Report on
MEDICARE COMPLIANCE
Volume 20, Number 17 • May 16, 2011

Another Court OKs 'One-Purpose Test' for Kickbacks, Upping Risks of M.D. Contracts

In a May 4 decision, the U.S. Court of Appeals for the Seventh Circuit became the fifth federal appeals court to embrace the "one-purpose test" for determining whether the anti-kickback law was violated. That means, for example, that even when payments between hospitals and physicians serve legitimate purposes, the payments are kickbacks if one purpose for them is to induce referrals.

"Your heart can be 99.9% pure but if 0.1% of it is entering into a transaction to induce referrals, you are guilty," says attorney Bob Wade, with Krieg DeVault in Mishawaka, Ind.

The court decision, along with the hyper enforcement climate, adds urgency for hospitals to bulletproof their physician agreements. Hospitals should memorialize the services physicians will perform, specify the fair-market value and require physicians to turn in timesheets and other documentation proving they lived up to their end of the deal, attorneys say.

Meanwhile, keep an eye out for new dangers in physician arrangements, such as multiple payments, says Jeff Sinaiko, president of Sinaiko Consulting in Los Angeles. One example is "stacking," which means breaking a physician's responsibility into components and paying separately for each. For example, hospitals recruit physicians and pay them full salaries while they build their practices. Because they don't yet have a full patient load, the doctors are asked to serve as medical directors within the scope of their employment, Sinaiko says. If they are paid extra to be medical directors and their total compensation is more than fair-market value, the hospital is smack in the middle of Stark and kickback territory, he says.

Illicit physician agreements can lead to false claims lawsuits and jail time, as the players in this recent decision show. The appeals court ruled against Roland Borrasi, M.D., who had been convicted of accepting a hospital salary in exchange for patient referrals.

Borrasi owned Integrated Health Centers, a group of providers in Romeoville, Ill. According to the court decision, Borrasi and two executives of Rock Creek Center, a psychiatric hospital in Lemont, Ill., cooked up a scheme to pay bribes to Borrasi and other Integrated physicians in exchange for "an increasing stream of Medicare patient referrals." Rock Creek paid Borrasi and the other physicians $647,204 "in potential bribes," the decision states. To hide them, Borrasi and the other physicians were given fake job descriptions (e.g., service medical director) and asked to submit dummied timesheets.

"According to minutes of Rock Creek's various committee meetings, Borrasi and some Integrated physicians occasionally attended meetings and submitted reports of their work. But they attended only a very small percentage of the actual meetings, and multiple witnesses testified to rarely seeing them in the Rock Creek facility for meetings or other duties," the decision explains. They were never expected to do real administrative work, according to testimony from Mahmood Baig, Rock Creek's director of operations.

Federal prosecutors ultimately charged Borrasi, Baig and Rock Creek CEO Wendy Mamoon with seven counts of violating the anti-kickback law and conspiracy in 2006. Baig pleaded guilty, but the other two went to trial in U.S. District Court in Chicago and were found guilty of all seven counts. Borrasi was sentenced to 72 months in prison and Mamoon got six months in jail; both were required to pay $497,204 in restitution.

In his appeal, Borrasi argued that he did not violate the anti-kickback law because he had an employment agreement with Rock Creek Center and therefore qualified for "safe harbor" immunity. For example, payments made under *bona fide* employment agreements are immune from kickback prosecution. Borrasi also urged the appeals court to adopt the "primary motivation doctrine," which would allow the jury to acquit him if the main reason for the hospital's payments was to compensate him for real services.

Seventh Circuit Agrees With Four Others

But the Seventh Circuit U.S. Court of Appeals didn't buy Borrasi's arguments. "Nothing in the Medicare fraud statute implies that only the primary motivation of remuneration is to be considered in assessing Borrasi's conduct," the court stated. Instead, it was persuaded by the reasoning of the U.S. Courts of Appeals for the third, fifth, ninth and tenth circuits, which have ruled in favor of "one-purpose" before. "We join our sister circuits in holding that if part of

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the payment compensated past referrals or induced future referrals, that portion of the payment violates [the anti-kickback law]." The decision quotes the case that started it all, *United States v. Greber:* "[T]he Medicare fraud statute is violated if 'one purpose of the payment was to induce future referrals.'"

What's tricky about the one-purpose rule in the real world is that hospitals, of course, want to keep or increase their referrals, lawyers say. "At the end of the day, everyone's in business to provide patient services," says San Francisco attorney Judy Waltz, who is not commenting on the Borrasi case specifically. "It's hard to see that one purpose [of financial arrangements] wouldn't be to retain or increase your business. So theoretically, it's almost impossible to get around the idea that one purpose is not to increase referrals." The difference, however, is that in a permissible arrangement, the payments must be made for actual services that are truly needed by the hospital and paid for fairly — and hospitals must be able to prove that, says Waltz, with Foley & Lardner LLP. She suggests that physicians sign attestations that they performed the services they were contractually bound to perform.

Wade says his clients also are frustrated by having to pretend they aren't negotiating deals partly to increase business. He tells them: "You can hope for, you can expect, you can even pray for referrals, but you can't enter into transactions to financially induce referrals."

'Stupid' Written Records Cause Big Trouble

Wade says "stupid e-mails" and "stupid minutes of meetings" — the kind that make a connection between financial arrangements and induced referrals — can nail a hospital. Wade advises hospitals to be very careful about what's written and said. It's OK for a CFO to estimate the increased volume of surgical procedures that will flow from the employment of a new surgeon. "But an e-mail that says 'We have to hire this surgeon because he otherwise will take all referrals to the competing hospital' could get you in trouble." In this case, the one-purpose intent is clear.

Even though Stark's employment exception allows hospitals to require employed physicians to refer all their patients to the hospital with some exceptions (e.g., the patient wants to go elsewhere), the anti-kickback law's employment safe harbor does not contain the same Stark-permitted referral requirement. As a result, "it's always a quandary whether to put [the referral requirement] into employment agreements," Wade says.

In fact, providers generally have misconceptions about the employment safe harbor. "They think they fit within the safe harbor as long as they issue a W-2, which means it's a *bona fide* employment relationship," Wade says, especially because the safe harbor does not explicitly require fair-market value compensation. But the government believes that any amount exceeding fair-market value is intended to induce patient referrals, Wade says. "They think it's implied. That is your one purpose" under the one-purpose test. But if you can show services were truly provided and compensated at fair-market value, "you cure all sins," he says. "Fair-market value is king."

Hospitals should be wary of multiple payments to physicians, which is more prevalent now with increased physician employment and the rise in payments for ED on-call coverage, Sinaiko says. Hospitals pay employed physicians a combination of a base salary plus a productivity bonus or pay them entirely based on productivity, which may or may not involve more pay for administrative services. He urges hospitals to carefully consider the total package for fair-market value. "Just because you divided physicians' time — surgical time, seeing patients, medical directorship, on-call to the ED — doesn't mean you can pay more than fair-market value [aggregately]," Sinaiko says. "You have to account for all the time correctly and fully."

Another risk: Certain types of physicians, such as anesthesiologists, are at the hospital for long periods of time. The hospital pays them to be there, but in some locales there may be no procedures for hours. If the anesthesiologist is selected as medical director, "there is a logical question about whether you should pay them for medical director duties on top of this," he says. "Every situation is different and there is no absolute rule of thumb," but Sinaiko advises hospitals to be careful about multiple payments in this context.

Here are Sinaiko's tips to avoid compliance problems related to medical directorships and other hospital-physician contracts:

◆ ***It's a red flag if a hospital's medical directorships are all identical.*** Some duties should be universal (e.g., oversee the quality of services, training), but Sinaiko says there should be differences. The medical director of the emergency department will not do all the same things as the medical director of the neonatal ICU. "Similarly, we will see differences in the amount of time and money paid based on specialty, volume and complexity," he notes. The medical director of a large cardiac unit may earn more than the medical director of a smaller, less complex unit, for example. The most important thing, though, is for hospitals to specifically describe what they expect from the medical director. "Show you have put some thought into this," Sinaiko says.

◆ ***Only pay physicians for time they spend on services that are spelled out in the contract and documented accordingly,*** he says. Just because physicians put four hours on a timesheet doesn't mean they should automatically collect a check without verification. Doctors may travel to conferences and even receive speaking fees and then mark

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down the time on their medical-director timesheets, perhaps with the justification that the conference was related to their specialty. But conference attendance is not stipulated in the contract and doesn't count. As a remedy, Sinaiko recommends approving a contract that calls for paying the medical director for up to X hours per year, at Y dollars per hour, so they are not paid for work they don't do just because the contract called for a set-in-stone amount.

◆ ***Conduct audits of contract terms.*** Are the contracts still current? Are the services still needed or did the outpatient surgery center close? Is the payment rate still fair-market value? Does the timesheet show services that are not in the contract (e.g., time the physician spent e-mailing)?

Waltz notes that the government is getting fierce in its pursuit of physicians — criminally, not just civilly. A criminal conviction for Medicare fraud means physicians will be excluded from Medicare and Medicaid. The aggressive tone means "the government doesn't want people like this in the program," she notes. A decade ago, the government's focus was almost exclusively on hospitals and their deep pockets.

Contact Wade at bwade@kdlegal.com, Waltz at jwaltz@foley.com and Sinaiko at jeff.sinaiko@sinaiko.com. The decision is United States of America v. Roland Borrasi (U.S. Court of Appeals, Seventh Circuit, May 4, 2011, No. 06 CR 916-2). ✧

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