THE STARK EXCEPTION FOR ANCILLARY PHYSICAL THERAPY AND OTHER ANCILLARY SERVICES

The following is a detailed explanation of the “in-office ancillary services” exception in the Stark Rules.

Statutory Background

Section 1877 of the Social Security Act, which is commonly referred to as the “Stark Rules,” was enacted in 1989. As originally enacted, the Stark Rules prohibited a physician from referring a patient for clinical laboratory services if the physician or any member of the physician’s immediate family had a financial relationship in the lab. Congress broadly defined “financial relationship” as including any ownership or investment interest or compensation arrangement between the physician or an immediate family member and the entity.[1] In 1993, Congress expanded the Stark Rules to cover ten designated health services (“DHS”), including physical and occupation therapy services.[2]

The Stark Rules contain specific exceptions that are intended to permit physician referrals in situations where the potential for abuse is minimal, including an exception for “in-office ancillary services.” Among other exceptions, the referral restriction does not apply to ancillary services that are furnished by an individual supervised by a physician in the group practice[3] in a building used by the group and billed under the group’s Medicare provider number.[4]

Regulations

CMS issued regulations, which provide more definitive guidance, state that the “in-office ancillary services” exception to the Stark referrals restriction will apply if three requirements relating to (1) physician supervision, (2) service location and (3) billing are satisfied.[5] These requirements are explained below.

Supervision Requirement

To satisfy the supervision requirement, ancillary services must be furnished personally by one of the following individuals: (a) the referring physician, (b) a physician who is a member of the same group practice as the referring physician, or (c) an individual who is supervised by the referring physician or by another physician in the group practice, provided the supervision complies with all other applicable Medicare payment and coverage rules for the services.[6]

Medicare coverage and billing rules that are applicable to the specific service apply in determining the level of physician supervision. For example, Medicare allows physician groups to bill for physical therapy services under the “incident to” rules[7] or therapist in private practice rules.[8] The “incident to” rules require the physician to “directly supervise” therapy. “Direct supervision” requires the physician to be present in the office suite and immediately available to provide assistance and direction throughout the

time the therapist is performing services.[9] Therefore, if a group bills Medicare under the "incident to" rules, the Stark reference to Medicare supervision requirements effectively requires the supervising physician to be present in the office suite where the therapy is provided.

In contrast, if the group bills Medicare for therapy services under the therapist in private practice rules, a physical therapist can personally supervise the services.[10] A physician need only certify the need for therapy.[11] Therefore, because the therapist in private practice rules do not require personal or direct physician supervision, physician groups billing therapy under these rules can satisfy the Stark supervision requirements with or without a physician on site.

Location Requirement

The location requirement allows a physician group to provide ancillary services either (1) in the "same building" [12] in which the group has a physician office[13] or (2) in a "centralized building"[14] that does not require a physician to be on site.

If a solo practitioner or group practice uses the "same building" option, the ancillary services must be provided at the same street address as an office of the solo practitioner or group.[15]

Two or more groups and/or solo practitioners can share ownership of ancillary services in the same building if they otherwise comply with the supervision and billing requirements of the in-office ancillary services exception. To comply, each group or solo practitioner that shares ownership must have a physician office in the building in which the ancillary facility is located.[16]

Ancillary services can also be provided in a "centralized building"[17] that is used by a group practice for the provision of some or all of the group practice's DHS.[18]

A group that uses the centralized building alternative will be subject to fewer restrictions than a group that uses the same building alternative. The centralized building alternative can be used whenever a single group practice owns the ancillary services as compared to sharing ownership with other physicians or groups. Because only a single group practice can use the centralized building alternative, solo practitioners can only use the same building alternative.

The "centralized building" alternative was intended to accommodate the concerns of group practices with multiple office locations that wanted to consolidate DHS operations for cost containment purposes. CMS has stated that even though Congress permitted group practices to provide centralized DHS, it did not intend to eviscerate the "in-office" element of the exception. CMS therefore interpreted the "centralized building" standard as requiring that the space (whether an entire building, subpart of a building or mobile unit) used for the provision of DHS be used exclusively by the group on a full-time basis (i.e., 24 hours per day, 7 days per week). To preclude part-time arrangements in the form of one-day rentals, CMS required that the "centralized building" be owned or leased exclusively by the group for at least six months. This rule precludes facilities shared by group practices in off-site buildings.[19]

Even though the "centralized building" provision was intended to accommodate the concerns of group practices with multiple office locations that wanted to consolidate DHS operations for cost containment purposes, CMS stated that it can discern nothing in the statue or legislative history that would prevent a group practice with only one office location from using a centralized building for the provision of DHS.[20]

CMS has also stated that referrals for ancillary services to a group practice from physicians not in the group or other group practices do not violate the Stark Rules, provided there are no impermissible financial relationships between the parties.[21]

If the "exclusive use" condition is met, a group practice should opt to locate ancillary services in a "centralized building," rather than in the "same building." If a group uses the centralized building alternative, it will not be subject to several conditions required to meet the "same building" standard.

This avoids a potential conflict between the ability of a group to accept DHS referrals from other groups and the requirement that the receipt of DHS not be the primary reason that the patient comes in contact with the referring physician or the group because this requirement only applies if the group uses the "same building" alternative.

Billing Requirement

The third condition required to meet the in office ancillary services exception is that the ancillary services must be billed by one of the following: (a) the physician performing or supervising the service, (b) the group practice of which the performing or supervising physician is a member under a billing number assigned to the group practice, (c) the group practice if the supervising physician is a "physician in the group" (as defined in 42 C.F.R. §411.351) under a billing number assigned to the group, (d) an entity that is wholly owned by the performing or supervising physician or by that physician's group practice under the entity's own billing number or under a billing number assigned to the physician or group, or (e) an independent third party billing company acting as an agent of the physician, group practice, or entity specified in (a) through (d) above under a billing number assigned to the physician, group practice, or entity. For these purposes, a group practice may have, and bill under, more than one Medicare billing number, subject to any applicable Medicare program restrictions.[22]

Wholly owned entities that qualify to do the billing under this rule may use their own billing numbers and need not use a number assigned to the physician or group practice that owns them. The entities must be wholly owned either by the physician performing or supervising the services or by the group practice; joint ventures between group practices and individual group practice physicians or that include other providers or investors do not qualify as wholly owned entities.[23]

Independent third-party billing companies may bill for ancillary services if they are acting as agents of a solo practitioner, group practice or entity, but the billing must be done under billing numbers assigned to the solo practitioner, group practice or entity, and the services may not be separately billed under the billing company's number.[24]

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[1] 42 U.S.C. §1395nn(a)(2).
[2] *Id.* at § 1395nn(h)(6).
[3] "Group practice" is defined in 42 U.S.C. §1395nn(h)(4) and 42 C.F.R. §411.352.
[4] 42 U.S.C. §1395nn(b)(2).
[5] 42 C.F.R. §411.355(b).
[6] 42 C.F.R. §411.355(b)(1)
[7] 42 C.F.R. §410.26; Medicare Benefits Policy Manual (MBPM) Ch. 15 §230.5.
[8] 67 Fed. Reg. 79987 (Dec. 31, 2002); 42 C.F.R. §410.60; MBPM Ch. 15 §230.4.
[9] 42 C.F.R. §410.26, 410.32(b)(3)(ii); MBPM Ch. 15 §230.5.
[10] 42 C.F.R. §410.60(a)(3)(ii), (c)(2); MBPM Ch. 15 §230.5.
[11] 42 C.F.R. §410.61, 424.24(c); MBPM Ch. 15 §220.
[12] "Same building" is defined as a structure with, or a combination of structures that share, a single street address as assigned by the U.S. Postal Service, excluding all exterior spaces (for example, lawns, courtyards, driveway, parking lots) and interior parking garages. For purposes of this rule, the "same building" does include a mobile vehicle, van or trailer. 42 C.F.R. §411.351.
[13] The extent to which physician services must be provided in the "same building" is explained in 42 C.F.R. §411.355(b)(2)(i). This requirement is satisfied if the physician office is open for patient care at least 35 hours/week and one or more group physicians regularly practice medicine there at least 30 hours/week. If this requirement is not met, the regulation provides two alternatives.
[14] 42 C.F.R. §411.355(b)(2).
[15] 42 C.F.R. §411.351.
[16] *Id.*
[17] A "centralized building" is defined as all or part of a building, including a mobile vehicle, van, or trailer that is owned or leased on a full-time basis (that is 24 hours per day, 7 days per week, for a term of not less than 6 months) by a group practice and that is used exclusively by the group practice. Space in a building or a mobile vehicle, van or trailer that is shared by more than one group practice, by a group practice and one or more solo practitioners, or

by a group practice and another provider (for example, a diagnostic imaging facility) is not a centralized building for purposes of this rule. This provision does not preclude a group practice from providing services to other providers (for example, purchased diagnostic tests) in the group practice's centralized building. In addition, a group practice may have more than one centralized building. 42 C.F.R. §411.351.

[18] 42 C.F.R. §411.355(b)(2)(iii).

[19] 42 C.F.R. § 411.351.

[20] 66 Fed. Reg. 3, 892.

[21] 66 Fed. Reg. 3, 893.

[22] 42 C.F.R. §411.355(b)(3).

[23] *Id*. at (b)(3)(iv).

[24] *Id*. at (b)(3)(v).