

**[Names and addresses of Requestors have been redacted]**

**Re: Advisory Opinion No. CMS-AO-98-002**

Dear [Redacted]:

We are writing in response to your request for an advisory opinion (AO), in which you pose the following question: Whether the partners and physician employees of a proposed partnership may, under the "in-office ancillary services" exception defined in section 1877(b)(2) of the Social Security Act (the Act), refer Medicare and/or Medicaid patients to the partnership for eyeglass prescriptions filled subsequent to cataract surgery with the insertion of an intraocular lens.

You have certified that all of the information you have provided in your request, including all supplementary materials and letters, is true and correct, and constitutes a complete description of the parties, relationships and facts regarding the proposed arrangement. In issuing this opinion we have relied solely on the facts and information you have presented to us. We have not undertaken an independent investigation of this information. If material facts have not been disclosed or have changed since we accepted your request, these differences could nullify the validity of this AO.

Based on the information provided, we conclude that the partners and employees of the proposed partnership would qualify for the in-office ancillary services exception.

## **FACTUAL BACKGROUND**

The two Requestors propose to form a partnership, "Partnership," for the purpose of providing ophthalmology services for patients, and eyeglasses and contact lenses for patients and non-patients. We are using the term non-patient to mean a person who gets a prescription for eyeglasses or contact lenses from someplace other than the partnership, but comes to Partnership to have that prescription filled.

Each Requestor has one ophthalmologist shareholder and several physician employees; each Requestor currently leases its own office space, and proposes an additional site for the partnership, so Partnership would operate at three locations. Requestors have proposed to assign all leases and employment contracts to Partnership, for those employees who have agreed to work for the partnership. <sup>1</sup>Each Requestor will contribute 50 percent of the assets of the partnership and will receive 50 percent of the revenues left after expenses are met and each employee has been paid. Each physician owner and physician employee is paid a salary that is unrelated to referrals.

## **LEGAL ANALYSIS**

### **A. The Referral Prohibition**

Section 1877 of the Act prohibits a physician from referring a Medicare patient to an entity for certain designated health services if the physician has a financial relationship with the entity, unless an exception applies. A financial relationship exists if the physician has an ownership or investment interest in the furnishing

entity, or a compensation arrangement with the entity. In the proposed arrangement, it appears that the physician partners will have an ownership interest in an entity that will furnish eyeglasses and contact lenses to patients following cataract surgery with the insertion of an intraocular lens. The partners will also have a compensation arrangement with the entity in the form of salary payments, as will other physician employees who will be paid a salary.

The list of designated health services that appears in section 1877 (h)(6) of the Act includes "prosthetic devices," which are defined in the Medicare statute in section 1861 (s)(8) as including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens. (This is the only circumstance under which Medicare covers prescription eyeglasses or contact lenses.) We have stated in a proposed rule covering a physician's referrals for designated health services that we are proposing to define the term "prosthetic devices" for the purposes of the referral prohibition in the same manner as it is defined in the Medicare statute. (See 63 FR 1678 (January 9, 1998.)) Although the proposed rule has not been promulgated in final form, it reflects our current interpretation of the law.

Section 1903(s) of the Act applies some of the referral rules to the Medicaid program.

<sup>1</sup>One of the employees of one of the Requestors has refused to assign his contract to the partnership. Requestors have since submitted that this physician has not renewed his contract, and will no longer be a factor in the proposed arrangement.

In the Medicaid context, eyeglasses are generally covered under a category separate from prosthetic devices under the authority of section 1905 (a)(12) of the Act. As we have explained in the proposed rule mentioned above, when the definition of a designated health service differs under a State's Medicaid plan (which lists the services a State covers) from the definition under Medicare, we propose to assume that the services included under the State's plan take precedence. (See 63 FR 1673-74.) In Requestors' state, eyeglasses are not considered to be a prosthetic device. As long as a State does not classify eyeglasses as a prosthetic device or otherwise as a designated health service, there are no physician referral implications for any Medicaid referrals for them.

Since it appears that the proposed arrangement would be a financial relationship for purposes of Medicare referrals under section 1877, the physicians involved can only refer to Partnership if an exception applies. The Requestors have specifically asked whether the in-office ancillary services exception would make the referrals of the partners and physician employees acceptable.

## **B. Group Practice**

Requestors have stated that they wish their partnership to be considered a group practice, and that they want this group practice to qualify for the in-office ancillary services exception.

To qualify for the in-office ancillary services exception, Requestors must first meet the definition of a group practice as set forth in section 1877(h)(4)(A) of the Act: "The term 'group practice' means a group of 2 or more physicians legally organized as a partnership . . . or similar association--(i) in which each physician who is a

member of the group provides substantially the full range of services which the physician routinely provides . . . through the joint use of shared office space, facilities, equipment and personnel, (ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group, (iii) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined, (iv) except as provided in subparagraph (B)(i) [which relates to profits and productivity bonuses], in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician, and (v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, . . . ”

### **1. Substantially the full range of services**

Section 1877(h)(4)(A)(i) requires that each member of the group provide “substantially the full range of services which the physician routinely provides . . . through the joint use of shared office space, facilities, equipment and personnel.” Requestors have certified that each physician who is a member of Partnership will practice the same range of ophthalmology services as the physician currently does. Further, since all leases have been assigned to the partnership, it appears that all facilities and office space will be shared, as well as the personnel who will be employed by the partnership.

### **2. Substantially all of the members’ services are provided through the group and are billed by the group**

Section 1877(h)(4)(A)(ii) requires that “substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group, . . . ” In our final regulation governing referrals for clinical laboratory services in 42 CFR 411.351, we defined a group practice by stating that at least 75 percent of the total patient care services of the group practice members must be furnished through the group and be billed in the name of the group. We measured “patient care services” by the total patient care time each member spends on these services. In our proposed rule covering referrals for other designated health services, we proposed to clarify certain aspects of the “substantially all” test. In the discussion at 63 FR 1688, we stated that we expect a group to look at a physician’s total patient care time during a week, furnished both inside and outside of the group practice, to determine what percent of this time is furnished through the one group. Requestors have indicated to us that member physicians will be performing 100 percent of their patient care services through Partnership. Provided that this is accurate, we conclude that they will meet this part of the test.

Requestors have certified in a letter to CMS that billing will be done under one billing number assigned to the partnership, all receipts from billing done on behalf of the partners and the employees of the partnership will be treated as receipts of the group, and expenses will be paid as expenses of the group. We therefore believe that this part of the test will be satisfied.

**3. Overhead expenses and income from the practice shall be distributed in accordance with previously determined methods**

CMS believes that this provision is ambiguous and has proposed to interpret it to mean that a group must have in place methods for distribution prior to the time period the group has earned the income or incurred the costs. (See 63 FR 1690).

The Partnership Agreement details that expenses of the practice such as rent, utilities, and salaries will be paid out of the income to the practice before any profits are distributed, and the employment contracts detail the precise amounts of each member's annual salary. Profits over and above salaries and expenses will be distributed on a 50 percent basis between the partners, as detailed in the Partnership Agreement. We therefore believe that the arrangement satisfies our interpretation of this part of the test.

**4. No physician member will be compensated, directly or indirectly, based on the volume or value of referrals**

Under section 1877(h)(4)(A)(iv), no physician member of the group may receive compensation based on the volume or value of that physician's own referrals. However, section 1877(h)(4)(B)(I) qualifies this statement by allowing that "a physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician."

Partnership's employment contracts indicate that physician employees will be compensated on a straight salary basis. These salaries are based on the number of hours worked, multiplied by a pre-determined amount that varies slightly among the employees. This variance reflects differences in education and experience among the members, and is not based on the volume or value of past or projected future referrals. In addition to salary, employees also receive a health benefit package. While there is no fair market value test for the compensation that a group practice can pay a physician member under section 1877(h) (4) (A), if a physician appears to be paid an inordinately high salary for his or her work, we would assume that the group is compensating the physician for referrals by including the payments as part of a set salary. Because we are not in a position to determine whether the wages and benefits under the arrangement are fair, we condition this advisory opinion on the requirement that the salaries and benefits are in line with what similarly situated ophthalmologists in the geographical area receive for comparable work, without the value of any referrals included in the development of the salary package.

The Partnership Agreement states that physician owners will each be paid both an annual salary and a 50 percent share of the profits, which will be based solely on the percentage of the ownership interest of each owner. The employees are to be paid on a pre-determined hourly salary, without receiving a bonus related to the volume or value of referrals for designated health services. Partnership has not proposed any other forms of compensation or incentives for owners or employees. It therefore appears that this part of the test will be satisfied.

## **5. Members of the group provide at least 75 percent of the physician-patient encounters**

CMS has proposed to interpret “member of the group” to include physician owners and employees of the group. (See 63 FR 1687.) Since Partnership has indicated in correspondence with CMS that all physician-patient encounters will be performed by members of the group, Partnership’s proposal will meet this part of the test.

### **B. In-office Ancillary Services Exception**

In order to qualify for the in-office ancillary services exception, Partnership must not only meet the definition of a group practice but also demonstrate that it meets the criteria set forth in section 1877(b)(2)(A) of the Act, which exempts services that are furnished “(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or another physician in the group practice, and (ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians’ services unrelated to the furnishing of designated health services, or (II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the centralized provision of the group’s designated health services (other than clinical laboratory services), . . . .” In addition, under (b)(2)(B), the services must be billed by the physician performing or supervising the services or the group practice of which such physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by the physician or the group practice.

#### **1. Services furnished or supervised by the referring physician or by a member of the same group practice**

Requestors would meet this part of the test if a member of the group personally furnishes or directly supervises a non-member in the furnishing of the designated health service. By regulation in 42 CFR 411.351, in terms of referrals involving only clinical laboratory services, we have interpreted “direct supervision” to mean “supervision by a physician who is present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed.” The January 9, 1998 proposed rule further defines “present in the office suite” as meaning that the physician must be present in the suite in which the services are being furnished, at the time they are being furnished, except that the definition does allow certain unexpected absences and certain routine absences of short duration. (See 63 FR 1684.)

Requestors can meet this requirement by assuring that at least one of the four physician members of the group is present at each of the three locations at any given time. Requestors have not specifically addressed this management issue in their communication with us, but have stated verbally that they intend to comply with CMS’s opinion on how to meet each prong of each test. The direct supervision requirement applies only to Medicare covered designated health services. Thus, as long as at least one physician member is in the office suite performing or directly supervising a non-member employee in the furnishing of eyeglasses or contact

lenses that qualify as designated health services that are covered under Medicare, this part of the test will be met.

## **2. Services furnished in an appropriate location**

Except as described below, designated health services must be furnished in a building in which the referring physician or another physician member of the group practice is furnishing physicians' services unrelated to the furnishing of designated health services. We have proposed to interpret "unrelated to designated health services" as any services that are not listed as designated health services in section 1877 (h) (6), even if these services lead to a physician requesting a designated health service (see 63 FR 1695). Since the partnership proposes to offer a broader range of ophthalmology services than those considered to be designated health services at each of its locations, we believe that this requirement will be met.

Alternatively, a group practice can meet the location test if the designated health services are furnished in another building that is used by the group for the centralized provision of designated health services. Partnership could arrange its locations such that no additional physicians' services are furnished where the eyeglasses are furnished, provided that a physician is on the premises to either furnish the eyeglasses or to directly supervise non-member employees who are furnishing the eyeglasses.

## **3. Services billed under the billing number assigned to the group practice**

Requestors have certified that partners and physician employees of Partnership would bill under a common billing number assigned to the partnership. Provided that they obtain and use a billing number assigned to the group practice, this provision will be met.

## **CONCLUSION**

We find that the proposed partnership arrangement is a group practice and that the designated health services performed or supervised by members of the group will meet the in-office ancillary services exception, provided that all of the above-mentioned criteria are met.

## **LIMITATIONS OF THIS OPINION**

The limitations that apply to this Advisory Opinion include the following:

- This AO and the validity of conclusions reached in it are based entirely on the accuracy of the information that you have presented to us.
- This AO is relevant only to the specific question(s) posed at the beginning of this opinion. This AO is limited in scope to the specific arrangement described in this letter and has no application to other arrangements, even those which appear to be similar in nature or scope.

- This AO does not apply to, nor can it be relied upon, by any individual or entity other than the Requestor. This AO may not be introduced in any matter involving an entity or individual that is not a Requestor to this opinion.
- Our Advisory Opinion authority originates from Section 1877 of the Social Security Act, which specifically contains a prohibition against certain physician referrals. This AO may not be construed as permission to avoid compliance with any other Federal, State or local laws which may apply to the arrangement.
- This AO will not bind or obligate any agency other than the U.S. Department of Health and Human Services. Under 42 CFR 411.382, CMS reserves the right to reconsider the issues posed in this AO and, where public interest requires, rescind or revoke this opinion.
- This opinion is also subject to any additional limitations set forth at 42 CFR 411.370 et seq.

Sincerely,

/S/

Robert A. Berenson, M.D.  
Director  
Center for Health Plans and Providers