

Ancillary Services Can Increase Revenues

Physicians are finding that adding ancillary services can help maximize practice profitability and better serve patients. Many patients like the convenience of getting medications in the medical office and having laboratory or diagnostic services done by the physician who is ordering them. Patients don't have to drive all over town for tests, and results come back quickly.

Physicians not only like to provide patients with the added convenience, but see these added services as a way to help boost practice revenue. Stagnant practice earnings and insurance claim hassles as well as reimbursement delays are leading many physicians to consider adding ancillary services to help increase revenue.

Between \$36 billion and \$47 billion was spent on complementary and alternative medicine (CAM) therapies in 1997, according to the National Center for Complementary and Alternative Medicine. Of that amount, between \$12 billion and \$20 billion was paid out-of-pocket for the services of professional CAM providers, says NCCAM.

“As professional reimbursement goes down, the way to try to enhance practice revenues and profitability is by maximizing the utilization of the practice resources.

This often means delivering ancillary services that are legal, appropriate, within quality-of-care standards and are needed by patients,” says Bruce A. Johnson, J.D., a consultant for the Medical Group Management Association (MGMA) and a healthcare attorney with the Denver office of Faegre & Benson, LLP.

Depending on the type of practice, physicians are adding many new services, with some falling outside of insurance coverage so that patients pay for them out-of-pocket. There is great demand for many of these services. For example, between \$36 billion and

Performance of Diagnostic Procedures in Family Physicians' Offices, May 2004

Diagnostic Procedure	Perform in Office Percent	Do Not Perform Percent	Not Reported Percent
EKG	87.5	9.8	2.7
Dermatologic procedures	83.4	14.2	2.4
Endometrial sampling	59.8	37.2	3.0
Spirometry	56.0	41.3	2.7
Audiometry	48.8	48.2	3.0
X-ray, chest	40.0	57.0	3.0
X-ray, other	39.8	56.9	3.3
Tympanometry	39.7	57.4	2.9
Colposcopy	35.6	61.2	3.2
Flexible sigmoidoscopy	28.7	68.4	2.9
Vasectomy	26.5	69.2	4.3
Holter monitoring	23.7	72.4	3.9
Tonometry	20.0	75.2	4.8
Cardiac stress testing, treadmill	14.4	81.5	4.1
Loop electrosurgery	13.4	82.7	3.9
Ultrasound imaging (OB)	13.2	82.9	3.9
Nasopharyngoscopy	8.5	88.0	3.5
Laryngoscopy	8.1	87.9	4.0
Mammograms	7.7	88.5	3.8
Rigid sigmoidoscopy	7.5	88.5	4.0
Echocardiography	6.5	88.4	5.1
Cardiac stress testing, 2-step	5.5	89.3	5.2
Colonoscopy	3.6	92.2	4.2
EGD	3.3	92.2	4.5

Note: Includes only active member respondents of the American Academy of Family Physicians.

Source: American Academy of Family Physicians, Practice Profile II Survey, May 2004.

\$47 billion was spent on complementary and alternative medicine (CAM) therapies in 1997, according to the National Center for Complementary and Alternative Medicine (NCCAM), part of the National Institutes of Health. Of that amount, between \$12 billion and \$20 billion was paid out-of-pocket for the services of professional CAM providers, says NCCAM. These fees represented more than the public paid out of pocket for all hospitalizations in 1997 and about half of what it paid for all out-of-pocket physician services, NCCAM reports.

Similarly, \$8.37 billion was spent on physicians' fees for cosmetic procedures by board-certified plastic surgeons in 2003, according to the American Society of Plastic Surgeons. Of this amount, over \$3 billion was spent on minimally invasive procedures such as Botox injections, chemical peels and laser hair removal—services generally not covered under healthcare plans.

Attorney Bruce Johnson says it is a good idea to look at ancillary services that complement your practice. "If I'm a cardiologist, I am going to start looking at the procedures and services that I order elsewhere that I might be able to deliver through my practice," he says.

Primary-care physicians are offering a wide range of ancillary

services. They include point-of-care medication dispensing, weight-loss services, in-office diagnostic tests such as Dexascan screening and X-rays, CT scans, physical therapy, nutrition counseling, cosmetic services such as Botox and chemical peels, and alternative treatments like acupuncture and massage. It is estimated that some practices may be able to earn as much as 15 percent or more from ancillary services.

Mr. Johnson says it is a good idea to look at ancillary services that complement your practice. "If I'm a cardiologist, I am going to start looking at the procedures and services that I order elsewhere that I might be able to deliver through my practice," he says. Pay attention to the classic business adage: start with what you know and then branch out from there, he adds.

From his work with medical practices, Mr. Johnson has found that gastroenterologists, general surgeons and orthopedists are now looking at starting ambulatory surgery centers. Orthopedists also are expanding their businesses by offering physical therapy

and MRI services. Cardiologists are starting CT centers, nuclear medicine services and different types of outpatient diagnostic clinics. Internal medicine and family practice groups, rheumatologists and pulmonary medicine groups are offering bone densitometry testing.

In addition, he says, you can also focus on offering the services your patients want and would use if you delivered the services. For example, some ob/gyns have started offering laser removal of hair and veins and laser skin resurfacing. Many women patients are pleased to be able to utilize these types of services when visiting their gynecologist.

What You Need to Consider

Before you move ahead with your plans, there are a number of factors to consider. If you don't intend to add staff, are the current people you employ willing to be trained to take on new responsibilities? You will also have to spend time training billing staff to handle ancillary claims.

In some cases, you may have to hire experienced technicians and therapists for the services you want to offer. What about office space to support this new enterprise? Will you need additional space or will you compromise your core business?

It is also important to incorporate each service into a coherent business plan. This will help you make sure that you have the necessary resources to launch these services and the right staff in place to support them.

Thoroughly assess the feasibility of adding ancillary services before you actually take the plunge. Forecast revenues and determine what your costs are likely to be. Take the time to look at the market in your area for the services you want to launch. If your area already is saturated with X-ray centers and services, this may not be the best ancillary service to start.

Don't just consider the best-case scenario for the services you intend to add, but also outline a worst-case scenario. Practice management experts say you should have an exit strategy or contingency plan in place in case your ancillary services project isn't successful.

There are a number of other points you need to consider as part of this assessment. For example, do you have a good idea about

what your service volume is likely to be? Your aim is to draw enough volume to make the venture profitable. Too often physicians tend to overestimate the volume they are likely to achieve, which could end up causing the venture to be a losing proposition. It is best to come up with some hard data that project anticipated volume.

As part of this analysis, study the payer situation. For example, if insurance plans have negotiated contracts for diagnostic testing with a local hospital, you and other physicians in the area may be restricted to referring patients to that facility. Determine how many patients you can actually refer to your ancillary service.

It is a good idea to check your contracts with third-party payers to see if they indicate that certain screening or diagnostic testing will be considered “in network” when performed through a group practice. This type of language will help you get reimbursements for your ancillary services.

It is best to focus on your own practice and not assume that other medical groups will start referring services to you.

In addition, part of your business feasibility assessment and analysis is to determine whether the services you will offer will be reimbursed, says Mr. Johnson. If your ancillary service is likely to be paid by a third party, determine how much will you actual-

ly receive in reimbursements, he explains. You can contact two or three of your payers that account for most of your reimbursements and find out how much they are likely to pay for your service.

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Getting insurance reimbursement for your ancillary service is important. “When you do the financial analysis that is part and parcel of developing a good ancillary service line, you might assume you can bring in \$100,000 to offset the \$80,000 worth of expenses you anticipate, when in fact you can't get any of this from the insurance company and as a result you have to do entirely self-pay,” says Mr. Johnson. In addition, when looking at the expenses of the new venture, be sure you factor in both di-

rect and indirect expenses.

To get an accurate idea of your costs and likely revenue, you may want to hire the services of a consultant to draw up the financial analysis, help supervise space planning, hire the right staff members and acquire the necessary state and Medicare licenses. Be prepared to pay \$10,000 or more for these services.

Many physicians are now starting to look into opening ambulatory surgery centers (ASCs). If you own the center, you are like-

Medicare Spending on Services by Ambulatory Surgical Centers, 2002

Procedure category	Medicare volume (percent of total)	Medicare ASC payments (percent of total)	Medicare payments (millions)	Percent volume growth, 2001–2002
Cataract removal and lens insertion	27.4%	47.5%	\$904	11.5%
Colonoscopy	19.5	14.8	282	27.8
Other eye procedures	11.3	9.3	176	10.9
Minor procedures –musculoskeletal	11.0	5.8	111	28.9
Upper gastrointestinal endoscopy	10.3	6.7	128	20.1
Other ambulatory procedures	4.5	3.0	56	17.9
Ambulatory procedures –musculoskeletal	3.5	2.6	50	18.8
Cystoscopy	2.8	1.9	36	9.6
Ambulatory procedures –skin	1.6	1.2	24	9.7
Arthroscopy	1.6	1.5	29	-0.2
Other services	6.5	5.6	106	29.0
Total	100.0	100.0	1,902	18.2

Source: Medicare Payment Advisory Commission.

ly to be reimbursed a facility fee for services performed therein; these fees will be much higher than the physician's fee. Be sure you find out what the payers will pay for the procedures you intend to perform.

There also are turnkey operations that will set up and assist in running the ASC for the physician, but they generally take a percentage of the earnings. One company, PainCare (www.paincare-holdings.com), began offering physician practices a comprehensive turnkey electro-diagnostic program in early 2004. Under the program, practices receive all equipment, technical training and support necessary to introduce electro-diagnostic medicine into the practice. Physicians in the program supply the necessary office space and manage all medical billing and collection activity.

While it is always better to have an insurance company pay for part of the service you plan to offer, it doesn't mean you can't offer the service if they won't pay. In this situation, be sure to factor into your business plan that the service will be paid out-of-pocket by patients.

It is also important to determine if the type of ancillary services you want to offer are considered legal under federal and state laws. For example, check with your attorney to make sure your plans and proposed compensation arrangements won't cause any legal hassles with the Stark regulations. "Few, if any federal regulations affect the structure and operation of physician group practices to the extent of this regulation," says Dr. William F. Jessee, president and CEO of MGMA.

You also want to be sure that you are not doing anything to violate the anti-kickback statutes. The federal anti-kickback law is designed to protect patients and the federal healthcare programs from fraud and abuse (*for more detail on the Stark regulations, see page 100*).

Point-of-Care Drug Dispensing

Dispensing medication is one way to boost practice profitability and provide a welcome convenience for patients who don't like waiting at the pharmacy to fill prescriptions. In approximately four out of five physician office visits, patients leave with at least one prescription. This represents 3 billion prescriptions being dispensed each year, with volume expected to in-

crease to over 4 billion by the year 2006.

Currently only about 10 percent of physicians have incorporated point-of-care dispensing into their practices, but it is expected to be a growing trend in the future as physicians look for ways to reduce medication errors and provide patients with greater convenience.

Medication errors stem from a number of factors. Some drug errors can be attributed to increased workloads required of pharmacists, a shortage of pharmacists and the rising number of prescriptions that are being written each year, experts say. Statistics indicate that medication dispensing errors occur in about 5 percent of all prescriptions coming out of a pharmacy.

In addition, it has been estimated that more than 3 million of the 8.8 million adverse drug events that occur each year in ambulatory care are preventable and result from illegible handwriting, unclear abbreviations and doses, unclear phone or verbal orders and ambiguous orders.

Point-of-care dispensing can help with these problems, say advocates of the service. In addition, it should not be considered a threat to pharmacists because the market is large and growing larger, they contend.

This type of ancillary service is relatively easy to start. It requires a moderate initial investment, which can be recouped in a relatively short period of time. User-friendly and affordable software makes it practical for physicians to manage an inventory of medications, track their own prescribing habits, maintain patient medical records and check for drug interactions.

In addition, physicians can dispense medication to patients for the same co-payment that patients would pay to a pharmacy. Companies that provide the software also connect physicians' offices to most HMOs' pharmacy benefit managers for claims adjudication and confirmation of reimbursement.

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For patients without drug coverage, practices can offer prices that are the same or better than those offered by pharmacies, according to Dr. Stephen Brodsky, a practice consultant who is founder and CEO of Med Solutions, as well as medical director for the data storage company Kardex. Further, it is possible to clear about \$5 to \$6 on each prescription per insured patient.

With these automated systems, the medications you offer will be prepackaged in counts that are commonly dispensed as well as bar coded, which helps promote accuracy. The drugs are packaged in a manufacturing environment where wholesalers contend

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there is zero tolerance for error. The bar code is applied in that environment, and the drugs are sealed in child-proof containers.

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For generic drugs, which tend to be easier to keep in stock, a patient's insurance co-payment will nearly always exceed the amount that a prescription costs. Dr. Brodsky also points out that getting prescriptions filled at the doctor's office also may help reduce the cost of more expensive hospital treatments because often the patient delays filling or never fills the prescription.

In addition, dispensing medication in your office also means you don't have to make all those calls to the pharmacy when there are questions about a prescription. Statistics indicate that reducing this hassle saves the practice more than \$5 per call.

Accuracy is further improved when physicians are not hand-writing prescriptions. Indecipherable or unclear prescriptions result in more than 150 million calls from pharmacists to physicians, asking for clarification. In most states, however, in-office dispensing does not obviate the need for a written prescription.

As far as dispensing restrictions on medical practices are concerned, seven states have such restrictions. They are Massachusetts, New Hampshire, New York, New Jersey, Texas, Montana and Utah. Moreover, the Federal Trade Commission has delivered an opinion indicating that restricting physician dispensing of medication constitutes restraint of free trade.

There are a number of pharmaceutical repackagers that offer point-of-care dispensing systems. The licensing fee for Tulsa's Physicians Total Care is about \$4,000 (plus sales tax) per practice site. The initial cost would be for a two-week supply of medications, which generally costs about \$2,000 to \$4,000 per physician. Other costs would be for a printer and a bar code reader, which together may cost several hundred dollars.

Physicians and staff will need to be trained to operate these systems, and the training requires a few hours for each user.

Managed-Care Radiology Cutbacks Seen

Health plans are taking steps to rein in the cost of radiology, according to a report by HealthLeaders-InterStudy, a provider of managed-care industry data and analysis. While prescription drug costs and hospital-payer contracts have received the most attention in the past five years, radiology costs have been growing at a remarkable rate.

"Radiology accounts for only 10 cents of each medical dollar spent by health plans," says Jan DuBose, an analyst with HealthLeaders. "But the segment is growing by 18 percent to 20 percent a year. In contrast, interventions in prescription drug management by health plans have slowed the growth rate of pharmaceutical costs to below 10 percent in some cases."

To battle the issues of duplication and overuse of expensive imaging, health plans are using precertification and radiology co-payments and dictating guidelines for physicians. Health plans may also require that imaging studies be performed according to guidelines from the American College of Radiology or other organizations, the report says.

"Central to radiology management is data gathering, which shows when providers' ordering and denial rates are outside the norm," Ms. DuBose says. "We expect more sophisticated use of data as vendors and health plans consider ways to reward quality and try to uncover why costs vary so much by region."

Companies in this field generally offer telephone and other support while the system is being set up in the physician's office.

In addition to Physicians Total Care (www.physicianstotal-care.com), other companies in this business include Allscripts Healthcare Solutions (www.allscripts.com) and MedVantx (www.medvantx.com).

The MedVantx Advantage Point Network programs focus on the use of "gold standard," inexpensive generics in targeted therapeutic classes covering a broad range of drug therapies. MedVantx points out that generic medications cost up to 75 percent

Experts say that if you expect to keep equipment for more than five years, it may be better to buy rather than lease. Another factor to consider involves the cost of maintaining the equipment and updating it. In some cases, the technology required may be changing so quickly that it may make more sense to lease it so you can update it more frequently.

less than their branded counterparts and represent the single largest opportunity for employer groups, health plans and patients to reduce cost.

The Allscripts system is available as a stand-alone model or as a fully integrated electronic health record. The company claims to deliver physicians' orders in as little as 24 hours. It has over 2,000 generic and brand-name medications as well as over 10,000 medical supplies. Further, Allscripts

uses the manufacturer's Average Wholesale Price (AWP) to ensure that its clients are in compliance with Office of Inspector General regulations. Renewal requests are electronically processed, reducing the need for chart pulls and phone calls from the pharmacy, says Allscripts.

What about Equipment?

If the ancillary services you decide to add require the acquisition of equipment, you need to consider whether buying or leasing the equipment makes more sense. In many situations, equipment manufacturers will be able to provide beneficial leasing arrangements (*see box next page*).

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It is a good idea to check with physicians in other practices who have already launched the service and find out whether they

Factors to Consider When Leasing Equipment

Often physicians decide that leasing medical equipment makes more sense than buying it because they don't want to be stuck with technology that is obsolete within a few years. In addition, corporations that manufacture medical equipment offer attractive leasing arrangements to physicians. Check with companies like GE Medical (www.gehealthcare.com) to find out what kind of leasing arrangements they offer.

Before you sign a lease, make sure you understand what is involved. With a lease, physicians generally don't have to make a down payment. Be sure you know when the lease begins and the date it ends. In addition, make sure you know what the lease payments will be and the type of maintenance agreement you receive.

"To assess whether the installments represent the fair market value for leasing the equipment, consider calculating the monthly rental installment based upon a per diem payment, which is computed by dividing the annual rental cost by the average number of business days in a year," writes Steven M. Harris, a partner with the Chicago law firm of Harris Kessler & Goldstein, in *American Medical News* (Oct. 7, 2002).

It is also possible to lease the equipment with the option to buy. Make sure this option is reflected in the lease. "That option should state that in consideration of the rental installments paid by you, you are granted an option to purchase the equipment from the lessor at the price and on the terms and conditions set forth in the equipment lease agreement," Mr. Harris writes.

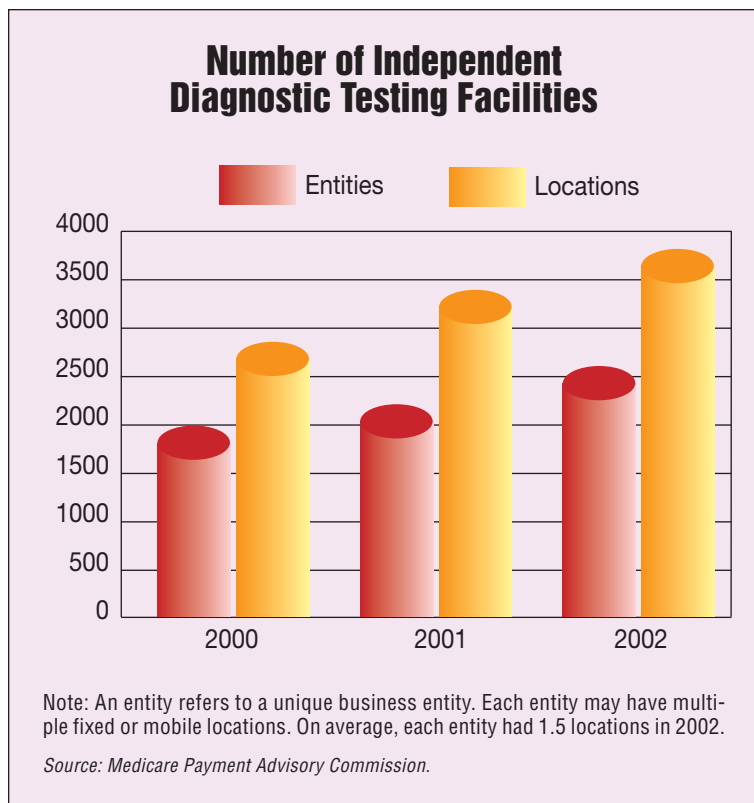
Protect yourself in the event a new, improved and technologically superior machine is introduced. It is best to include a provision in the lease agreement that allows you to switch to the next generation of machine before your lease expires.

Also be mindful of the risk of loss for the equipment. "An equipment manufacturer will often attempt to pass the risk of loss, which includes damage, destruction or theft of the equipment, to you upon shipment," Mr. Harris points out. He offers this advice: "You should not accept the risk of loss until you have received, inspected and insured the equipment for public liability and property damage insurance coverage."

have purchased the equipment or if they believe leasing to be more favorable. It also is possible to purchase refurbished equipment or equipment that is becoming available when a hospital's lease on the equipment expires. It is important to make sure that this equipment still has a long useful life.

Some doctors are opening diagnostic imaging centers to help capture some of the revenue they are sending out of their offices to these centers. But review this option carefully. There is a tremendous financial commitment involved in ventures of this size. In addition, launching such a center may create problems with local hospitals because of the competition that it creates.

There also are concerns about potential abuse by referring doctors. The Medicare Payment Advisory Commission (MedPAC)



found that imaging utilization grew faster than any other physician services between 2001 and 2002. Some types of imaging, such as nuclear medicine and advanced MRI, grew more than 17 percent, according to the MedPAC report. Some health plans are requiring preauthorization for these diagnostic tests and may try to reduce the amount of testing that is done by suggesting a different course of action.

Many cardiologists now provide in-office nuclear imaging services, which have become more widely performed in recent years. Nuclear medicine is not currently subject to the Stark regulations, but it is likely to be down the road, predicts Mr. Johnson of MGMA.

Nevertheless, the American Society of Nuclear Cardiology estimates that 5 million procedures involving cardiac nuclear imaging are done annually, up from about 3 million procedures in 1999. The test is vital for diagnosing the level of heart disease in a patient.

Imaging equipment often involves hundreds of thousands of dollars to acquire. “You will need to have some sense of what your utilization of imaging services will be to complete the financial analysis for your practice,” says Mr. Johnson. Your analysis should include how much you will be able to use the equipment during your normal practice day. “For example, if you can only use the equipment for half of the day, then you might explore other means to maximize its use, such as leasing out the equipment to other parties,” he explains.

If you are looking into lab services, experts say, make sure you understand federal laboratory and self-referral laws. The Clinical Laboratory Improvement Amendments (CLIA) law imposes certain quality control and assurance procedures, personnel requirements, test management procedures, proficiency testing and inspections on laboratories in physicians' offices.

Laboratory Services

Many physicians have found that setting up their own laboratories not only helps produce more revenue, but provides a convenience for patients. Test results can be available in an hour instead of days, which helps reduce follow-up phone calls, additional visits and paperwork.

Many internal medicine and family medicine practices as well as some pediatric offices have enough volume to justify the expense involved in establishing in-office labs. Whether or not this ancillary service makes financial sense for your practice depends a great deal on the state in which you practice, says Mr. Johnson. "Some states reimburse laboratory services pretty well, while others don't," he explains.

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There are turnkey operations available that can establish laboratory services for the medical practice. Many claim that they can purchase supplies at lower prices than an individual practice is able to do. In addition, they have the expertise to comply with Medicare anti-kickback statutes as well as CLIA regulations.

Consider hiring a medical technologist as a consultant to help set up a laboratory that meets the standards set by CLIA and help train your laboratory staff. Another option is to hire a technologist

who is already qualified to perform laboratory services.

If you already offer in-practice laboratory services or are thinking of adding them, the American College of Physicians (ACP) offers software that can help you determine the profitability of such ventures. The Office Laboratory Check Up program is free to ACP members and is available to nonmembers for \$175 (for more information, log on to www.acponline.org/pmc/newlabcheck.htm).

The program uses Excel spreadsheets to analyze and improve the overall financial health of your office lab. With the help of this program, you can perform "what if" scenarios. ACP maintains it is the first software program designed to meet the specific needs of small- and medium-sized physician office labs.

The software also helps determine the feasibility of starting or maintaining a lab or a particular machine. It examines a practice's demographics, costs, personnel and other practice information. The software also can help determine the optimal mix of

tests to perform internally versus those sent out to reference labs.

In addition, the program helps you determine how to set a viable fee schedule for managed-care contracting and determine what mix will maximize the profitability of your laboratory testing. Other questions it will help you answer include the following: How would a proposed capitation rate for lab testing affect my lab financially? At what prices can I afford to compete with other vendors for contracted lab services?

Best of all, it offers a mechanism to help you develop bids on managed care and other contracts for lab services—allowing you to negotiate with payers to maintain or add tests that otherwise would be referred out.

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One such company is Polestar Laboratories in Escondido, Calif. It provides a turnkey reference laboratory called SMART-lab for medical practices. It employs the laboratory technologist, provides all consumables and reagents, services the equipment and monitors compliance with all pertinent regulations and standards, including HIPAA, COLA and CLIA, JCAHO, as well as the Stark I and II rules. Its start-up services include designing a

Physician Fees for Cosmetic Procedures

(national average)

Botox injection	\$376
Cellulite treatment	165
Chemical peel	607
Laser hair removal	429
Laser skin resurfacing	2,378
Laser treatment of leg veins	449
Microdermabrasion	176
Sclerotherapy	323
Collagen treatment	373

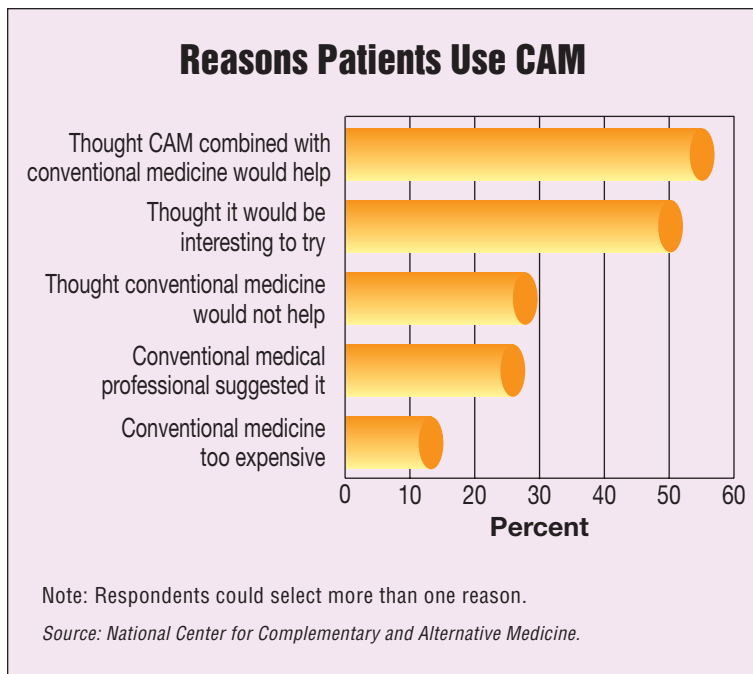
Source: American Society of Plastic Surgeons; data reflect fees paid to board-certified plastic surgeons.

laboratory that is specific to your testing needs and training of office staff in test ordering, coding and billing.

In accordance with Stark regulations, practices own their own SMARTlab and purchase the equipment with monthly payments through a leasing company. Polestar’s clients include large, multi-specialty physician groups as well as solo practitioners in primary care, internal medicine, endocrinology, urology and cardiology. For more information, visit the company’s Website (www.polestarlabs.com).

Non-Traditional Services

You may consider offering some non-traditional services, such as Botox injections, laser hair removal, collagen, vein therapy, skin products, acupuncture and massage. Practice management experts say that in some cases you can hire professionals to deliver these services and still make a profit. In other situations, physicians themselves provide the alternative care by taking



continuing education courses. Another option is to train your existing medical staff to deliver the services.

One group, MedCosmetic in Gladstone, Mo., offers seminars throughout the country to physicians interested in adding ancillary cosmetic services to their practices. The seminars include sessions on growing a successful cosmetic laser practice and integrating skin care products into a medical practice. (For more information, go to www.medcosmetic.com).

Both the partners in MedCosmetic, Dr. James Mirabile and Dr. Howard Ellis, are board-certified ob/gyns. They point out that cosmetic services already generate tens of billions of dollars in income every year.

As far as payments for these services are concerned, keep in mind that some insurance plans cover alternative care such as massage or acupuncture for specific medical conditions. If carriers don't reimburse the services, you

Keep in mind that a violation of the Stark regulations can result in a hefty penalty. There are civil monetary penalties of \$15,000 for each violation. Further, any claim paid as a result of an improper referral is an overpayment and punishable by a \$100,000 civil monetary penalty.

must negotiate an hourly rate with patients and be sure to request payment at the time the service is provided. In addition, there may be state licensure requirements and specialty certification for therapists such as acupuncturists and chiropractors.

As far as massage and acupuncture are concerned, some medical practices have added these services. "Nevertheless, they are going to be multi-specialty groups or single-specialty niche groups," says Mr. Johnson.

But many doctors are discovering that patients want complementary and alternative medicine (CAM) therapies to be made available to them through their personal physicians. The practice of holistic medicine integrates conventional and complementary therapies to promote optimal health and to prevent and treat disease by addressing contributing factors, according to the American Holistic Medicine Association (www.holisticmedicine.org), the membership of which consists of allopathic and osteopathic physicians who have integrated alternative therapies into their practices.

Patients use CAM for a wide array of diseases and conditions, according to the National Center for Complementary and Alternative Medicine (NCCAM). Americans are most likely to use CAM for back, neck, head or joint aches, or other painful conditions; colds; anxiety or depression; gastrointestinal disorders, or sleeping problems, says NCCAM. It appears that CAM is most often used to treat and/or prevent musculoskeletal conditions or other conditions involving chronic or recurring pain.

NCCAM estimates that 36 percent of adults in the U.S. are using some form of CAM. Overall, it says, CAM use is greater by:

- Women than men.
- People with higher educational levels.
- People who have been hospitalized in the past year.
- Former smokers, compared with current smokers or those who have never smoked.

Many mainstream healthcare facilities and university health centers are incorporating alternative therapies to meet patient demands. Medical schools are offering a growing number of courses that address alternative therapies. A 1998 survey of the nation's 125 medical schools, published in the *Journal of the American Medical Association*, revealed that 75 offered elective courses in CAM or included CAM topics in required courses.

Stay on the Right Side of Stark

Before launching any ancillary service, make sure your practice will not be in violation of Stark regulations. The Stark statute (officially known as The Physician Self-Referral Law, but referred to as the Stark rules after the legislation's sponsor, Representative Pete Stark of California) prohibits physicians from referring Medicare and Medicaid patients to entities in which they or their immediate family may have a financial interest.

The law applies to 11 designated health services, which include clinical laboratory services, physical therapy services, radiology and certain other imaging services, outpatient prescription drugs and radiation therapy services and supplies.

There is a list of designated health services by CPT code. If the service is not included on the list, then the Stark law would not apply. For the most part, some of exceptions include X-ray, fluoroscopy or ultrasonic procedures that require the insertion of

a needle, catheter, tube or probe through the skin and diagnostic nuclear medical procedures.

In addition, the Stark statute establishes a number of exceptions that describe situations in which referrals between a doctor and an entity are not prohibited.

The financial relationships that trigger the prohibition on referrals include any ownership or investment interest in the entity as well as any compensation arrangement with the entity.

There are several questions to consider when dealing with Stark, according to the American Association of Family Physicians. First, determine if the arrangement involves a referral of a Medicare or Medicaid patient by a physician or an immediate family member of a physician.

Further, is the referral for a “designated health service,” and is there a financial relationship of any kind between the referring physician or a family member and the entity to which the referral is being made? If you answer “no” to all these questions, then Stark does not apply. If you answer “yes” to all three questions, you will have to check to see if there are any exceptions that apply to your situation. There are almost 20 exceptions to the statute.

Keep in mind that a violation of the law can result in a hefty penalty. There are civil monetary penalties of \$15,000 for each violation. Further, any claim paid as a result of an improper referral is an overpayment and punishable by a \$100,000 civil monetary penalty.

The Stark statute became effective in 1995, but it wasn’t until 2001 that the federal government released final regulations for the law. In addition, the Centers for Medicare and Medicaid Services published the Stark II /Phase II Interim Final Rule in 2004. The 169-page rule incorporates into the regulations statutory exceptions including those that apply to ownership and investment, rural hospitals, and recruitment and employment relationships.

The “same building” rules modify previous ones for designated health services such as laboratory work and imaging by establishing three alternative tests, each of which requires a referring physician or group practice to maintain an office in the building where the services are provided and satisfy parameters relating to hours and physician services.

The in-office ancillary services exception, for example, allows physicians to refer patients for certain ancillary designated health services within their own practice, provided that certain location, supervision and billing requirements are satisfied.

The interim regulations address the issue of when groups can share equipment, space and personnel for designated health services by creating stricter tests for what qualifies as the “same building.” The “same building” rules modify previous ones for designated health services such as laboratory work and imaging by establishing three alternative tests, each of which requires a referring physician or group practice to maintain an office in the building where the services are provided and to satisfy parameters relating to hours and physician services. The three standards stipulate that:

- The service site is at the group’s main location, which is open for business at least 35 hours a week and staffed by group physicians at least 30 hours a week.
- The site where the physician refers the patient for the service is one at which the physician or group usually sees the patient. The office must be open at least eight hours a week and staffed by the referring physician at least six hours a week.
- The referring physician orders the service during an office visit on the site where the service is performed, or the referring physician must be on site while the service is performed. The office must be open at least eight hours a week and staffed by the referring physician or members of the same group for six hours a week.

Physicians have to satisfy the requirements of one of the three tests to meet the “same building” requirement. Under these new rules, the test is now tied to the relationship of the patient and the practice. If the patient comes only for designated health services and not for professional services, the services are not considered ancillary to the practice.

It also is important to thoroughly check out the regulations to make sure you are following the legal ways to divide revenue among physicians in your group from ancillary services.

One potential strategy, if you are subject to Stark regulations, is to divide ancillary revenue according to overall productivity, as measured by a physician’s total relative value units.

MGMA hosts a service called StarkCompliance Solutions that offers guidance on the self-referral regulations. The service, which consists of a Website plus periodic bulletins, provides information and guidance on the Stark statute. For example, it allows you to assess whether a medical group meets all of the requirements of a “group practice” under the law, and to understand what specific ancillary and other designated health services are subject to the Stark law. In addition, it contains a business ideas suite that reviews business arrangements that may be feasible for physicians, medical groups and other provider organizations.

Twelve-month subscriptions to StarkCompliance Solutions are \$150 for MGMA members and \$495 for others. For more information, log on to www.starkcompliance.com.

Don't neglect compliance with federal and state anti-kickback statutes. Under the federal law, which is a criminal statute, anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal healthcare program business, including Medicare and Medicaid, can be held accountable for a felony. Violations of the law are punishable by up to five years in prison, criminal fines up to \$25,000, administrative civil money penalties up to \$50,000, and exclusion from participation in federal healthcare programs.

Similar to Stark, there are several statutory exemptions to the federal anti-kickback law, as well as related regulatory safe harbors, which protect arrangements that might otherwise be illegal. If in doubt, check with an attorney who is familiar with the Stark law and anti-kickback statutes.