



**If** your physician practice is exempt from the Stark law prohibition on self-referrals because it meets the "group practice" exception, changes are on your horizon as the government seeks to redefine what ancillary services can be operated by a physician group in its offices. The government is also looking to change the rules on purchased radiology reads and to add new requirements for independent diagnostic testing facilities. Meanwhile, a Florida court of appeals holds that the Florida Medical Association would not be immune under the Florida peer review immunity statute if it sanctioned a physician for the expert testimony he gives in a professional liability lawsuit. And a recent New York Times story on a Dartmouth Medical School study of the frequency of cardiac surgeries, angioplasties and drug treatment fuels the debate on financial impacts on medical decisionmaking. **This, and more, in this month's edition of the newsletter.**

#### **CHANGES IN THE WORKS**

##### **CMS Target: "Pod Labs"**

If you have ever thought about avoiding the federal prohibition against self referrals by leasing a cubicle in which you can perform laboratory services that you would bill and collect for, think again. One of the key exceptions to the federal Stark law (the statute that prohibits physicians from referring patients for "designated health services" by companies owned by the physicians) allows physician groups to provide testing, laboratory and other ancillary services if the services qualify as "in-office ancillary" services performed by a "group practice." Key to meeting those qualifications is whether the physician group operates in a "centralized building." In the Federal Register on August 8, 2006, the Centers for Medicare and Medicaid Services proposed changing the "centralized building" definition. In the proposed change, the leased space would have to exceed 350 square feet. Further, the equipment needed to perform the services there would have to be permanently located in that space. The commentary to the rule says the changes are targeting "pod laboratories," which have already been under CMS's scrutiny. In pod laboratories, the "lab" is little more than a cart that is moved between cubicles leased by different physician groups in one small room.

##### **No longer able to purchase the technical component as usual?**

Also proposed in the August 8, 2006 Federal Register is a new rule about purchased diagnostic tests in contractual arrangements. The contractual arrangement exception would include the anti-markup requirements found in the purchased diagnostic test exception. That means that if the technical component of a diagnostic test would be billed by a physician under a reassignment vis a vis a contractual arrangement, the amount billed to Medicare, minus deductibles and copays, must be the lowest of (1) the physician or the other provider's net charge to the billing physician or medical group; (2) the billing physician's or medical group's actual charge; or (3) the fee schedule amount had the physician billed directly. The proposal also suggests that the following should be adopted: (1) the test must be ordered by a physician who is financially independent of the person or entity performing the test and of doing the interpretation, (2) the physician performing the interpretation does not see the patient, and (3) the physician billing must have performed the technical component of the test. CMS is soliciting comments to this proposal.

[Email us](#) to request consultation about purchasing diagnostic tests.

## **Peer Review Immunity Analyzed**

Both Florida statutes and the federal Health Care Quality Improvement Act provide immunity to a member of a peer review body that operates to evaluate peer/physician performance for the purpose of improving quality. A Florida Court of Appeal addressed those statutes in an opinion filed July 11, 2006 against the Florida Medical Association and individual physicians. In the case, a physician who practices primarily in California sued after he had provided testimony in a professional liability case. The physician defendants believed that the testimony fell below reasonable professional standards, was made for the sole purpose of propagating a frivolous lawsuit for financial gain and contained false testimony. The defendants expressed this belief in a letter to the Florida Medical Association and asked the FMA to issue an opinion about the physician's testimony and to report its finding to the Board of Medicine for disciplinary action "to prevent the Medical profession from being terrorized by similar experts."

Then the physician who provided the expert testimony sued the FMA and the individual defendants. He alleged the statements were false and were submitted by the FMA's Expert Witness Committee of the FMA's Council on Ethical and Judicial Affairs, which the physician contended was organized for the purpose of "intimidating, hindering and deterring persons ... from appearing as expert witnesses on behalf of plaintiffs."

FMA and the physicians filed motions to dismiss, saying that they were immune under the Florida peer review statute and the federal Health Care Quality Improvement Act. The trial court agreed and dismissed, but the appeals court reversed, finding that nothing in the statutes reasonably supports an interpretation that a peer review committee is shielded from liability for an act taken by the committee on a claim that a physician's testimony in a medical malpractice action fell below acceptable professional standards.

## **New York Times: "Heart Procedure is Off the Charts in an Ohio City"**

In Elyria, Ohio, people with blocked arteries are three times more likely to receive angioplasties for blocked arteries than if they lived elsewhere in Ohio. That is one of the more extreme results in a Dartmouth Medical School study published in the August 18, 2006 New York Times that is being widely circulated in the medical community. The study examined Medicare data over a multi-year period to identify outliers in certain procedures. The Times seems to have picked up on the Elyria statistic and ran with it. To read the highly-circulated Times article, [click here.](#)

## **Chiropractor CME Rule Change Proposed**

The Florida Board of Chiropractic Medicine is proposing new CME requirements to address record keeping and documentation, as well as coding and ethics. An HIV/AIDS course is proposed to be mandated. For a complete list of the proposed changes, [email us.](#)

## **CME scales back DME requirements**

On August 14, 2006, the Centers for Medicare and Medicaid Services released its final quality standards for suppliers of durable medical equipment. The final version of the standards is substantially scaled back from the September 2005 draft. CMS reduced the number of product specific standards from 16 in the draft to 3 in the final rule. To obtain a copy of the final rule, [email us.](#)

## **BUSINESS TIP OF THE DAY: Managed Care Contract Negotiation**

Do you know what your fee schedule is for the payors with whom your group is contracted? Are you systematically challenging denials and take backs? Do you know the statutory process for addressing take backs by payors? The answers to these should be addressed by routine analysis of your relationships with

managed care and insurance companies. The starting point, however, is to negotiate good terms with those companies in your contracts with them. If you have not re-negotiated your agreements with payors recently, now may be the time. To schedule a consultation about your managed care contracts, email us.

***The content of this newsletter is not legal advice and should not be relied on as legal advice.  
Consult your attorney for advice on these and other legal matters.***

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