most professional liability policies were claims-occurred policies. As a result, there was no need to buy tail coverage because the typical policy provided insurance protection for any claim made for acts that occurred while the physician was an employee, even if the claim did not arise until after termination of employment. Thus, if you are fortunate enough to be covered by a claims-occurred policy, the cost of professional liability insurance after employment is a nonissue. Unfortunately, most insurance policies today are claims-made policies, and it is that type of policy that most of my clients must deal with on a day-to-day basis.

The general rule has been that medical groups will pay for the professional liability coverage during the period the physician is employed. Once the physician terminates employment, however, most medical groups place the burden of purchasing the tail coverage policy on the terminating employee. One exception to this rule may occur if the particular medical specialty has a reasonable professional tail coverage cost.

When I represent medical groups, I always recommend that the medical group does not pay for the tail coverage. When I represent the individual physician, I attempt to carve out situations when the medical group would pay (ie, the employment agreement is terminated because the medical group has materially breached the agreement, or the medical group terminates the employment of the physician without cause). Medical groups are hesitant to pay for tail coverage if they terminate the agreement for cause because it creates a litigious environment, which questions the meaning of "for cause" and "material breach."

An occasional compromise is that the medical group and the physician may agree to split the cost of tail coverage if the physician leaves for whatever reason in the short term. For example, if the physician's employment is terminated within 1 to 2 years of employment, the medical group may pay a portion of the cost (say 50%) and the physician pays the remaining 50%, so long as the physician leaves the area and does not compete with the medical group.

Many factors will determine which posture can be used in negotiating an employment agreement. If the physician is highly trained in a subspecialty, an existing medical group may be willing to make an exception and provide tail coverage as an enticement to the physician to join. On the other hand, if the medical group has had disappointing experiences with physicians voluntarily leaving the group, and not as a result of the group not fulfilling its obligations, then it is more likely they will not make this accommodation.

Employment With Hospital Systems

Because of the economic climate, a number of physicians and physician groups have or are considering becoming

TABLE 3. TYPES OF MALPRACTICE POLICY COVERAGE

- **Occurrence Policies:** Cover acts of malpractice that occurred during the policy year, regardless of when the patient or physician is first notified of the alleged malpractice.
- **Claims-Made Policies:** Cover acts of malpractice when the claim is reported during that policy year, even if the malpractice occurred years before.

employees of hospital systems. The major advantage of joining a hospital system is that the physician generally will be insured under the hospital system's professional liability policy as an employee. Thus, if there is a liability claim, the hospital will defend and pay for any claim because the physician is an employee, not an independent contractor. If you are entering into an arrangement with a hospital system, it is important to clearly identify the following factors: (1) whether you are an employee or independent contractor; (2) whether the hospital system's coverage is self-insured, or insured through a third-party carrier; and (3) the terms and conditions of the hospital system's insurance policy. If it is a claims-occurred policy, there is no need for the physician to have to buy a tail policy when he or she terminates employment. On the other hand, if the hospital policy is a claims-made policy, it is extremely important that the physician's employment agreement with the hospital specify whether the hospital or the physician is responsible for paying for the tail coverage, if any.

Changes to Coverage

You should also be aware that when physicians join a hospital system or any other health care provider, the type of insurance coverage can change. Even if they have a claims-occurred policy on the date of employment, that may not be the situation at the time of termination of employment. Medical groups and hospitals change insurance coverage and policies from time to time depending upon the cost and other circumstances. Therefore, to fully protect yourself, you should clearly spell out in the employment agreement that upon termination of employment, the hospital system will pay all costs and expenses relating to professional liability coverage for the period of employment, including any required tail coverage, regardless of whether the hospital system has a claims-made or claims-occurred policy at the date of employment termination.

Self-Insurance

Because of the dramatic increase in the cost of professional liability insurance policies from traditional insurance carriers, some medical groups have established their own self-insured insurance program. When I negotiate an employment agreement for a physician who joins a medical group that has a self-insurance program, I first advise the physician of the major issues unique to such a program. The establishment of a self-insured insurance program should only be considered if conventional insurance policies cannot be obtained or if the cost of conventional policies is economically prohibitive for the group. Extreme caution and care should be taken when establishing such a self-insured program.

A major detriment is the maintenance of sufficient reserves to cover several significant claims that may occur within a short period of time. Although self-insured programs generally have a supplemental insurance policy to cover a portion of the excess claims, any group seriously considering such a program should do an in-depth analysis of the self-insured program. The group should also analyze how to position the entity's assets and the physicians' individual assets in an asset protection program, in the event the self-insured program does not have sufficient funds to pay significant claims.

CONCLUSION

Your ability to negotiate your employment agreement will be determined in large part by your economic reality and your own needs. If you do not plan to stay at this position long, you may prefer a verbal agreement and a handshake, with the parties filling in the details as you go along, leaving you free to join a competing practice at your leisure, but recognizing the danger of not having a written agreement specifying each party's rights and obligations during and after employment. On the other hand, a physician seeking employment at a sought-after practice with an ample supply of resumes may also find that there is no room to negotiate even the most basic provisions. It is always preferable to get all promises and covenants in writing. You cannot rely upon verbal promises that are not put in the written agreement. Regardless of your situation, it remains important for all fellows to be aware of the terms of their employment agreement and to seek a legal opinion regarding any provision with which you are uncomfortable before you sign. ■

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Components of Physician Reimbursement

2007 endovascular AAA repair coding, coverage, and payment.

BY ALEX AU-YEUNG

The rigors and trials of medical school and residence programs often do not prepare physicians for the potentially confusing and frustrating world of reimbursement. In order to understand physician reimbursement, you need to understand the three key components of reimbursement from the payers' perspective: coding, coverage, and payment. Physician coding is based on International Classification of Diseases (ICD-9) diagnosis codes and Current Procedural Terminology (CPT) codes for procedures. Coverage is based on payer-specific coverage decisions that may limit the coverage of certain procedures based on the appropriate diagnoses. Payment is based on the payer arrangements with the providers. For Medicare, physician payments are based on a physician fee schedule specific to geographic localities. The foundation of these components of reimbursement is built on the complete and concise documentation of the reason for the procedures and description of the procedures performed.

COMPLETE AND CONCISE DOCUMENTATION

Payers such as Medicare make their payment decisions based on precise diagnosis and procedural coding. Accurate coding determines coverage as well as payment decisions for the payer. To code accurately, you must document clearly and completely why the procedure was performed, who performed the procedure, what was done, and how it was performed (Table 1).

COORDINATE PROCEDURE WITH PHYSICIAN COLLEAGUES

Before performing any procedure, especially endovascular abdominal aortic aneurysm (AAA) repair, you must decide with your physician colleagues how the procedure will be performed and coded. Reaching a previous agreement among the physicians will avoid misunderstandings regarding documentation, coding, and equitable payment for specific aspects of the procedure (Tables 2 through 4). For example, if a vascular surgeon and an interventional radiologist are performing the procedure together as co-surgeons (-62 modifier) or as an assistant surgeon (-80 or -82 modifier), both physicians should document their aspect of the procedure and clearly state the components of the procedures performed as co-surgeons or assistant surgeons. Depending on the scenario, Medicare payments can differ greatly based on the documentation and coding of the procedures. It is also helpful to describe why more than one physician is required.

DOCUMENT ALL APPLICABLE DIAGNOSES

Complete identification and documentation of the primary and all other diagnoses impacts Medicare coverage decisions as well as Medicare hospital inpatient payment assignments. Incorrect or nonspecific diagnoses may lead to coverage denials or incorrect Medicare hospital inpatient diagnosis-related group (DRG) assignments. For endovascular AAA repair, the absence of documentation and coding of a complication and/or comorbidity can cause a hospital discharge to track to DRG 111 instead of DRG 110, an average difference of $7,000 per discharge.

ICD-9 Diagnosis Codes

441.4—AAA without mention of rupture; other diagnoses (complications and comorbidities)

TABLE 1. QUESTIONS TO ASK WHEN CODING

Who?	Identify the primary surgeon and other physicians involved in the procedure (eg, co-surgeon, assistant surgeon)
Why?	Identify the applicable principal diagnosis as well as complications and comorbidities (especially important for proper hospital Medicare inpatient payment)
What?	Procedural summary included in your operative note, describing primary procedures performed using key "CPT terminology" to define steps
How?	Detailed description of the order and technique used to perform procedures and the interpretation of the imaging

TABLE 2. SINGLE SURGEON

Single physician operator deploying modular bifurcated stent graft with one docking limb, right and left iliac extension cuff
Medicare Carrier/Locality: National

CPT	Modifier	Modifier	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2007 Adjusted Payment	
34812	50, 51	150%	50%	$265.47	Femoral artery exposure bilateral
36200	50, 51	150%	50%	$112.55	Catheter placement bilateral
34802		100%	100%	$1,251.75	Deploy AneuRx graft
34825	51	100%	50%	$352.64	Deploy extension for AAA right iliac
34826		100%	100%	$206.92	Extension add-on aortic cuff proximal to stent graft
75952	26	100%	100%	$223.97	Endovascular AAA repair radiological supervision and interpretation
75953	26	100%	100%	$67.84	Endovascular AAA repair extension radiological supervision and interpretation
75953	26	100%	100%	$67.84	Endovascular AAA repair extension radiological supervision and interpretation
Physician No. 1				**$2,548.98**	**Total: $2,548.98**

TABLE 3. TWO SURGEONS

Two surgeons deploying modular bifurcated stent graft with one docking limb, right and left iliac extension cuff
Medicare Carrier/Locality: National

CPT	Modifier	Modifier	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2007 Adjusted Payment	
34812	50, 51	150%	50%	$265.47	Femoral artery exposure bilateral
36200	50, 51	150%	50%	$112.55	Catheter placement bilateral
34802	62	62.5%	100%	$782.34	Deploy AneuRx graft co-surgeon
34825	62, 51	62.5%	50%	$220.40	Deploy extension for AAA co-surgeon
34826	62	62.5%	100%	$129.33	Extension add-on co-surgeon
Physician No. 1				**$1,510.09**	
34802	62	62.5%	100%	$782.34	Deploy AneuRx graft co-surgeon
34825	62, 51	62.5%	50%	$220.40	Extension add-on co-surgeon
34826	62	62.5%	100%	$129.33	Extension add-on co-surgeon
75952	26	100%	100%	$223.97	Endovascular AAA repair radiological supervision and interpretation
75953	26	100%	100%	$67.84	Endovascular AAA repair extension radiological supervision and interpretation
75953	26, 59	100%	100%	$67.84	Endovascular AAA repair extension radiological supervision and interpretation
Physician No. 2				**1,491.72**	**Total: $3,001.81**

TABLE 4. ASSISTANT SURGEON

Primary and assistant surgeon deploying modular bifurcated stent graft with one docking limb, right and left iliac extension cuff
Medicare Carrier/Locality: National

CPT	Modifier	Modifier	Multiple Procedure Modifier Adj Pymt = Adjusted Payment (-51)	2007 Adjusted Payment	
34812	50, 51	150%	50%	$265.47	Femoral artery exposure bilateral
36200	50, 51	150%	50%	$112.55	Catheter placement bilateral
34802	80	16.0%	100%	$200.28	Deploy AneuRx graft assistant
34825	80, 51	16.0%	50%	$56.42	Deploy extension for AAA assistant
34826	80	16.0%	100%	$33.11	Extension add-on assistant
Physician No. 1				**$667.83**	
34802		100.0%	100%	$1,251.75	Deploy AneuRx graft
34825	51	100.0%	50%	$352.64	Extension add-on
34826		100.0%	100%	$206.92	Extension add-on
75952	26	100%	100%	$223.97	Endovascular AAA repair radiological supervision and interpretation
75953	26	100%	100%	$67.84	Endovascular AAA repair extension radiological supervision and interpretation
75953	26, 59	100%	100%	$67.84	Endovascular AAA repair extension radiological supervision and interpretation
Physician No. 2				**$2,170.96**	**Total: $2,838.79**

TABLE 5. MODIFIERS THAT IMPACT MEDICARE-ALLOWABLE PAYMENTS

Modifier	Description	Payment Impact
26	Professional component	Professional component of Medicare fee schedule
50	Bilateral procedure	150% of Medicare fee schedule
51	Multiple procedure reduction	50% reduction of Medicare fee schedule applied to select surgical procedures
59	Distinct procedure or service	Overrides coding edits for duplicate procedures
62	Two surgeons work together as primary surgeon	62.5% of Medicare fee schedule
80	Assistant surgeon	16% of Medicare fee schedule

SUMMARIZE PROCEDURES USING CPT TERMINOLOGY

Incorporating a summary in your documentation of procedures performed will simplify and eliminate coding confusion. By using key CPT code descriptions in the summary, your coder will be able to identify the correct code to bill. Specifically identifying the endovascular AAA stent graft type will help identify the correct CPT code to bill for the procedure. The stent graft design impacts the coding for the procedure.

CPT 2007 Code Descriptions: Prosthesis Code

34802—Modular bifurcated prosthesis with one docking limb (AneuRx, Medtronic Vascular, Santa Rosa, CA; Excluder, Gore & Associates, Flagstaff, AZ).

34803—Modular bifurcated prosthesis with two docking limbs (Zenith, Cook Medical, Bloomington, IN).

34804—Unibody bifurcated prosthesis (PowerLink, Endologix, Inc., Irvine CA).

CPT 2007 Code Descriptions: Procedural Code

34812—Open femoral artery exposure for delivery

of endovascular prosthesis, by groin incision, unilateral.

(Note: Closure is considered part of the procedure and is not coded or reimbursed separately.)

36200—Introduction of catheter, aorta.

34802—Endovascular repair of infrarenal AAA or dissection using modular bifurcated prosthesis (one docking limb).

75952-26—Endovascular repair of infrarenal AAA or dissection, radiologic supervision and interpretation; professional component.

34825—Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal AAA or iliac aneurysm, false aneurysm, or dissection; initial vessel.

75953-26—Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiologic supervision and interpretation; professional component.

34826—Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal AAA or iliac aneurysm, false aneurysm, or dissection; each additional vessel (list separately in addition to code for primary procedure).

DOCUMENT IN DETAIL THE TECHNIQUE AND FINDINGS

The body of the documentation should clearly describe the technique used to perform the intervention listed in the operative note summary. You or your certified coder will use this component of your documentation to determine the appropriate CPT codes and necessary modifiers. Modifiers are used to describe the specific situation or circumstance in which the procedure was performed, as well as to affect how much the procedure will be reimbursed (Table 5).

CONCLUSION

Complete and concise documentation simplifies coding, eliminates coverage denials, and expedites and ensures accurate payment. The mystery of physician reimbursement becomes clearer as you understand and use CPT descriptions in your documentation and make use of professional coding resources from the Society of Vascular Surgery and the Society of Interventional Radiology. ■

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Governmental Regulations Affecting Medical Practices

What you need to know about the Anti-Kickback Act, Stark Law, and the False Claims Act.

BY BLAIR A. KEAGY, MD

As compensation for professional services decreases and practice overhead increases, physicians have turned to ancillary services to maintain financial viability. As providers add new service lines and enter into relationships with hospitals and other entities, they face regulations that are easily violated if laws affecting these programs are not understood. This article provides an overview of legal constraints that may affect physician practices.

ANTI-KICKBACK ACT

The federal Anti-Kickback Act was intended to protect patients and federal health care programs by eliminating the corrupting influence of money on health care decisions. Anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business can be accountable under this law and may result in up to 5 years in prison, criminal fines of up to $25,000, civil penalties up to $50,000, and exclusion from participation in federal health care programs. Penalties may apply to all parties in the transaction. In addition, the tax-exempt status of a hospital or other exempt facility may be jeopardized for violations of the Anti-Kickback Act. As opposed to the Stark Law, the Anti-Kickback statute is a felony offense.

A flagrant example would be payment of cash by a surgeon to members of a family practice group in return for their referral of patients for operative procedures. A receipt of payment by a physician from another entity also constitutes a violation (see the sidebars for examples of physician culpability).

The Anti-Kickback Act is very broad and thus alarmed health care providers because they had the potential for prosecution for relatively innocuous arrangements. In 1987, Congress authorized the Office of the Inspector General (OIG) to design "safe harbors" for various arrangements that might have benefit but in which the participants could potentially face felony litigation. These safe harbors immu-

ANTI-KICKBACK CASE STUDIES

CASE 1. CASH PAYMENTS FOR REFERRALS

During an investigation of a clinical laboratory in Florida for massive Medicare fraud, it was discovered that the entity had been paying kickbacks to physicians in return for their referrals. Prosecutors accused primary care physicians of receiving nearly $1 million in bogus consulting fees in return for their business. It was determined that the lab paid monthly fees between $500 and $1,500 to consulting physicians based on the volume of their referrals. Their duties were defined as "medical review" or "test review." In one case, the laboratory paid the annual fee for a physician's hunting lodge membership. Twelve of these providers were indicted for violating the federal Anti-Kickback law. Two of the physicians were convicted at trial and sentenced to prison terms in addition to monetary fines. The remaining 10 physicians pleaded guilty, and they faced probation and community service in addition to fines. All 12 physicians faced mandatory 5-year exclusion from Medicare and Medicaid. The government did not contest the fact that the blood tests they had ordered were medically necessary.[1]

CASE 2. BILLING FOR FREE SAMPLES

In one of the largest health care fraud settlements in history, TAP Pharmaceuticals (Lake Forest, IL), agreed to pay $875 million to resolve civil and criminal charges based on marketing conduct and fraudulent drug pricing. TAP provided free samples of its drug Lupron to physicians who subsequently sought Medicare reimbursement for administering the free sample. Five physicians were charged and were alleged to have conspired to receive excessive Medicare reimbursements. TAP was also charged with giving physicians excessive gifts including trips to golf and ski resorts and free consulting services. Legal claims included conspiracy to defraud Medicaid, conspiracy to violate the prescription drug marketing act, and violations of the federal Anti-Kickback statute.[2]

nize certain payment and business practices from prosecution. They included such things as investments in ambulatory surgical centers (ASC), joint ventures in underserved areas, practitioner recruitments in underserved areas, subsidies for obstetrical malpractice insurance in underserved areas, and cooperative hospital services organizations.

In 2006, the OIG established a new safe harbor under the federal Anti-Kickback Act for certain arrangements related to electronic prescribing and electronic health records. It would protect hospitals and other entities that provide recipients, such as physician practices, with nonmonetary remuneration in the form of computer hardware or software. These regulations became effective October 10, 2006.

STARK LAW

The Stark Law, also known as the Ethics in Patient Referrals Act, became effective January 1, 1992 and was known as Stark I after Fortney "Pete" Stark, representative from the state of California. It prohibits physicians from making referrals to entities in which that physician or an immediate family member has a financial relationship. The purpose behind the Stark Law was to prevent abuse in the medical system stimulated by a physician's financial gain when ordering unnecessary tests or treatments. Ownership interest can be direct or indirect, such as through a holding company. Penalties for violation of the Stark Law range up to $15,000 for each service and exclusion from federal health care programs. Lack of knowledge of the provisions of the law does not preclude liability. The government defines the services called Designated Health Services (DHS) that are covered by this law. They include:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Speech and language pathology services
- Radiology services including MRI and CT scans
- Radiation therapy services
- Durable medical equipment
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Nuclear medicine studies were previously exempted from the Stark Law, but this changed in January of 2007.

Of importance to the practicing physician is the existence of exceptions that do permit a physician's financial participation in DHS. However, understanding the complexities of these exceptions is difficult. Examples include fair market value compensation arrangements, certain space and equipment rentals, and some types of incentive plans in the managed care setting.

One of the most widely used exceptions is that which applies to properly organized group practices. If the practice functions as a group and provides medical services to its patients, physicians in the group are permitted to engage in various ancillary services that fall under DHS. The service must be seen as an extension of the practice, and restrictions on the location of the facility and type of supervision must be met. Case 3 includes two examples of Stark Law violations.

In summary, the existence of three tenets constitute a Stark Law violation:

- The existence of a financial relationship between a physician or family member and another entity

STARK CASE STUDIES

CASE 3. REFERRAL TO HEALTH CARE SYSTEM WITH FINANCIAL INTEREST

A physician owner of a medical clinic settled allegations that he violated the Stark Law by paying a fine of $1.7 million. The government stated that patients were referred to a home health agency where the physician had a significant ownership interest.

In a similar case, a lawsuit was lodged against an orthopedic surgeon stating that the surgeon illegally referred patients to a home health care system in which he had a significant financial interest. The lawsuit stated that 48 patients were self-referred and this resulted in Medicare/Medicaid billings totaling $250,000. The dollar amount of the settlement was not made public.[3]

CASE 4. UNDERCHARGING FOR OFFICE SPACE AND NURSING CARE

A physician group and a hospital in Rapid City, South Dakota, paid more than $6.5 million in fines to settle allegations that they violated the Stark Law. They were alleged to have billed Medicare for services that resulted from referrals from physicians with whom it had improper financial relationships. The hospital allegedly rented office space to physicians at only 10% of the market value and undercharged physicians for nursing services. The entities did not meet the exception requirements to the Stark Law. Various compensation arrangements do fall under the exception requirements such as personal service agreements and leases, but they are generally required to be consistent with fair market value. The parties denied guilt and agreed to enter Corporate Integrity Agreements with the federal government to ensure future compliance.[4]

- Proof that the physician referred a patient to the entity for a DHS
- An exception does not exist

One of the central tenets of the "in-office" exception is that physicians must not receive compensation based directly or indirectly on the volume of DHS referrals. In addition, the service supplied must generally be in the same building as the offices of the practice. However, it may be performed in another building if the practice owns or leases the space on a full-time basis. In-office ancillary services must be directly supervised. Case 4 is an example of an improper physician/hospital relationship that was alleged to have violated the Stark Law.

There are legal firms that specialize in Stark Law arrangements, and the Medical Group Management Association has a section of its Web site dedicated to understanding the law's complexities.

STARK LAW VERSUS ANTI-KICKBACK ACT

There is sometimes confusion regarding the differences between the Stark Law and the Anti-Kickback Act. The following points emphasize these differences:

- The Anti-Kickback statute includes criminal and civil penalties for entities or individuals that knowingly pay, offer, or receive financial remuneration to generate referrals covered under the CMS services, whereas the Stark Law results only in civil penalties.
- The Anti-Kickback statute encompasses all services covered under governmental programs, whereas the Stark Law refers to a list of DHSs.
- The Stark Law generally applies to physicians, whereas the Anti-Kickback statute is a more broadly encompassing statute.
- The Anti-Kickback Act generally requires a demonstration of intent to violate the law.

In some cases, financial arrangements between physicians and hospitals may violate both the Stark Law and the Anti-Kickback Act.

FALSE CLAIMS ACT

The False Claims Act is sometimes referred to as the "Lincoln Law." The purpose of the law was to respond to fraud from companies selling supplies to the Union Army. One example of this was shipping boxes of sawdust to the military instead of guns. Under its provisions, private citizens known as "realtors" could sue offending companies, and they received 50% of the amount recovered. The government received the rest. These were the first whistle-blowers.

The law was revised and, in 1986, it prohibited any type of fraud against the US government. With regard to health care, it prohibits the deliberate submission of a false or fraudulent claim for payment from any federal health care program. In addition, "whistle-blowers" receive anywhere from 15% to 30% of monies recovered by the government. Attorneys representing these individuals or entities are guaranteed compensation for their regular hourly fees. Examples of false claims include:

- Claim for a service not reasonable and necessary
- Claim for a service that was never provided
- Claim for a service in which the diagnosis code has been knowingly listed incorrectly
- Claim for a service provided by an unlicensed practitioner
- Claim for a higher level of service than was provided

CMS violations result in penalties of up to $2,000 for each improper item or service. The practice is also liable for civil penalty between $5,500 and $11,000 for each false claim and could be held liable for three times the amount of the claim. In the first 6 months of the 2005 fiscal year, settlements in judgments falling under the False Claims Act amounted to nearly $900 million. An example of a False Claim violation is shown in Case 5.

FALSE CLAIMS CASE STUDY

CASE 5. BILLING FOR UNNECESSARY OR UNPROVIDED SERVICES

A Roswell, Georgia obstetrician was accused of billing the Medicaid program for services that were never provided and services that were not medically necessary. He billed Medicaid for patients he had never seen and for sonograms that were not provided. In one case, he billed Medicaid for 92 sonograms on a single patient over a 3 1/2 year period. He pled guilty to defrauding Georgia's Medicaid program of more than $1 million. He was sentenced to 5 years in prison, ordered to pay restitution of $1,055,000, serve 500 hours of community service, surrender his medical license, and was banished from the Georgia Medicaid program.[5]

GAINSHARING

Gainsharing originated with manufacturing firms, and many large companies allow workers to share financially in productivity improvements as a result of workers' contributions. In health care, gainsharing is an arrangement whereby a physician or group of physicians develops cost-saving measures in certain treatment protocols, which would result in financial savings. In this type of arrangement, the hospital and the physician or physicians would share the profits gained from this endeavor.

Although in some cases such streamlined programs might be beneficial, the OIG has usually indicated that

these associations violate the Civil Monetary Penalties section of the Social Security Act. This prohibits hospitals and physicians from conspiring to reduce benefits to Medicare beneficiaries. Fines of up to $2,000 may be imposed for each affected patient.

There have been cases where the OIG has sanctioned some gainsharing arrangements. This occurred at an Atlanta hospital in reference to a cardiac surgical program. Subsequent to this, however, a federal court ruled that another gainsharing arrangement at the Robert Wood Johnson Hospital in New Jersey was in violation of the law and ordered the program terminated. Because of the potential benefit of gainsharing programs for patient efficiency and safety, the OIG is allowing six new programs to function on a trial basis starting in 2007.

FEDERAL REGULATIONS

In addition to the previously mentioned laws, there are additional areas in which physicians may face federal regulations. Five of them are listed in the following paragraphs.

Concierge Medicine

Physicians have had to expand their patient base in order to maintain the financial integrity of their practice. Many providers believe this results in a decrease in the quality of care. In order to provide quality care to a smaller number of individuals, some practices utilize concierge medicine.

In this instance, the patient pays a fee to the practice for preferred treatment, which may include longer office visits, physician accompaniment to a visit with a specialist, and 24/7 access to the physician or the practice. This fee is paid in addition to the health care premiums charged by third-party providers. Problems may arise with CMS if they believe any of the added services are covered by their Medicare benefits.

Medical Directorships

In the past, medical directorships were used by hospitals as a means of conveying money to a physician or group of physicians who served as directors of various programs in the hospital. In many instances, the duties of the medical director were not specified, and the amount of compensation was excessive. Theoretically, hospitals could use this mechanism to maintain the loyalty of physicians on its staff and ensure the flow of patients to the institution for diagnostic and therapeutic procedures.

In many cases, medical directors serve a valuable function, although it is probably best to refer to these as *medical consultation agreements*. The hospital should specify the duties that will be performed by the medical director and the time that will be spent in these efforts. The compensation should be at fair market value.

Industry-Physician Relationships

There is increasing concern by the government, the public, and the medical community about actions of the pharmaceutical and device industries when attempting to get their product to the marketplace. Several large firms have been indicted for their actions in this regard.

In addition, there is growing concern about the influence that gifts and payments from the pharmaceutical and device manufacturing industry have on various treatment recommendations by physicians. The pharmaceutical industry has developed a code of ethics relative to physician relationships, and device manufacturers have done the same. Their latter code of ethics (AdvaMed) is a voluntary commitment to facilitate ethical interactions with health care providers and those responsible for purchasing medical equipment.[6]

ASCs

ASCs have some special considerations with regard to legal statutes. Most of these entities are established as limited liability companies and may be owned by physician groups or in conjunction with a hospital. They are subject to accreditation by various national organizations including a Medicare certification if they accept CMS patients. In some states, a Certificate of Need is required.

Generally, the Stark Law does not apply in these arrangements because global payments for the facility include routine testing as a part of the surgical procedure. The professional fee is billed by the physician's office. With regard to the Anti-Kickback Act, certain safe harbors apply to the ASC. Their purpose is to ensure that physicians and surgeons use the ASC to perform procedures related to their practice and not solely for economic gain.

Advanced Beneficiary Notice

In the case of noncovered services, the beneficiary of such services is expected to pay unless he or she had no way of knowing that the services were not covered. In these cases, the physician may ask the patient to sign a form indicating that there was prior knowledge that the service would not be covered. This form must be signed if the physician wants to bill the patient.

In an emergency situation when the patient is incapable of signing, the physician cannot seek payment from the patient. If the patient needs treatment and refuses to sign such a form, the physician can choose either not to provide the service or to provide the service realizing that he/she may not receive payment.

CONCLUSION

Economic realities in today's health care environment have placed a significant strain on medical practices. Physicians have increased their clinical volume in an effort to maintain the financial viability of their practices. A point has been reached, however, where increasing patient load will have a detrimental effect on the quality of care. For this reason, many practices have looked for alternative sources of funding. As ancillary services are added, providers face a number of federal and state regulations, many of which were described in this article. The statements and descriptions in this article were not meant to provide legal advice. Rather, the article serves as a means of familiarizing physicians with the problems they will face and the areas in which they will most likely need legal counsel. ■

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