PUBLICATION

OIG Advisory Opinion 12-06: Provision of Anesthesia Services at Physician-Owned ASCs [Ober|Kaler]

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On May 25, 2012, the U.S. Department of Health and Human Services, Office of Inspector General (OIG) issued Advisory Opinion 12-06 concerning two proposed arrangements for the provision of anesthesia services at physician-owned ambulatory surgical centers (ASCs, or Centers). The OIG concluded that both proposals could potentially generate prohibited remuneration under the antikickback statute.

The requestor is a physician-owned anesthesia services provider that provides anesthesia services on an exclusive basis at several physician-owned ASCs. The Centers bill and collect fees for the ASC facility services from Medicare and other payors, while the requestor independently bills patients and third-party payors, including Medicare, for the professional anesthesia services provided at the Centers. The requestor claims to be contemplating two potential modifications to its current arrangement with the ASCs in an attempt to compete with other anesthesia groups that are engaging in similar practices and to stem the loss of its business.

Under the first proposed arrangement (Arrangement A), the requestor would continue to serve as the exclusive provider of anesthesia services at the Centers, and would bill and retain all collections for its services. In a departure from the current arrangement, however, the requestor would begin paying the Centers for "Management Services," including pre-operative nursing assessments, adequate space for the requestor's physicians and materials, and assistance with transferring billing documentation to the requestor's billing office. According to the requester, the Centers already receive payment for the expenses associated with the Management Services through the Medicare ASC facility fee and similar reimbursement from private payors. Under Arrangement A, however, the requestor would pay the Centers an additional per-patient fee for Management Services, and the Centers would continue to receive the facility fees from Medicare and other payors. The per-patient fee would be set at fair market value, would not take into account the volume or value of referrals or other business between the parties, and would exclude federal health care program patients.

The OIG concluded that the "carve out" of federal health care program beneficiaries from the Management Services fees that the requestor would pay to the Centers under Arrangement A would not reduce the risk of fraud and abuse because the requestor would serve as the exclusive provider of anesthesia services for all of the Centers' patients, including federal health care program beneficiaries. Consequently, carving out federally insured patients does not reduce the risk that the requestor's per-patient payments for Management Services, which compensate the Centers twice for the same services, could be an inducement for the Centers to refer federal program beneficiaries to the requestor or to select the requestor as the exclusive provider of anesthesia services.

Under the second proposed arrangement (Arrangement B), the Centers' physician-owners would establish subsidiaries to exclusively furnish and bill for anesthesia-related services at the Centers. The subsidiaries would then engage the requestor as an independent contractor to provide anesthesia services on an exclusive basis, and would pay the requestor a negotiated rate for those services. The fees paid to the requestor would be paid out of collections made by the subsidiaries for anesthesia-related services, with the subsidiaries retaining any profit.

Although the remuneration generated by surgical services performed in the Centers under Arrangement B would qualify for protection under the ASC safe harbor, the OIG concluded that the remuneration the subsidiaries would distribute to the Centers' physician-owners under Arrangement B would not qualify for any safe harbor protection. According to the OIG, the ASC safe harbor protects returns on investments only when the investment entity itself is a Medicare-certified ASC, which is defined as "any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization." The subsidiaries cannot qualify as Medicare-certified ASCs for purposes of the ASC safe harbor because they would be established solely to provide anesthesia services to the Centers' patients. Thus, the subsidiaries' income would not be protected by the ASC safe harbor. The OIG also concluded that neither the employment safe harbor nor the personal services and management contracts safe harbor would protect the remuneration from the subsidiaries under Arrangement B.

The OIG concluded that Arrangement B poses more than a minimal risk of fraud and abuse, and that it has many of the hallmarks of suspect arrangements that the OIG has identified in prior opinions and Special Advisory Bulletins:

- The Centers' physician-owners would be expanding into a related line of business – anesthesia services — that would be wholly dependent on the Centers' referrals.
- The Centers' physician-owners would not actively participate in running the subsidiaries, but would instead contract out virtually the entire operation to the requestor.
- The physician-owners would face minimal business due to their control of the referral stream to the subsidiaries.
- The requestor is an established provider of the same services that the subsidiaries would provide, and would otherwise be a competitor in the absence of the proposed arrangement.
- The requestor and the Centers' physician-owners would share in the economic benefit of the subsidiaries.

In short, the OIG determined that Arrangement B was apparently "designed to permit the Centers' physician-owners to do indirectly what they cannot do directly; that is, to receive compensation, in the form of a portion of the Requestor's anesthesia services revenues, in return for their referrals to the Requestor."

Comments

While one can fairly debate whether the arrangements described in the OIG Advisory Opinion are desirable as a matter of health care policy, the OIG's analysis in this Advisory Opinion is flawed. At the outset, it is important to note that the Advisory Opinion request clearly was filed to obtain a negative Advisory Opinion. Thus, the facts were skewed in a way designed to achieve that result. Indeed, the arrangement described as "Arrangement A" is so clearly problematic under the antikickback statute that it does not warrant further discussion.

This is not true of Arrangement B. In analyzing that arrangement, the OIG conceded that a wholly owned subsidiary of the ASC could have safe-harbored arrangements (either personal service or employment) with the anesthesiologists and CRNAs. Notwithstanding this, the OIG opined that safe harbor protection is *not* available for the flow of revenue up to the ASC parent and ultimately to the ASCs owners, because the arrangements would be with a wholly owned subsidiary, rather than the ASC itself.

This exalts form over substance. The fact that the revenue comes from a wholly owned subsidiary rather from the ASC itself should not be viewed as material for purposes of the antikickback analysis. Antitrust law has long recognized that a corporation and its wholly owned subsidiaries should be analyzed as a single

enterprise. *Copperweld Corporation v. Independence Tube Corporation*, 467 U.S. 752 (1984). This same concept should apply under the antikickback statute.

The Advisory Opinion is unclear as to whether the OIG would reach a similar conclusion in the event that the anesthesiologists and/or CRNAs were employed by, or contracted directly with, the ASC. To the extent that the Advisory Opinion suggests that they could not, it is incorrect. Medicare-certified ASCs are expressly permitted to purchase anesthesia services pursuant to safe-harbored arrangements and then to bill for those services under a reassignment of benefits. *See* MLN Matters MM6358, Processing and Payment of Physician and Non-Physician Practitioner Services Reassigned to Ambulatory Surgical Centers. An ASC that does this clearly retains its status as an ASC both for purposes of ASC certification and compliance with the ASC safe harbor. While the safe harbor does exempt payments for "ancillary services" from its protection, this carve-out is not applicable to physician services. "Ancillary services" is a term of art that applies only to ancillary technical services provided integral to covered surgical procedures. Thus, the arrangement would be safe harbored.

Notwithstanding its analytical flaws, the Advisory Opinion does provide a fairly clear statement of the OIG's view of these types of arrangements. Thus, providers would be well-advised to review any arrangement between an ASC and an anesthesia provider very carefully.