# "ORTHOPAEDIC OUTPATIENT CLINICS: LIFE VEST IN SHARK (STARK) INFESTED WATER?"

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Several California hospitals have begun to operate orthopaedic outpatient clinics as a vehicle through which to recruit new physicians or to retain their existing physician bases. In certain settings, hospitals utilize these clinics as a pathway to help insure full time orthopedic surgical coverage. These clinics do not require separate licensure; they are exempt[1] because they operate as outpatient departments of the hospitals. This article focuses on key issues that present from the operation of these outpatient clinics.

First, physicians are primarily attracted to the outpatient clinic model as a means to reduce their practice overhead significantly. In the typical private practice setting, physicians are responsible for providing (and paying for) office space, equipment, furniture and furnishings, supplies, personnel, billing and collection, and administrative support (collectively, the "**Facilities**"). Under the outpatient clinic model, the hospital provides the lion's share of these items. The physicians remain responsible to provide professional liability insurance, billing and collection services, and reduced management and administrative support.

For each patient encounter in the outpatient setting, the hospital seeks to recover the cost of providing the Facilities by submitting a separate bill to the applicable third party payer. Correspondingly, the attending physician (or his or her orthopedic group) submits a bill to the same payer with a location modifier to denote that the patient encounter occurred in an outpatient facility. In theory, the hospital should receive reimbursement from the payer for the cost of the Facilities. In turn, the physician should receive a reduced fee from the payer for his or her professional services in recognition of the payment to the hospital for the Facilities. And, in theory, the savings to the physician from not having to provide (and pay for) the Facilities should be greater than the aggregate reduction in fees occasioned by the application of the location modifier in billing for professional services.

Unfortunately, theory sometimes conflicts with practice when the hospital and physician submit bills to commercial payers, and when physicians receive global surgical fees that include reimbursement for post-operative visits. The Medicare program recognizes the billing dichotomy in the clinic setting. The Medicare program will reimburse the hospital in respect of the Facilities furnished for each patient visit. Likewise, the Medicare program will reimburse the physician for professional services at a lower rate in recognition of the location modifier.[2] In contrast, the majority of commercial payers are either unable or unwilling to separately reimburse both the hospital and the physician. Instead, these commercial payers reimburse the physician for the office visit as if the encounter occurred in the private practice setting, even when the physician includes the location modifier on the bill. As a result, the physician receives a global fee from the commercial payer that includes reimbursement for the Facilities.

Likewise, a physician will receive a ***global surgical fee*** both from the Medicare program and commercial payers. That fee will include reimbursement for post-operative visits. Those visits will occur in the outpatient clinic setting in which the physician will utilize the Facilities. However, the facility fee received by the hospital in connection with the surgery (inpatient or outpatient) will not include reimbursement for the Facilities in the outpatient clinic setting.

**Importantly, the physician should not retain the entire surgical global fee, even if the hospital permits the physician to do so. Instead, the physician should utilize a portion of the global surgical fee to reimburse the hospital for the Facilities. The failure of the physician to reimburse the hospital and/or the unwillingness of the hospital to accept reimbursement from the physician for the Facilities could be construed as consideration paid by the hospital to the physician in exchange of patient referrals, a violation of federal and state anti-kickback laws.**

Aside from the billing-related issues, there remain many traps for the unwary. First, physicians will no longer be able to operate ancillary services covered by federal and state self-referral prohibitions (*e.g.*, diagnostic imaging and physical therapy) following affiliation with an outpatient clinic. Physicians typically operate these services pursuant to the so-called in office ancillary services exception to the self-referral prohibitions. This exception requires the physicians to control the office space in which they operate the covered ancillary services.[3] The hospital controls the office space under the outpatient clinic model. As a result, the physicians likely will lose ancillary service revenue. However, physicians can mitigate this financial loss by attempting to sell their ancillary service product lines to the clinic-sponsoring hospital.[4]

Second, physicians that affiliate with an outpatient clinic continue to bill and collect fees for their professional services. In the absence of a valid recruitment arrangement, the sponsoring hospital cannot guarantee the net income of the physicians that staff

(Continued on Page 10)

the outpatient clinic. Hence, the income of the participating physicians generally remains dependent on their productivity and, correspondingly, their ability to compete successfully with other physicians that staff the outpatient clinic for patients from traditional referral sources.

In some instances, an orthopedic group will attempt to negotiate the exclusive right to provide orthopedic services in the outpatient clinic, similar to arrangements under which a hospital "closes" an inpatient department and awards an exclusive contract to a group of physicians. Under California law, however, a hospital that contracts with the Medi-Cal program cannot "close" any department or service other than radiology, anesthesiology and pathology.[5]

Third, a physician typically affiliates with an outpatient clinic through a professional services agreement ("**PSA**") with the sponsoring hospital. The PSA is an important document and governs the relationship of the physician and hospital during the term of the affiliation with the outpatient clinic. Among other matters, the PSA should address the obligation of the hospital to furnish the Facilities, the separate billing and collection functions of the parties, the payment by the physician of a portion of the global fee to reimburse the hospital in respect of Facilities furnished for patient visits in outpatient clinic. The PSA should also cover the obligation of the hospital to provide those ancillary services that are necessary for quality patient care in a convenient location. In addition, the PSA should cover obligations of the parties regarding the provision of professional liability, comprehensive general liability and property damage insurance coverage. In many instances, the proposed PSA is either silent on many of these key provisions, or the provisions are *very* hospital friendly.

The PSA should also address the term of the affiliation, the events that permit either party to terminate the arrangement, and the rights of the physician following dissociation from the outpatient clinic. While the PSA often times will provide for a fixed term, the PSA may also give either party the right to terminate at any time, without cause, with advance written notice. In that case, the term of the PSA is only as long as the notice period, notwithstanding the expectation of the participating physician. *Importantly*, the physician needs to consider how he or she will practice following dissociation from the outpatient clinic. For example, the physician may need to lease new office space and fund the cost of tenant improvements. The physician will also have to provide furniture and equipment, and hire support personnel. In essence, the physician will have to recreate the Facilities that the hospital had been providing under the PSA.

The looming financial exposure can be more acute in the case of an orthopedic group that sells its leasehold interest, tangible assets, and ancillary service product lines to the sponsoring hospital concurrently with the execution of the PSA. For one, even if the orthopedic group could recreate the Facilities, the cost of rebuilding the ancillary service product lines, and especially an ambulatory surgical center, could be prohibitive following the termination of the PSA. This result could be problematic for an orthopedic group that relied on ancillary service revenue to help supplement professional fees, and pay overhead. In short, the "exit" provisions are critical because the proceeds of any sale prior to affiliation with the outpatient clinic are generally not sufficient alone to permit the physician(s) to retire. The time to consider these issues is *before* the parties execute the PSA, after which the hospital will have substantially greater leverage.

Physicians should understand that the implementation by hospitals of the outpatient clinic model is a relatively recent development. There are currently no court cases that address the legal issues that present, nor has the Legislature addressed this health care delivery system through new statutes or regulations. Given this legal vacuum, some hospitals have attempted to structure the outpatient clinic in ways that historically have proven problematic. Physicians are cautioned that such arrangements could run afoul of several federal and state laws, including antitrust, anti-kickback, and the corporate practice of medicine prohibitions. Physicians should understand that participation in any such improper transaction could constitute unprofessional conduct and expose the physicians to disciplinary action by the Medical Board of California.

In closing, there are pros and cons to the outpatient clinic model. If structured correctly, physicians or groups of physicians can benefit greatly from their affiliation with an outpatient clinic. That said, and as in many transactions, the "devil is in the detail."

1. Section 1206(d) of the Health and Safety Code.
2. A physician submits a false claim when failing to include the location modifier in the bill. The lack of the location modifier implies that the physician furnished the Facilities when, in fact, the hospital furnished such items in connection with the patient encounter. By excluding the location modifier, the physician is requesting payment for goods and services not actually furnished to the Medicare beneficiary, the very essence of a false claim.
3. Physicians typically give up their private practice offices – and the overhead associated with those offices – following affiliation with an outpatient clinic.
4. The purchase price must be fair market value and should be determined by an independent third party. Differences of opinion between the hospital and physician often arise over the valuation methodology. Not surprisingly, the purchase price can vary markedly depending on the methodology employed by the appraiser.
5. California Welfare & Institutions Code Section 14087.28