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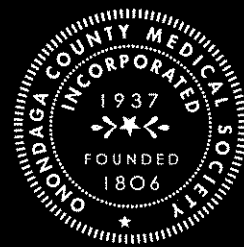


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ONONDAGA COUNTY MEDICAL SOCIETY

# Bulletin

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# Reassignment - Congress Giveth and CMS Attempts to Taketh Away

By Marc S. Beckman, J.D.

The Medicare Reassignment rules made news last Winter when, through Section 952 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the so-called Medicare Modernization Act, or MMA), Congress substantially relaxed the rules concerning the use of independent contractors. As discussed below, however, the recently released proposed Medicare Physician Fee Schedule for 2005 attempts to pull back some of that flexibility, and of course, add a little confusion into the mix.

For those not already aware, Medicare has a rule that prohibits anyone other than a Medicare beneficiary, or the physician or other person that actually provided services to such patient, to receive payment for such services, unless an exception applies. The exceptions to the reassignment prohibition, therefore, become very important for many common physician relationships. For example, possibly the most commonly used exception is for payments made to the employer of the physician. By use of this exception, an employer (such as a professional corporation (PC)) is permitted to directly bill and receive payment for the services of its physician employees. This exception is fairly straightforward in that the principal element is a bona fide employee-employer relationship between the parties whereby the physician, as a

condition of employment, agrees to turn over to the employer all fees related to such employment. Non-physician practitioners are permitted to reassign in the same manner.

Prior to the enactment of MMA, there was no similar exception for independent contractors. In order for an entity to bill and collect for the services of an independent contract, the independent contractor physician's services had to be performed on the premises owned or leased by the entity. For example, imagine a PC composed of internal medicine physicians entering into an independent contractor relationship with another physician to assist in coverage on an on-going periodic basis. So long as the independent contractor provides the services in the office of the PC, Medicare does not object. But when that independent contractor made rounds in the hospital or skilled nursing facility covered by the PC's physicians, then the exception is not met and billing by the PC was precluded.

Another common example of the use of independent contracts involves the provision of professional interpretations for diagnostic tests. The so-called "clinic exception" permitted independent contractors to provide professional interpretations for other group practices, and permit such group practices to bill

for the services of the independent contractor if the services of the independent contractor were provided on premises leased or owned by the group. Therefore, an independent contractor radiologist could review CT scans performed by an orthopedic practice (within the confines of the Stark Law's in-office ancillary services exception), and be paid a set fair market value fee while the orthopedic group bills globally, so long as the radiologist performed the interpretations while in the group's office.

The problematic example of the reassignment prohibition which prompted Section 952 of the MMA manifested itself in Hospital Emergency Departments. It is often the case that a Hospital enters into a contractual arrangement with a PC to provide medical staffing to the ED and for the PC to bill and collect for the professional medical services provided to patients in the ED. The problem would arise if the PC wanted or needed to utilize independent contractors instead of employees, or if the PC was acting more like a staff leasing company and leasing employees to staff the ED. In this case, however, the PC does not own or lease the applicable space in the ED. Therefore, the clinic exception cannot be utilized and neither can the employment exception.<sup>1</sup>

The federal General Accounting Office's report 03-185 (March 2003), recommended to Congress that it permit reassignment of benefits to staffing companies that retain contractor physicians. The GAO felt that this would actually enhance program integrity efforts because it would force the staffing companies to enroll in the Medicare program and be subject to

CMS oversight. CMS responded to a draft of the GAO report indicating that it felt that since the GAO report concluded that the program is not more vulnerable for improper billing when there is a staffing company contract arrangement, CMS would prefer that the entire prohibition on reassignment by contractors be eliminated rather than tailoring the change to staffing companies.

Accordingly, through Section 952 of the MMA, Congress simply provided that reassignment is permitted where a service is provided under a contractual arrangement between such physician to an entity if, under the contractual arrangement, the entity submits the bill for the service *and other safeguards as [CMS] may determine to be appropriate*. This language deleted the prior statutory requirement that the service have been performed in a "clinic" (among other places) from which the "clinic exception" was born.

CMS had its first crack at Section 952 of the MMA through Medicare Transmittal 111, dated February 27, 2004. This transmittal provided:

The contractual arrangement between the entity and the physician or other person *should* include the following program integrity safeguards:

1. Joint and several liability is shared between the entity submitting the claim and the person actually furnishing the service, for any Medicare overpayment relating to such claim.
2. The person furnishing the service has unrestricted access to claims submitted by the entity for the services provided by that person.

Not willing to permit the rule to stand as above, CMS now makes clear in the 2005 Proposed Physician Fee Schedule that it feels the "should" ought to be changed to "must", and makes it known that parties to this type of reassignment contract will be jointly and severally liable for what is billed to the Medicare program.

CMS also goes at length in the Proposed Fee Schedule to point out that compliance with the Stark Law and the Medicare Reassignment Exception will be treated distinctly. For example, the Proposed Fee Schedule reminds physician group practices that the Stark Law's in-office ancillary services exception, requires that independent contractors provide services to the group practice's patients in the group's facilities in order to be considered "a physician in the group practice." In summary, it is a requirement of the Stark Law in-office ancillary services exception to comply with the reassignment exception for an independent contractor to be considered a physician in the group. Furthermore, even though that reassignment exception now permits services to be provided by the independent contractor on or off the group practice's premises, CMS reminds us that Stark still requires the services to be provided on the premises for this exception to be used.

In addition, to add a bit of further confusion to the mix it would also appear that CMS is proposing to revise 42 C.F.R. Section 424.80 to provide that physician employees will be treated like independent contractors for purposes of the above two requirements, established by Congress for independent contractors. That is, physician employees will now be jointly and severally liable for all amounts billed to

Medicare, together with their employers, and physician employees would also have unrestricted access to the billing records of their employers with respect to services they provide. It must be presumed that the same applies to non-physician practitioners as well.

Finally, it is essential to note that CMS ends its discussion on this topic with the following statement. "We intend to monitor reassignment arrangements for potential program abuse." Earlier, CMS indicated that it feels that the new reassignment exception created by Congress in the MMA "may create new fraud and abuse vulnerabilities which may not become apparent until the program has experience with the new contractual arrangements addressed in Section 952 of the MMA."

*Editor's Note: The author is a partner in the law firm of Scolaro, Shulman, Cohen, Fetter & Burstein, P.C. The information provided is not intended to be used as or to be considered as a substitute for specific legal advice.*

1 CMS previously added confusion to this issue through the Phase I Stark Law Regulations issued on January 4, 2001. The Phase I Regulations indicated that leased employees would be treated the same as employees so long as they would be considered bona fide employees under state law. CMS took the opposite approach for purposes of the reassignment rules. Under the proposed 2005 fee schedule, the net effect would now be about the same since CMS is proposing to add joint and several liability for employees as well as independent contractors and leased employees.

## TODAY Study – A Look at Type 2 Diabetes In Children

The Joslin Diabetes Center at SUNY Upstate Medical University is one of 12 sites around the country to participate in a research study to look at treatment of children and adolescents with type 2 diabetes. Once seen only in adults, type 2 diabetes is on the rise in children.

The TODAY (Treatment Options for type 2 Diabetes in Adolescents and Youth) study is the first clinical trial sponsored by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), one of the National Institutes of Health (NIH) under the Department of Health and Human Services, to focus on type 2 diabetes in youth.

Participants will be randomly assigned to one of three treatment groups: metformin alone; metformin and rosiglitazone in combination; and metformin plus intensive lifestyle change aimed at losing weight and increasing physical activity. Researchers plan to enroll 750 children and teens 10 to 17 years old diagnosed with type 2 diabetes in the past 2 years. The trial is expected to last 5 years.

The TODAY study's main goal is to determine how well and for how long each treatment approach controls blood glucose levels. The study will also evaluate:

The safety of the treatments; the effects of the treatments on insulin

production, insulin resistance (a hallmark of type 2 diabetes in which cells do not effectively use insulin), body composition, nutrition, physical activity and aerobic fitness, risk factors for eye, kidney, nerve, and heart disease, quality of life, and psychological outcomes; the influence of individual and family behaviors on treatment response; the cost-effectiveness of the treatment.

Many drugs are available to treat type 2 diabetes in adults, but metformin, which lowers the liver's production of glucose, is the only oral drug approved by the Food and Drug Administration to treat type 2 diabetes in children. Rosiglitazone, the other oral medicine used in the TODAY study belongs to a class of insulin-sensitizing drugs called the thiazolidinediones (TZDs). It helps muscle cells respond to insulin and use glucose more efficiently.

TODAY is the first clinical study to look at the effects of intensive lifestyle change aimed at lowering weight by cutting calories and increasing physical activity in youths with type 2 diabetes. The NIDDK-sponsored LookAHEAD trial is currently studying the benefits of weight loss in adults with type 2 diabetes.

Once seen only in adults, type 2 diabetes has been rising steadily in all children, especially African American, Hispanic American and American