Published in Anesthesiology News
January 2011

THE COMPANY MODEL: IS TAKING LESS MONEY TO WORK AT A SURGICENTER WORTH JAIL TIME?

BY: MARK F. WEISS, J.D.

When asked why he robbed banks, Willie Sutton responded, “Because that’s where the money is.”

Owners of ambulatory surgery centers (ASCs), who often are surgeons, are seeking a share of anesthesia fees for the same reason. But instead of a gun, many are turning to a new model of money extraction: the company model.

Demanding a kickback—“Bob, if you want to provide anesthesia at Greenacres ASC, you’ve got to pay us 30 cents on the referred dollar”—is clearly illegal. But even if far more ASC owners are willing to try that approach than they likely would admit, some are choosing a slightly softer tactic—forcing anesthesiologists to work for an entity affiliated with the surgicenter. That entity distributes a share of the anesthesia fees back to the ASC owners.

In these cases, the conversation might go like this: “Bob, if you want to provide anesthesia at Greenacres ASC, you’ve got to become an employee of our entity, Greenacres Anesthesia Services. We’ll even pay you commensurately with your production. In fact, we’ll pay you the lion’s share, 70 cents on the dollar!”

These entities become the “companies” of the company model. Of course, demanding 30% as a direct kickback has the same economic effect as forcing the anesthesiologists into an entity that rewards them with a 70% share.

But is the company model structure legal? That’s the $25,000 fine *plus* five years in jail *plus* exclusion from Medicare and Medicaid question. And don’t forget possible civil monetary penalties.

Business Models

To better understand the issues of the company model, it helps to consider the evolution of anesthesiologist–ASC business models.

Features of an ASC That Might Run Afoul of Federal Rules

- The owner expands into a related line of business that is dependent on direct or indirect referrals from, or on other business generated by, the owner’s existing business.
- The owner does not operate the new business—the manager/supplier does—and does not commit substantial funds or human resources to it.
- Absent participation in the joint venture, the manager/supplier would be a competitor in the new line of business, providing services, billing and collecting in its own name. The anesthesiologists working for the captive entity would otherwise be engaged in the business of providing anesthesia for their own account.
- The owner and the manager/supplier share in the economic benefit of the owner’s new business.
- The aggregate payments to the owner vary based on the owner’s referrals to the new business

—*M.W.*

The conventional, fee-for-service relationship between anesthesiologists and ASCs mirrors the traditional relationship between anesthesiologists and hospitals: The anesthesiologists, directly or through an anesthesiologist-owned entity, provide services to the patients of the ASC for their own account, akin to surgeons performing their cases at the facility. The facility charges a fee and the physicians, both surgeons and anesthesiologists alike, charge their own, independent professional fees.

In many cases, the relationship between the anesthesiologists and the ASC takes on an additional dimension. The anesthesiologists might take on duties beyond providing care to patients, such as serving as the facility's medical director. In compensation for those services, and to avoid a kickback (the provision of those services for free being an inducement to receive the referral of anesthesia cases), the ASC pays a stipend equal to the fair market value of the specific duty.

Sometimes the volume of cases or reimbursement earned from covering the ASC's anesthesia needs is insufficient to attract or retain anesthesiologists. The ASC then must pay a stipend to the clinicians or their professional entity in order to supplement their billings.

Over time, some ASC owners began to question the conventional model of their facility's relationship with anesthesiologists. For some, it was an issue of economics. Many ASCs were located in markets that already were saturated. Others were located in areas that became economically depressed, while some had cost structures that reduced or eliminated profitability.

For many, however, it was a question of greed. Surgeon-owners saw that anesthesiologists were earning much more than they were taking home. They viewed anesthesia as a franchise that had value, and they wanted a share of it.

Captivity

No matter the motive, a second ASC–anesthesia business model took form, one that I refer to as the "captive model." This model has the anesthesiologists working for the ASC as employees or as independent subcontractors—the defining characteristic being that the ASC pays anesthesiologists either a fixed amount or a fee based on productivity. The ASC may bill anesthesia fees under its own name, or it may use the name of the anesthesiologists. In either case, anesthesia fees eventually find their way into the ASC's bank account.

Over the past several years, the captive model has morphed into the company model. Some ASCs found that insurers rejected claims for reimbursement for anesthesia fees when billed under the facility's name. In states such as California that prohibit the corporate practice of medicine, lay entity ASCs cannot provide medical services and therefore cannot employ anesthesiologists or even subcontract with them under a financial structure in which the ASC participates. Some ASCs had neither of these problems but simply wanted to separate out, perhaps for management purposes or perhaps to disguise their real intent, anesthesia coverage as a separate entity.

In some instances, it was not even the ASC itself that sought to change the relationship with their anesthesia providers by forming an anesthesia company owned by the ASC itself or by all of the ASC's owners. Instead, it was a subset of the ASC's owners, usually one or more surgeon-owners with referral clout, who sought to skim a bit of the profit cream off the top of anesthesia services.

Key Compliance Issues

The federal anti-kickback statute (AKS) prohibits remuneration—that is, the transfer of anything of value—for referrals. State laws differ in their treatment, scope and interpretation, but generally contain similar provisions barring remuneration for referrals, sometimes expressed as anti-kickback or fee-splitting prohibitions. Because of the variations in state laws, this article focuses on the federal concepts applicable to patients covered under Medicare and Medicaid.

Courts have interpreted the AKS to apply even when an arrangement may have many legitimate purposes; the fact that one of the purposes is to obtain money for the referral of services or to induce further referrals is sufficient to trigger a violation of the law.

Certain exceptions, known as safe harbors, define permissible practices not subject to the anti-kickback statute because regulators believe they are unlikely to result in fraud or abuse. The failure to fit within a safe harbor does not mean that an arrangement violates the law; there's just no free pass.

The question, then, for the company model is whether it runs afoul of federal anti-kickback law. To be sure, each deal must be analyzed carefully before it is structured. But it is possible to highlight the significant likelihood that many company model deals are illegal.

The U.S. Department of Health and Human Services Office of Inspector General (OIG) has issued two fraud alerts applicable to the analysis of company model deals: its 1989 Special Fraud Alert on Joint Venture Arrangements, which was republished in 1994, and a 2003 Special Advisory Bulletin on Contractual Joint Ventures.

The OIG considers a joint venture to mean any arrangement, whether contractual or involving a new legal entity, between parties in a position to refer business and those providing items or services for which Medicare or Medicaid pays.

The OIG has made clear in its safe harbor regulations and other documents that compliance with both the form and the substance of a safe harbor is required in order for it to provide protection. In other words, even if planners generally work to fit a company model deal into the confines of a safe harbor, the OIG demands that if an underlying intent is to obtain a benefit for the referral of patients, the safe harbor would be unavailable and the AKS would be violated.

Fraud Alert and Advisory Bulletin

The fraud alert states: “Under these suspect joint ventures, physicians may become investors in a newly formed joint venture entity. The investors refer their patients to this new entity, and are paid by the entity in the form of ‘profit distributions.’ These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary program expenditures.”

In describing questionable features of suspect joint ventures, the fraud alert provides several examples, including:

- Investors are chosen because they are in a position to make referrals (e.g., the surgeon-owners of the ASC who become the owners of the company model entity);

- One of the parties may be an ongoing entity already engaged in a particular line of business (e.g., the anesthesiologists); and
- The referring physician's investment may be disproportionately small and the returns on investment may be disproportionately large compared with a typical investment in a new business enterprise (e.g., the company model, which requires only nominal start-up capital).

Notice that the features of the company model include many of those stated by the OIG in the alert to be questionable.

The 2003 advisory bulletin sheds even more light on the analysis of company-model structures. It focuses on questionable contractual arrangements in which a health care provider in an initial line of business, termed the "owner," expands into a related health care business by contracting with an existing provider of the related item or service, the "manager/supplier," to provide the new item or service to the owner's existing patient population. Note that the term "existing provider" is not limited to situations in which anesthesiologists have an existing relationship with the ASC at the time the company model joint venture is formed.

The advisory bulletin lists some of the common elements of these problematic structures (sidebar). They appear to hint at a company model structure in which an ASC (or some or all of its surgeon-owners) forms solely for the purpose of providing anesthesia services to itself. Little capital is required. The anesthesiologists, not the owners, provide the services. But for their engagement by the company, they would be providing anesthesia services for their own account. The company's owners capture a share of the anesthesia revenue. And, importantly, the more cases the ASC or its surgeons refer to the company, the more money those company owners make.

The bulletin states that despite attempting to fit the contracts creating these joint venture relationships into one or more safe harbors, such protection might not be available. The OIG views the discount given within the joint venture's common business enterprise (e.g., the anesthesiologists agree to be paid less by the company than they would receive if they billed independently of the joint venture) as not qualifying for the safe harbor applicable to discounts.

Even if the contracts could fit within one or more safe harbors, the bulletin states that they would protect only the payments from the owner *to the manager/supplier* for actual services rendered, not the "payment" from the manager/supplier back *to the owner* in the form of its agreement to provide services to the joint venture for less than the available reimbursement—that is, the "discount" given within the joint venture.

Again, the failure to qualify for safe harbor protection does not mean that a venture is illegal; it does mean that it might receive additional scrutiny that could lead to prosecution.

In 2009, the American Society of Anesthesiologists (ASA) requested that the OIG issue a special advisory bulletin on the company model. The ASA renewed that request in June 2010. Although the OIG acknowledged the initial request, at the time of this writing it had yet to act.

The Bottom Line …

The bottom line is that company model ventures are fraught with kickback danger for all parties involved. Although it may be possible that a particular instance qualifies for safe harbor protection, the OIG's

position as expressed in both the fraud alert and the advisory bulletin demonstrates that these arrangements are subject to special scrutiny.

As the government's focus on weeding out health care fraud intensifies, the need to fully understand the risks grows. Each situation must be analyzed carefully as there is a high chance of an AKS violation leading to criminal fines, civil penalties, exclusion as a provider and even imprisonment.

… and an Important Postscript

The fraud alert and the advisory bulletin clearly indicate that there is no requirement that a fraudulent joint venture be operated through a new legal entity. Captive model structures in which anesthesiologists work directly for the ASC itself, whether as employees or as independent subcontractors, are joint ventures.

The financial relationships within those captive model joint ventures is as equally suspect as those within company model joint ventures, a fact most often glossed over. In fact, the company model format may simply be a slightly slicker variation of the captive model—slicker because it provides the ASC with an alternative way to bill for anesthesia professional fees, and in states with a strong prohibition on the corporate practice of medicine, creates a medical entity to hold the anesthesia business.

In other instances, the company model is simply a captive model with stickier fingers; instead of the ASC or its owners sharing in the anesthesiologists' pie, a subset of the surgeon-owners takes that slice for itself.

Viewed in the light, the captive model and the company model are two sides of the same coin, one that the surgeon-owners of ASCs are attempting to put into their pocket. Both models pose significant dangers of falling on the wrong side of anti-kickback rules.

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Mark F. Weiss is an attorney who specializes in the business and legal issues affecting anesthesia and other physician groups. He holds an appointment as clinical assistant professor of anesthesiology at USC's Keck School of Medicine and practices with the Advisory Law Group, a firm with offices in Los Angeles and Santa Barbara, Calif. He can be reached by email at markweiss@advisorylawgroup.com and by phone at 800-488-8014.