Recent OIG Advisory Opinion has Implications for Certain Contractual Arrangements Between Independent Medical Practices

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The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services recently published an advisory opinion (issued: November 5, 2013; posted: November 12, 2013) unfavorable to a proposed arrangement between an anesthesia services provider and a psychiatry practice group for the provision of anesthesia services in connection with electroconvulsive therapy (ECT) procedures (the Proposed Arrangement). While limited to the facts presented, this advisory opinion may have broader implications for certain types of professional service arrangements between independent medical practices, as further discussed below.

Background

The advisory opinion was requested by an anesthesia group practice (the Requestor). In 2011, the Requestor was in the process of renegotiating its long-standing exclusive arrangement with a particular hospital (the Hospital) for the provision of anesthesia services other than pain management. The psychiatry practice group (the Psychiatry Group), which performs ECT procedures, had previously relocated to the Hospital in late 2010. One of the physician owners of the Psychiatry Group, identified in the advisory opinion as "Dr. X," is board certified in both anesthesiology and psychiatry.

The Psychiatry Group and Dr. X factored into the Requestor's contract negotiations with the Hospital. The Hospital insisted that its 2011 contract with the Requestor permit Dr. X to provide anesthesia services for ECT patients at the Hospital as a "carve out" to the Requestor's exclusive arrangement with the Hospital, with the Requestor also agreeing to provide coverage for Dr. X. The 2012 contract between the Hospital and the Requestor also contained this exclusivity carve-out and a similar coverage requirement with respect to Dr. X. The 2012 contract also provided that if either the Hospital or the Psychiatry Group determined that an additional anesthesiologist was needed for Hospital ECT procedures, the Psychiatry Group would enter into good-faith contract negotiations with the Requestor for the Requestor to provide such anesthesia services. This particular provision, which the OIG referred to as the "Additional Anesthesiologist Provision," also provided that if such negotiations failed, and if the Psychiatry Group's last offer to the Requestor was at fair market value (as reasonably determined by the Hospital), either the Psychiatry Group or Dr. X could contract with another anesthesiologist to provide anesthesia services for ECT without violating the Requestor's exclusive arrangement with the Hospital.

The Proposed Arrangement

After the 2012 contract between the Requestor and the Hospital went into effect, the Psychiatry Group informed the Requestor that an additional part-time anesthesiologist was needed for Hospital ECT procedures and offered the Proposed Arrangement. Under the Proposed Arrangement, the Requestor would provide an anesthesiologist for ECT procedures every Monday and as necessary to provide vacation coverage for Dr. X and emergent coverage. The patients receiving such procedures would include beneficiaries of federal healthcare programs, such as Medicare and Medicaid. The Requestor would reassign its right to bill for anesthesia services provided during such periods to the Psychiatry Group. In return, the Psychiatry Group would pay the Requestor at a fixed, per-diem rate. In requesting this advisory opinion, the Requestor indicated that the per-diem rate would be below fair market value and also less than what it would receive if it billed directly for

the services. Thus, under the Proposed Arrangement, the Psychiatry Group would in effect net the difference between the amounts collected and the per-diem payments made.

The OIG's Analysis

According to the OIG, this flow of funds could implicate the federal anti-kickback statute.[1] First, the per-diem payments to the Requestor would not qualify for protection under the professional services/management contracts safe harbor to the anti-kickback statute, since these payments would be neither set in advance (in aggregate) nor consistent with fair market value. Second, there would be no safe-harbor protection for the Psychiatry Group's retention of the difference between its revenues from the Requestor's anesthesia services and its per-diem payments to the Requestor. It was this aspect of the Proposed Arrangement, coupled with the Additional Anesthesiologist Provision, that apparently caused the OIG greatest concern:

> The Proposed Arrangement appears to be designed to permit the Psychiatry Group to do indirectly what it cannot do directly; that is, to receive compensation, in the form of a portion of the Requestor's anesthesia services revenues, in return for the Psychiatry Group's referrals of ECT patients to Requestor for anesthesia services. The Additional Anesthesiologist Provision gave the Psychiatry Group the ability to solicit this remuneration for its ECT patient referrals by allowing the Psychiatry Group to contract with an anesthesiologist other than Requestor if Requestor and the Psychiatry Group were not successful in negotiating the terms of an agreement for Requestor to provide ECT anesthesia services.

According to the OIG:

> The Additional Anesthesiologist Provision is the vehicle that makes the Proposed Arrangement possible; if the Additional Anesthesiologist Provision had not been included in the 2012 Contract, Requestor's exclusivity rights would have precluded the Psychiatry Group from billing for any anesthesia services provided at the Hospital other than those provided by Dr. X.

Note, however, that the Additional Anesthesiologist Provision is contained in a contract between the Requestor and the Hospital. This advisory opinion did not formally considered the Hospital's relations with either the Requestor or the Psychiatry Group. But that did not prevent the OIG from offering the following:

> Although we have not been asked to opine on, and express no opinion regarding, any aspect of Requestor's relationship with the Hospital, we cannot exclude the possibility that: (i) the Hospital agreed to negotiate for the Additional Anesthesiologist Provision in exchange for, or to reward, the Psychiatry Group's continued referral of patients to the Hospital for ECT procedures; (ii) the Hospital leveraged its control over its large base of anesthesia referrals to induce Requestor to agree to the Additional Anesthesiologist Provision; and (iii) Requestor agreed to the Additional Anesthesiologist Provision in exchange for access to the Hospital's stream of anesthesia referrals.

Conclusion

Given the set facts provided by the Requestor, the OIG determined that the Proposed Arrangement would involve a significant risk of generating prohibited remuneration under the anti-kickback statute. OIG advisory opinions are limited to the facts provided by the requesting parties, and it is not clear how far concerns expressed under this advisory opinion may generalize to other practice service arrangements, particularly those not involving provisions like the Additional Anesthesiologist Provision in hospital contracts. Nonetheless, this advisory opinion may have troubling implications for existing independent contractual arrangements between separate medical practices and/or individual physicians, where one party reassigns its billing rights for professional services to the other and is paid by the other for such services at specified contractual rates. Even where these arrangements have been structured to satisfy the professional services/management contracts safe harbor, thus protecting the contractual service-rate payments, if revenues from reassigned

1 42 U.S.C. § 1320a-7b(b).

claims exceed such payments, the government may view the difference as prohibited remuneration. To access this advisory opinion, please click here.[2]

2 http://oig.hhs.gov/compliance/advisory-opinions/index.asp#2013.

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