

Issue brief: Physician self-referral

Introduction

Physician self-referral continues to be a priority issue in health care. In the midst of an increasingly challenging economic environment, physicians are facing shrinking health care reimbursements as well as a corresponding increase in competition. The decreases in physician reimbursement and growth in competition has motivated some to oppose physicians' efforts to create independent practice facilities and to place tighter restrictions on physicians' referring to in-office ancillary services, such as radiology and physical therapy.

Comparison of state self-referral laws with federal statute

Although physician self-referral is regulated at the federal level through the Stark law, its application is limited only to Medicaid and Medicare referrals. State law restrictions on self-referral can, and often do, apply to physician self-referral arrangements regardless of payment source, including state Medicaid programs. While many of these state laws seem to be quite similar to the Stark statute, a number of them differ from the federal law. The following are three significant differences that often exist between the Stark statute and state self-referral restrictions.

- **Difference #1: State laws may apply to more payers**
State self-referral prohibitions are generally not limited to the payer involved. Although the Stark statute only applies to Medicaid and Medicare referrals, state referral restrictions will generally apply regardless of payment source, although a few are confined to specific payment programs, such as Medicaid.
- **Difference #2: State laws may apply to more providers**
State self-referral prohibitions are often broader than Stark in terms of providers regulated. The Stark statute applies only to physician referrals. Many state statutes apply, however, to a broader category of providers, e.g., chiropractors, optometrists, nurses, physical therapists.
- **Difference #3: State laws may encompass a broader range of services**
Stark currently applies only to referrals for "designated health services." "Designated health services" are comprised of the following 12 types of services: (1) clinical laboratory services; (2) physical therapy services; (3) occupational therapy services; (4) Outpatient speech-language pathology services; (5) radiology services, including ultrasound, MRI and CT scans; (6) radiation therapy services; (7) DME; (8) parenteral and enteral nutrients, equipment and supplies; (9) prosthetics, orthotics and prosthetic devices; (10) home health services; (11) outpatient prescription drugs; and (12) inpatient and outpatient hospital services. State self-referral statutes and regulations often apply to a much broader category of referrals, e.g., referrals to a "health care service." Although a number of state laws use the term "designated health services," be aware that a state's definition of this phrase may differ from that in the Stark law.

Types of state self-referral laws

At least 35 states have enacted laws or administrative rules restricting physician self-referral arrangements. These state laws can vary greatly in terms of complexity and breadth of application. They can be classified in the following three categories:

1. **Most restrictive:** Laws that prohibit physician self-referral *except in certain specific circumstances*, and, even when those specific circumstances exist, *self-referral is only permitted if the physician discloses his/her financial interest to the patient at the time of referral*.
2. **Moderately restrictive:** Laws that prohibit physician self-referral *except in certain specific circumstances*, and *do not contain disclosure requirements*.
3. **Least restrictive:** Laws that allow physician self-referral, so long as the physician discloses his/her financial interest to the patient at the time of referral.

AMA Policy

H-140.861 Physicians' Self-Referral

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

- (1) Ensure that referrals are based on objective, medically relevant criteria.
- (2) Ensure that the arrangement:
 - (a) is structured to enhance access to appropriate, high quality health care services or products;
 - (b) within the constraints of applicable law:
 - (i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
 - (ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
 - (iii) adheres to fair business practices vis-à-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
- (3) Take steps to mitigate conflicts of interest, including:

- (a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
 - (b) establishing mechanisms for utilization review to monitor referral practices; and
 - (c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
- (4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral. (CEJA Rep. 1, I-08)

D-270.995 Physician Ownership and Referral for Imaging Services

Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services. (Res. 235, A-04; Reaffirmed in lieu of Res. 901, I-05)

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