



Effective: December 8, 2003

United States Code Annotated [Currentness](#)

Title 42. The Public Health and Welfare

Chapter 7. Social Security ([Refs & Annos](#))

▣ [Subchapter XVIII. Health Insurance for Aged and Disabled \(Refs & Annos\)](#)

▣ [Part E. Miscellaneous Provisions \(Refs & Annos\)](#)

→ § 1395nn. **Limitation on certain physician referrals**

(a) Prohibition of certain referrals

(1) In general

(1) In general

Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then--

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

(B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

(2) Financial relationship specified

(2) Financial relationship specified

For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph is--

(A) except as provided in subsections (c) and (d) of this section, an ownership or investment interest in the entity, or

(B) except as provided in subsection (e) of this section, a compensation arrangement (as defined in subsection (h)(1) of this section) between the physician (or an immediate family member of such physician) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) General exceptions to both ownership and compensation arrangement prohibitions

Subsection (a)(1) of this section shall not apply in the following cases:

(1) Physicians' services

In the case of physicians' services (as defined in [section 1395x\(q\)](#) of this title) provided personally by (or under the personal supervision of) another physician in the same group practice (as defined in subsection (h)(4) of this section) as the referring physician.

(2) In-office ancillary services

In the case of services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)--

(A) that are furnished--

(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or by another physician in the group practice, and

(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of designated health services, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice--

(aa) for the provision of some or all of the group's clinical laboratory services, or

(bb) for the centralized provision of the group's designated health services (other than clinical laboratory services),

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse, and

(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by such physician or such group practice,

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) Prepaid plans

In the case of services furnished by an organization--

(A) with a contract under [section 1395mm](#) of this title to an individual enrolled with the organization,

(B) described in [section 1395l\(a\)\(1\)\(A\)](#) of this title to an individual enrolled with the organization,

(C) receiving payments on a prepaid basis, under a demonstration project under [section 1395b-1\(a\)](#) of this title or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization,

(D) that is a qualified health maintenance organization (within the meaning of [section 300e-9\(d\)](#) of this title) to an individual enrolled with the organization, or

(E) that is a Medicare+Choice organization under part C of this subchapter that is offering a coordinated care plan described in [section 1395w-21\(a\)\(2\)\(A\)](#) of this title to an individual enrolled with the organization.

(4) Other permissible exceptions

In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(5) Electronic prescribing

An exception established by regulation under [section 1395w-104\(e\)\(6\)](#) of this title.

(c) General exception related only to ownership or investment prohibition for ownership in publicly traded securities and mutual funds

Ownership of the following shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A) of this section:

(1) Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) which may be purchased on terms generally available to the public and which are--

(A)(i) securities listed on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis, or foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis, or

(ii) traded under an automated interdealer quotation system operated by the National Association of Securities Dealers, and

(B) in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous 3 fiscal years, stockholder equity exceeding \$75,000,000.

(2) Ownership of shares in a regulated investment company as defined in [section 851\(a\) of the Internal Revenue Code](#) of 1986, if such company had, at the end of the company's most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding \$75,000,000.

(d) Additional exceptions related only to ownership or investment prohibition

The following, if not otherwise excepted under subsection (b) of this section, shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A) of this section:

(1) Hospitals in Puerto Rico

In the case of designated health services provided by a hospital located in Puerto Rico.

(2) Rural providers

In the case of designated health services furnished in a rural area (as defined in [section 1395ww\(d\)\(2\)\(D\)](#) of

this title) by an entity, if--

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area; and

(B) effective for the 18-month period beginning on December 8, 2003, the entity is not a specialty hospital (as defined in subsection (h)(7) of this section).

(3) Hospital ownership

In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if--

(A) the referring physician is authorized to perform services at the hospital;

(B) effective for the 18-month period beginning on December 8, 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7) of this section); and

(C) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

(e) Exceptions relating to other compensation arrangements

The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B) of this section:

(1) Rental of office space; rental of equipment

(A) Office space

(A) Office space

Payments made by a lessee to a lessor for the use of premises if--

(i) the lease is set out in writing, signed by the parties, and specifies the premises covered by the lease,

(ii) the space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if such payments do not exceed the lessee's pro rata share of expenses for such space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using such common areas,

(iii) the lease provides for a term of rental or lease for at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Equipment

(B) Equipment

Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if--

(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

(ii) the equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee,

(iii) the lease provides for a term of rental or lease of at least 1 year,

(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) Bona fide employment relationships

Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if--

(A) the employment is for identifiable services,

(B) the amount of the remuneration under the employment--

(i) is consistent with the fair market value of the services, and

(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,

(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and

(D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).

(3) Personal service arrangements

(A) In general

(A) In general

Remuneration from an entity under an arrangement (including remuneration for specific physicians' services furnished to a nonprofit blood center) if--

- (i) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement,
- (ii) the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity,
- (iii) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement,
- (iv) the term of the arrangement is for at least 1 year,
- (v) the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and except in the case of a physician incentive plan described in subparagraph (B), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,
- (vi) the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and
- (vii) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(B) Physician incentive plan exception

(i) In general

(i) In general

In the case of a physician incentive plan (as defined in clause (ii)) between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

- (I) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity.
- (II) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to [section 1395mm\(i\)\(8\)\(A\)\(ii\)](#) of this title, the plan complies with any requirements the Secretary may impose pursuant to such section.
- (III) Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance

with the requirements of this clause.

(ii) “Physician incentive plan” defined

(ii) “Physician incentive plan” defined

For purposes of this subparagraph, the term “physician incentive plan” means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

(B) Physician incentive plan exception

(i) In general

(i) In general

In the case of a physician incentive plan (as defined in clause (ii)) between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(I) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity.

(II) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to [section 1395mm\(i\)\(8\)\(A\)\(ii\)](#) of this title, the plan complies with any requirements the Secretary may impose pursuant to such section.

(III) Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause.

(ii) “Physician incentive plan” defined

(ii) “Physician incentive plan” defined

For purposes of this subparagraph, the term “physician incentive plan” means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

(4) Remuneration unrelated to the provision of designated health services

In the case of remuneration which is provided by a hospital to a physician if such remuneration does not relate to the provision of designated health services.

(5) Physician recruitment

In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospi-

al, if--

(A) the physician is not required to refer patients to the hospital,

(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(6) Isolated transactions

In the case of an isolated financial transaction, such as a one-time sale of property or practice, if--

(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to an employer, and

(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(7) Certain group practice arrangements with a hospital

(A) [FN1] In general

(A) [FN1] In general

An arrangement between a hospital and a group under which designated health services are provided by the group but are billed by the hospital if--

(i) with respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under [section 1395x\(b\)\(3\)](#) of this title,

(ii) the arrangement began before December 19, 1989, and has continued in effect without interruption since such date,

(iii) with respect to the designated health services covered under the arrangement, substantially all of such services furnished to patients of the hospital are furnished by the group under the arrangement,

(iv) the arrangement is pursuant to an agreement that is set out in writing and that specifies the services to be provided by the parties and the compensation for services provided under the agreement,

(v) the compensation paid over the term of the agreement is consistent with fair market value and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

(vi) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity, and

(vii) the arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(8) Payments by a physician for items and services

Payments made by a physician--

(A) to a laboratory in exchange for the provision of clinical laboratory services, or

(B) to an entity as compensation for other items or services if the items or services are furnished at a price that is consistent with fair market value.

(f) Reporting requirements

Each entity providing covered items or services for which payment may be made under this subchapter shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including--

(1) the covered items and services provided by the entity, and

(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A) of this section), or with a compensation arrangement (as described in subsection (a)(2)(B) of this section), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provides [\[FN2\]](#) services for which payment may be made under this subchapter very infrequently.

(g) Sanctions

(1) Denial of payment

(1) Denial of payment

No payment may be made under this subchapter for a designated health service which is provided in violation of subsection (a)(1) of this section.

(2) Requiring refunds for certain claims

(2) Requiring refunds for certain claims

If a person collects any amounts that were billed in violation of subsection (a)(1) of this section, the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) Civil money penalty and exclusion for improper claims

(3) Civil money penalty and exclusion for improper claims

Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than \$15,000 for each such service. The provisions of [section 1320a-7a](#) of this title (other than the first sentence of subsection (a) and

other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(4) Civil money penalty and exclusion for circumvention schemes

(4) Civil money penalty and exclusion for circumvention schemes

Any physician or other entity that enters into an arrangement or scheme (such as a cross-referral arrangement) which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil money penalty of not more than \$100,000 for each such arrangement or scheme. The provisions of [section 1320a-7a](#) of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(5) Failure to report information

(5) Failure to report information

Any person who is required, but fails, to meet a reporting requirement of subsection (f) of this section is subject to a civil money penalty of not more than \$10,000 for each day for which reporting is required to have been made. The provisions of [section 1320a-7a](#) of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under [section 1320a-7a\(a\)](#) of this title.

(6) Advisory opinions

(A) In general

(A) In general

The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(B) Application of certain rules

(B) Application of certain rules

The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) of this section and take into account the regulations promulgated under [subsection \(b\)\(5\) of section 1320a-7d](#) of this title in the issuance of advisory opinions under this paragraph.

(C) Regulations

(C) Regulations

In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(D) Applicability

(D) Applicability

This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after August 5, 1997, and before the close of the period described in [section 1320a-7d\(b\)\(6\)](#) of this title.

(6) Advisory opinions

(A) In general

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The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

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The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) of this section and take into account the regulations promulgated under [subsection \(b\)\(5\) of section 1320a-7d](#) of this title in the issuance of advisory opinions under this paragraph.

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In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

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This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after August 5, 1997, and before the close of the period described in [section 1320a-7d\(b\)\(6\)](#) of this title.

(h) Definitions and special rules

For purposes of this section:

(1) Compensation arrangement; remuneration

(A) The term “compensation arrangement” means any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity other than an arrangement involving only remuneration described in subparagraph (C).

(B) The term “remuneration” includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

(C) Remuneration described in this subparagraph is any remuneration consisting of any of the following:

(i) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

(ii) The provision of items, devices, or supplies that are used solely to--

(I) collect, transport, process, or store specimens for the entity providing the item, device, or supply, or

(II) order or communicate the results of tests or procedures for such entity.

(iii) A payment made by an insurer or a self-insured plan to a physician to satisfy a claim, submitted on a fee for service basis, for the furnishing of health services by that physician to an individual who is covered by a policy with the insurer or by the self-insured plan, if--

(I) the health services are not furnished, and the payment is not made, pursuant to a contract or other arrangement between the insurer or the plan and the physician,

(II) the payment is made to the physician on behalf of the covered individual and would otherwise be made directly to such individual,

(III) the amount of the payment is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account directly or indirectly the volume or value of any referrals, and

(IV) the payment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(2) Employee

An individual is considered to be “employed by” or an “employee” of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of [section 3121\(d\)\(2\) of the Internal Revenue Code](#) of 1986).

(3) Fair market value

The term “fair market value” means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(4) Group practice

(A) Definition of group practice

(A) Definition of group practice

The term “group practice” means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association--

(i) in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel,

(ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group,

(iii) in which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined,

(iv) except as provided in subparagraph (B)(i), in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician,

(v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, and

(vi) which meets such other standards as the Secretary may impose by regulation.

(B) Special rules

(i) Profits and productivity bonuses

(i) Profits and productivity bonuses

A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.

(ii) Faculty practice plans

(ii) Faculty practice plans

In the case of a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, subparagraph (A) shall be applied only with respect to the services provided within the faculty practice plan.

(B) Special rules

(i) Profits and productivity bonuses

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A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus

based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.

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(5) Referral; referring physician

(A) Physicians' services

(A) Physicians' services

Except as provided in subparagraph (C), in the case of an item or service for which payment may be made under part B of this subchapter, the request by a physician for the item or service, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a "referral" by a "referring physician".

(B) Other items

(B) Other items

Except as provided in subparagraph (C), the request or establishment of a plan of care by a physician which includes the provision of the designated health service constitutes a "referral" by a "referring physician".

(C) Clarification respecting certain services integral to a consultation by certain specialists

(C) Clarification respecting certain services integral to a consultation by certain specialists

A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy, if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician".

(6) Designated health services

The term "designated health services" means any of the following items or services:

(A) Clinical laboratory services.

(B) Physical therapy services.

(C) Occupational therapy services.

(D) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services.

(E) Radiation therapy services and supplies.

(F) Durable medical equipment and supplies.

(G) Parenteral and enteral nutrients, equipment, and supplies.

(H) Prosthetics, orthotics, and prosthetic devices and supplies.

(I) Home health services.

(J) Outpatient prescription drugs.

(K) Inpatient and outpatient hospital services.

(7) Specialty hospital

(A) In general

(A) In general

For purposes of this section, except as provided in subparagraph (B), the term “specialty hospital” means a subsection (d) hospital (as defined in [section 1395ww\(d\)\(1\)\(B\)](#) of this title) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

(i) Patients with a cardiac condition.

(ii) Patients with an orthopedic condition.

(iii) Patients receiving a surgical procedure.

(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

(B) Exception

(B) Exception

For purposes of this section, the term “specialty hospital” does not include any hospital--

(i) determined by the Secretary--

(I) to be in operation before November 18, 2003; or

(II) under development as of such date;

(ii) for which the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date;

(iii) for which the type of categories described in subparagraph (A) at any time on or after such date is no different than the type of such categories as of such date;

(iv) for which any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

(v) that meets such other requirements as the Secretary may specify.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, § 1877, as added Dec. 19, 1989, [Pub.L. 101-239, Title VI, § 6204\(a\)](#), 103 Stat. 2236, and amended Nov. 5, 1990, [Pub.L. 101-508, Title IV, § 4207\(e\)\(1\)](#) to (3), (k)(2), formerly § 4027(e)(1) to (3), (k)(2), 104 Stat. 1388-121, 1388-122, 1388-124; Aug. 10, 1993, [Pub.L. 103-66, Title XIII, § 13562\(a\)](#), 107 Stat. 596; renumbered and amended Oct. 31, 1994, [Pub.L. 103-432, Title I, §§ 152\(a\), \(b\), 160\(d\)\(4\)](#), 108 Stat. 4436, 4444; Aug. 5, 1997, [Pub.L. 105-33, Title IV, § 4314](#), 111 Stat. 389; Nov. 29, 1999, [Pub.L. 106-113, Div. B, § 1000\(a\)\(6\)](#) [Title IV, § 524(a)], 113 Stat. 1536, 1501A-387; Dec. 8, 2003, [Pub.L. 108-173, Title I, § 101\(e\)\(8\)\(B\), Title V, § 507\(a\)](#), 117 Stat. 2152, 2295.)

[FN1] So in original. No subpar. (B) was enacted.

[FN2] So in original. Probably should be “provide”.

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1989 Acts. [House Report No. 101-247](#), [House Conference Report No. 101-386](#), and Statement by President, see 1989 U.S. Code Cong. and Adm. News, p. 1906.

1990 Acts. [House Report No. 101-881](#) and [House Conference Report No. 101-964](#), see 1990 U.S. Code Cong. and Adm. News, p. 2017.

1993 Acts. [House Report No. 103-111](#) and [House Conference Report No. 103-213](#), see 1993 U.S. Code Cong. and Adm. News, p. 378.

1997 Acts. [House Report No. 105-149](#), [House Conference Report No. 105-217](#), and Statement by President, see 1997 U.S. Code Cong. and Adm. News, p. 176.

1999 Acts. Statement by President, see 1999 U.S. Code Cong. and Adm. News, p. 290.

2003 Acts. [House Conference Report No. 108-391](#) and Statement by President, see 2003 U.S. Code Cong. and Adm. News, p. 1808.

Part C of this subchapter, referred to in subsec. (b)(3)(E), is Medicare+Choice Program, which is classified to [42 U.S.C.A. § 1395w-21 et seq.](#)

References in Text

Section 222(a) of the Social Security Amendments of 1972, referred to in subsec. (b)(3)(C), is section 222(a) of

Pub.L. 92-603, Oct. 30, 1972, 86 Stat. 1329, which is set out as a note under section 1395b-1 of this title.

Section 300e-9(d) of this title, referred to in subsec. (b)(3)(D), was redesignated section 300e-9(c) of this title by Pub.L. 100-517, § 7(b), Oct. 24, 1988, 102 Stat. 2580, eff. Oct. 24, 1995.

Section 1395w-104(e)(6) of this title, referred to in subsec. (b)(5), was in the original “section 1860D-3(e)(6)”, and was translated as reading “section 1860D-4(e)(6)”, meaning section 1860D-4(e)(6) of the Social Security Act, which is classified to [42 U.S.C.A. § 1395w-104\(e\)\(6\)](#), to reflect the probable intent of Congress. Section 1860D-3, which is classified to section 1395w-103 of this title, does not contain a subsec. (e), and section 1860D-4(e)(6) relates to electronic prescription program regulations.

The Internal Revenue Code, referred to in subsecs. (c)(2) and (h)(2), is classified to Title 26.

Part B of this subchapter, referred to in subsec. (h)(5)(A), is classified to [42 U.S.C.A. § 1395j et seq.](#)

Codifications

Amendment by section 524(a) of Pub.L. 106-113 [Title V], directory language of which read “Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended--

“(1) in subparagraph (C), by striking ‘or’ at the end;

“(3) by adding at the end the following:

“(2) in subparagraph (D), by striking the period at the end and inserting ‘, or’; and

“(E) that is a Medicare+Choice organization under part C that is offering a coordinated care plan described in section 1851 [section 1395w-21(a)(2)(A) of this title] to an individual enrolled with the organization.”,

was executed by striking out “or” at the end of subpar. (C), as directed by section 524(a)(1) of H.R. 3426, striking out the period at the end of subpar. (D) and inserting “or”, as directed by section 524(a)(2) of H.R. 3426, and adding subpar. (E), as deemed to be directed by section 524(a)(3) of H.R. 3426, as the probable intent of Congress, in view of the apparent placement out of sequence of pars. (2) and (3) of section 524(a) of H.R. 3426.

Amendments

2003 Amendments. Subsec. (b)(5). Pub.L. 108-173, § 101(e)(8)(B), added par. (5).

Subsec. (d)(2). Pub.L. 108-173, § 507(a)(2), rewrote par. (2), which formerly read:

“(2) Rural provider

“In the case of designated health services furnished in a rural area (as defined in section 1395ww(d)(2)(D) of this title) by an entity, if substantially all of the designated health services furnished by such entity are furnished to individuals residing in such a rural area.”

Subsec. (d)(3)(A). Pub.L. 108-173, § 507(a)(1)(A)(i), struck out “, and” at the end of subpar. (A) and inserted a semicolon.

Subsec. (d)(3)(B). Pub.L. 108-173, § 507(a)(1)(A)(ii), added a new subpar. (B) and redesignated former subpar. (B) as subpar. (C).

Subsec. (d)(3)(C). Pub.L. 108-173, § 507(a)(1)(A)(ii), redesignated former subpar. (B) as subpar. (C).

Subsec. (h)(7). Pub.L. 108-173, § 507(a)(1)(B), added par. (7).

1999 Amendments. Subsec. (b)(3)(C) to (E). Pub.L. 106-113 [§ 524(a)] struck out “or” at the end of subpar. (C), struck out the period at the end of subpar. (D) and inserted “, or” and added subpar. (E). See Codifications note set out under this section.

1997 Amendments. Subsec. (g)(6). Pub.L. 105-33, § 4314, added par. (6).

1994 Amendments. Pub.L. 103-432, § 160(d)(4), substituted “4207” for “4027” as the section number of the section of Pub.L. 101-508 which had amended this section in 1990. This substitution of section numbers served to remove a technical error in the section numbering scheme of Pub.L. 101-508 but otherwise resulted in no changes in text.

Subsec. (f). Pub.L. 103-432, § 152(a)(1), (4), (5), substituted in introductory text “ownership, investment, and compensation arrangements” for “ownership arrangements”, and, in concluding text, substituted “designated health services” for “covered items and services” and struck therefrom “Such information shall first be provided not later than October 1, 1991.” following “shall specify” and end sentence authorizing the Secretary to waive reporting requirements of this section and chapter 35 of Title 44 by entities in a State so long as such reporting occurs in at least 10 States and by providers in a State, excepting designated items and services, including parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services.

Subsec. (f)(2). Pub.L. 103-432, § 152(a)(2), (3), substituted “investment interest (as described in subsection (a)(2)(A) of this section), or with a compensation arrangement (as described in subsection (a)(2)(B) of this section),” for “investment interest (as described in subsection (a)(2)(A) of this section)” and “immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity” for “immediate relatives have such an ownership or investment”, respectively.

Subsec. (h)(6). Pub.L. 103-432, § 152(b)(1), (2), substituted in subpar. (D) “services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services” for “or other diagnostic services” and inserted in subpars. (E), (F), and (H) before the period “and supplies”.

1993 Amendments. Subsec. (a)(1). Pub.L. 103-66, § 13562(a)(1), substituted “designated health services” for “clinical laboratory services” wherever appearing and inserted “an” before “immediate family member”.

Subsec. (a)(2). Pub.L. 103-66, § 13562(a)(1), inserted “of such physician” wherever appearing, inserted “an” before “immediate family member”, added “and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service” after “or other means”, and substituted “subsection (h)(1)” for “subsection (h)(1)(A)”.

Subsec. (b)(2). Pub.L. 103-66, § 13562(a)(1), inserted “(other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)” in opening provisions and “under a billing number assigned to the group practice,” in subpar. (B), substituted “directly supervised” for “employed by such physician or group practice and who are personally supervised” in subpar. (A)(i), “designated health services” for “clinical laboratory services” in subpar. (A)(ii)(I) and “(aa) for the provision of some or all of the group's clinical laboratory services, or (bb) for the centralized provision of the group's designated health services (other than clinical laboratory services), unless the Secretary determines other terms and conditions under which

the provision of such services does not present a risk of program or patient abuse” for “for the centralized provision of the group’s clinical laboratory services” in subpar. (A)(ii)(II).

Subsec. (b)(3). Pub.L. 103-66, § 13562(a)(1), added subpar. (D) and made several accommodating changes.

Subsec. (b)(4). Pub.L. 103-66, § 13562(a)(1), redesignated former par. (5) as (4) and struck out former par. (5) which related to financial relationships with hospitals which did not involve the provision of clinical laboratory services.

Subsec. (b)(5). Pub.L. 103-66, § 13562(a)(1), redesignated former par. (5) as (4).

Subsec. (c). Pub.L. 103-66, § 13562(a)(1), expanded existing exception to include ownership of mutual funds and securities listed on regional or foreign exchanges and reduced publicly-traded corporation shareholder equity threshold amount from \$100,000,000 to \$75,000,000.

Subsec. (d). Pub.L. 103-66, § 13562(a)(1), substituted references to designated health services for clinical laboratory services wherever appearing and inserted requirement in par. (2) that qualifying rural providers furnish substantially all such designated health services to persons residing in such rural areas.

Subsec. (e)(1). Pub.L. 103-66, § 13562(a)(1), expanded exception to include certain payments made by a lessee for equipment and modified existing exception relating to rental of office space by including lessee payments if the space rented or leased was not in excess of what was reasonable and necessary for the legitimate business purposes of such lease or rental and was used exclusively by the lessee and by allowing the lessee to make certain payments for common area use.

Subsec. (e)(2). Pub.L. 103-66, § 13562(a)(1), modified existing exception relating to employment relationships by permitting productivity bonus payments based upon services performed personally by a physician or immediate family member and by including physician relationships with non-hospital employers.

Subsec. (e)(3). Pub.L. 103-66, § 13562(a)(1), revised specifications for qualifying service arrangements and added the physician incentive plan exception.

Subsec. (e)(4), (5). Pub.L. 103-66, § 13562(a)(1), added par. (4) and redesignated former pars. (4) and (5) as (5) and (6), respectively.

Subsec. (e)(6). Pub.L. 103-66, § 13562(a)(1), redesignated former pars. (5) and (6) as (6) and (7), respectively, and in par. (6), as so redesignated, expanded the existing exception to include the sale of a practice.

Subsec. (e)(7). Pub.L. 103-66, § 13562(a)(1), redesignated former par. (6) as (7) and, as so redesignated, substituted existing provisions for provisions relating to compensation arrangements involving payments by a group practice of salaries of member physicians.

Subsec. (e)(8). Pub.L. 103-66, § 13562(a)(1), added par. (8).

Subsec. (f). Pub.L. 103-66, § 13562(a)(3), substituted “designated health services” for “clinical laboratory services”.

Subsec. (g)(1). Pub.L. 103-66, § 13562(a)(4), substituted “designated health service” for “clinical laboratory service”.

Subsec. (h). Pub.L. 103-66, § 13562(a)(2), in addition to revising existing definitions, added definition of “Designated Health Services” and struck out definitions of “Investor”, “Interested Investor” and “Disinterested Investor”.

1990 Amendments. Subsec. (b)(4). Pub.L. 101-508, § 4207(e)(2), added par. (4). Former par. (4) was redesignated (5).

Subsec. (b)(5). Pub.L. 101-508, § 4207(e)(2), redesignated par. (4) as (5).

Subsec. (f). Pub.L. 101-508, § 4207(e)(3)(B), (C), in the provisions following par. (2), substituted “October 1, 1991” for “1 year after December 19, 1989” in the existing sentence and added new following sentences providing that the requirement of this subsection shall not apply to covered items and services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this subchapter very infrequently, and that the Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of Title 44 with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing clinical laboratory services) so long as such reporting occurs in at least 10 States, and that the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type.

Subsec. (f)(2). Pub.L. 101-508, § 4207(e)(3)(A), substituted “the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A) of this section) in the entity, or whose immediate relatives have such an ownership or investment” for “the names and all of the medicare provider numbers of the physicians who are interested investors or who are immediate relatives of interested investors”.

Subsec. (g)(5). Pub.L. 101-508, § 4207(k)(2), added at the end the following new sentence: “The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.”

Subsec. (h)(6). Pub.L. 101-508, § 4207(e)(1)(C), added par. (6). Former par. (6) was redesignated (7).

Subsec. (h)(7)(A). Pub.L. 101-508, § 4207(e)(1)(A), (C), redesignated par. (6) as (7) and, in subpar. (A) of par. (7) as so redesignated, substituted “in the case of an item or service for which payment may be made under part B, the request by a physician for the item or service,” for “in the case of a clinical laboratory service which under law is required to be provided by (or under the supervision of) a physician, the request by a physician for the service,”.

Subsec. (h)(7)(B). Pub.L. 101-508, § 4207(e)(1)(B), (C), redesignated par. (6) as (7) and, in subpar. (B) of par. (7) as so redesignated, struck out “in the case of another clinical laboratory service,” following “Except as provided in subparagraph (C),”.

Effective and Applicability Provisions

1999 Acts. Pub.L. 106-113, Div. B, § 1000(a)(6) [Title V, § 524(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A-388, provided that: “The amendment made by this section [amending this section] shall apply to services furnished on

or after the date of the enactment of this Act [Nov. 29, 1999, which is the date of enactment of Pub.L. 106-113, 113 Stat. 1501, which in Div. B, § 1000(a)(6), enacted into law this Act as an Appendix].”

1994 Acts. Section 152(d) of Pub.L. 103-432 provided that:

“(1) The amendments made by subsections (a) and (b) [amending subsecs. (f) and (h)(6)(D) to (F), (H) of this section] shall apply to referrals made on or after January 1, 1995.

“(2) The amendment made by subsection (c) [amending provisions set out as a note under this section] shall apply as if included in the enactment of OBRA-1993 [Pub.L. 103-66, Aug. 10, 1993, 107 Stat. 312, for classification of which to the Code, see Tables].”

1993 Acts. Section 13562(b) of Pub.L. 103-66, as amended Pub.L. 103-432, Title I, § 152(c), Oct. 31, 1994, 108 Stat. 4437, provided that:

“(1) **In general.**--Except as provided in paragraph (2), the amendments made by this section [amending subsecs. (a) to (f), (g)(1) and (h) of this section] shall apply to referrals--

“(A) made on or after January 1, 1992, in the case of clinical laboratory services, and

“(B) made after December 31, 1994, in the case of other designated health services.

“(2) **Exceptions.**--With respect to referrals made for clinical laboratory services on or before December 31, 1994--

“(A) the second sentence of subsection (a)(2), and subsections (b)(2)(B) and (d)(2), of section 1877 of the Social Security Act [former subsecs. (a)(2), (b)(2)(B), and (d)(2) of this section] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]) shall apply instead of the corresponding provisions in section 1877 (as amended by this Act) [this section];

“(B) section 1877(b)(4) of the Social Security Act [former subsec. (b)(4) of this section] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]) shall apply;

“(C) the requirements of section 1877(c)(2) of the Social Security Act (as amended by this Act) [subsec. (c)(2) of this section] shall not apply to any securities of a corporation that meets the requirements of section 1877(c)(2) of the Social Security Act [former subsec. (c)(2) of this section] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]);

“(D) section 1877(e)(3) of the Social Security Act (as amended by this Act) [subsec. (e)(3) of this section] shall apply, except that it shall not apply to any arrangement that meets the requirements of subsection (e)(2) or subsection (e)(3) of section 1877 of the Social Security Act [former subsec. (e)(2) or (e)(3) of this section] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]);

“(E) the requirements of clauses (iv) and (v) of section 1877(h)(4)(A), and of clause (i) of section 1877(h)(4)(B), of the Social Security Act (as amended by this Act) [subsec. (h)(4)(A)(iv) and (v) and (h)(4)(B)(i) of this section] shall not apply; and

“(F) section 1877(h)(4)(B) of the Social Security Act [former subsec. (h)(4)(B) of this section] (as in effect on the day before the date of the enactment of this Act [Aug. 10, 1993]) shall apply instead of section 1877(h)(4)(A)(ii) of such Act (as amended by this Act) [subsec. (h)(4)(A)(ii) of this section].”

[Amendment by section 152(c) of Pub.L. 103-432 effective as if included in the enactment of OBRA-1993, Pub.L. 103-66, 107 Stat. 312, which was approved Aug. 10, 1993, see section 152(d)(2) of Pub.L. 103-432, set out as note under this section.]

1990 Acts.. Section 4207(e)(5), formerly 4027(e)(5), of Pub.L. 101-508, renumbered Pub.L. 103-432, Title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: “The amendments made by this subsection [enacting subsec. (b)(4) and redesignating as subsec. (b)(5) former subsec. (b)(4); amending subsec. (f)(2), subsec. (f) third sentence, and enacting last two subsec. (f) sentences respecting requirements and waiver of requirements; and enacting subsec. (h)(6) and redesignating as subsec. (h)(7) former subsec. (h)(6) and amending such subsec. (h)(7) of this section] shall be effective as if included in the enactment of section 6204 of the Omnibus Budget Reconciliation Act of 1989 [Pub.L. 101-239, § 6204, amending this section and set out as notes hereunder].”

1989 Acts. Section 6204(c) of Pub.L. 101-239 provided that:

“(1) Except as provided in paragraph (2), the amendments made by this section [enacting this section and section 1395l of this title and note provisions under this section] shall become effective with respect to referrals made on or after January 1, 1992.

“(2) The reporting requirement of section 1877(f) of the Social Security Act [subsec. (f) of this section] shall take effect on October 1, 1990.”

Prior Provisions

A prior section 1395nn, Act Aug. 14, 1935, c. 531, Title XVIII, § 1877, as added and amended Oct. 30, 1972, Pub.L. 92-603, Title II, §§ 242(b), 278(b)(8), 86 Stat. 1419, 1454; Oct. 25, 1977, Pub.L. 95-142, § 4(a), 91 Stat. 1179; Dec. 5, 1980, Pub.L. 96-499, Title IX, § 917, 94 Stat. 2625; July 18, 1984, Pub.L. 98-369, Div. B, Title III, § 2306(f)(2), 98 Stat. 1073; Oct. 21, 1986, Pub.L. 99-509, Title IX, § 9321(a)(1), 100 Stat. 2016; Aug. 18, 1987, Pub.L. 100-93, § 4(c), 101 Stat. 689, which enumerated offenses relating to the Medicare program and the penalties for such offenses, was repealed by Pub.L. 100-93, § 4(e), Aug. 18, 1987, 101 Stat. 689, effective at the end of the fourteen-day period beginning on Aug. 18, 1987, and inapplicable to administrative proceedings commenced before the end of such period, under section 15(a) of Pub.L. 100-93, set out as a note under section 1320a-7 of this title. See section 1320a-7b of this title.

Change of Name

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see Pub.L. 108-173, § 201, set out as a note under [42 U.S.C.A. § 1395w-21](#).

Application of Exception for Hospitals Under Development

Pub.L. 108-173, Title V, § 507(b), Dec. 8, 2003, 117 Stat. 2296, provided that:

“For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act [subsec. (h)(7)(B)(i)(II) of this section], as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary shall consider--

“(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

“(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.”

Studies

Pub.L. 108-173, Title V, § 507(c), Dec. 8, 2003, 117 Stat. 2296, provided that:

“(1) **MedPAC study.**--The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine--

“(A) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

“(B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

“(C) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

“(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

“(E) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

“(2) **HHS study.**--The Secretary shall conduct a study of a representative sample of specialty hospitals--

“(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

“(B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

“(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

“(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals.

“(3) **Reports.**--Not later than 15 months after the date of the enactment of this Act [Dec. 8, 2003], the Commission and the Secretary, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes.”

Deadline for Certain Regulations

Section 6204(d) of Pub. L. 101-239, as amended Pub.L. 101-508, Title IV, § 4207(e)(4)(B), formerly § 4027(e)(4)(B), Nov. 5, 1990, 104 Stat. 1388-122, renumbered Pub.L. 103-432, Title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, provided that: “The Secretary of Health and Human Services shall publish final regulations to carry out section 1877 of the Social Security Act [this section] by not later than October 1, 1991.”

GAO Study of Ownership by Referring Physicians

Section 6204(e) of Pub. L. 101-239, which directed the Comptroller General to conduct a study of the ownership of hospitals and other providers of Medicare services by referring physicians, was repealed, effective Oct. 19,

1996, by Pub.L. 104-316, Title I, §§ 101(e), 122(h)(1), Oct. 19, 1996, 110 Stat. 3837.

Statistical Summary of Comparative Utilization

Section 6204(f) of Pub.L. 101-239, as amended Pub.L. 101-508, Title IV, § 4207(e)(4)(A), formerly § 4027(e)(4)(A), Nov. 5, 1990, 104 Stat. 1388--122, renumbered Pub.L. 103-432, Title I, § 160(d)(4), Oct. 31, 1994, 108 Stat. 4444, and amended Pub.L. 104-316, Title I, § 122(h)(2), Oct. 19, 1996, 110 Stat. 3837, directed Secretary of Health and Human Services, not later than June 30, 1992, to submit to Congress a statistical profile comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities, for the States and entities specified in subsec. (f) of this section (other than entities providing clinical laboratory services).

[Amendment of section 6204(f) of Pub.L. 101-239 by Pub.L. 104-316 (which required no change in text) effective Oct. 19, 1996, see section 101(e) of Pub.L. 104-316, set out as a note under section 130c of Title 2, The Congress.]

CROSS REFERENCES

State grants for medical assistance programs, payment to States, medicare physician referral limitations, see [42 USCA § 1396b](#).

FEDERAL SENTENCING GUIDELINES

See [Federal Sentencing Guidelines § 2B4.1](#), 18 USCA.

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[200 ALR, Fed. 173](#), Construction and Application of Paperwork Reduction Act of 1980 (Pra), [44 U.S.C.A. §§ 3501 et Seq.](#)

[162 ALR, Fed. 147](#), Construction and Application of “Reverse False Claim Provision” of False Claims Act ([31 U.S.C.A. § 3729\(A\)\(7\)](#)).

[132 ALR, Fed. 601](#), Illegal Remuneration Under Medicare Anti-Kickback Statute (Social Security Act § 1128B) ([42 U.S.C.A. §§ 1320a-7b](#)).

[76 ALR, Fed. 409](#), Use of Plea Bargain or Grant of Immunity as Improper Vouching for Credibility of Witness in Federal Cases.

[43 ALR, Fed. 484](#), Judicial Review of Administrative Determination Involving Medicare as Precluded by [42 U.S.C.A. § 405\(H\)](#).

[27 ALR, Fed. 407](#), Construction and Application of Provision of [Rule 9\(B\), Federal Rules of Civil Procedure](#), that Circumstances Constituting Fraud or Mistake be Stated With Particularity.

[70 ALR 4th 132](#), Filing of False Insurance Claims for Medical Services as Ground for Disciplinary Action Against Dentist, Physician, or Other Medical Practitioner.

[7 ALR 305](#), Right to Hire One Who Violates No Contract in Leaving Another's Employment.

Encyclopedias

[61 Am. Jur. Proof of Facts 3d 245](#), Liability of a Physician for Improper Referral of Patients to a Medical Care-Facility in Which the Physician Has a Financial Interest.

Treatises and Practice Aids

[Norton Bankruptcy Law and Practice 2d § 157:6](#), Antikickback and Antireferral Laws.

[West's Federal Administrative Practice § 6302](#), Legislation.

[West's Federal Administrative Practice § 6346](#), Quality Control -- Utilization and Quality Control Peer Review Organization.

NOTES OF DECISIONS

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[1/212](#) . Generally

Statute that prohibited home health services provider (HHA) from billing Medicare program, and Medicare program from paying for services provided to patients who had been referred by physicians with whom HHA had any financial relationship, unless exception was met, applied prior to issuance of final regulations for that statute, although regulation then in effect only prohibited HHA from billing Medicare program if certifying physicians received more than \$25,000 or 5% of HHA's operating expenses for year, whichever was less; statute and prior regulation overlapped, but they were not mutually exclusive, statute was self-executing, and exception would have circumvented legislative intent. [U.S. ex rel. Roberts v. Aging Care Home Health, Inc., W.D.La.2007, 474 F.Supp.2d 810. Health ↪ 533](#)

[3/434](#) . Law governing

Remedies available to United States for alleged unjust enrichment under Medicare program arose under federal law, not state law. [U.S. ex rel. Roberts v. Aging Care Home Health, Inc., W.D.La.2007, 474 F.Supp.2d 810. Federal Courts ↪ 431](#)

1. Agreements in violation

Physician recruitment agreement pursuant to which a doctor agreed to refer patients to hospital in return for interest free loan, free office space, rent and utility subsidies, and reimbursement for malpractice insurance, violated the Medicare-Medicaid Antifraud and Abuse Amendments to the Social Security Act, and was unenforceable under Texas law. [Polk County, Tex. v. Peters, E.D.Tex.1992, 800 F.Supp. 1451, 132 A.L.R. Fed. 787. Health ↪ 533; Health ↪ 487\(4\)](#)

2. Designated health services

Stark law was amended by Congress to expand scope of “designated health services,” for which referrals are

prohibited, from clinical laboratory services to include, inter alia, hospital inpatient and outpatient services. [U.S. ex rel. James M. Thompson v. Columbia/HCA Healthcare Corp., S.D.Tex.1996, 938 F.Supp. 399](#), affirmed in part, vacated in part [125 F.3d 899](#), rehearing denied, on remand [20 F.Supp.2d 1017](#). [Health 535\(4\)](#)

3. Leases

Lease agreement did not violate “not less than one year” term requirement in Antikickback Statute (AKS), even though agreement contained termination clauses; agreement on its face specified term of two years, lease was for fair market value, there was no evidence that value of lease was determined in any way that took into account volume or value of referrals or business generated, and space rented did not exceed that which was reasonably necessary to accomplish commercially reasonable business purpose of rental. [U.S. ex rel Perales v. St. Margaret's Hosp., C.D.Ill.2003, 243 F.Supp.2d 843](#). [Health 485](#)

4. False claim action

Diabetes treatment center could be liable under False Claims Act, where center caused a claim to be presented by an entity that was covered by the Stark laws, regardless whether the center would be directly liable under the Stark laws. [U.S. ex rel. Pogue v. Diabetes Treatment Centers of America, Inc., D.D.C.2002, 238 F.Supp.2d 258](#). [United States 120.1](#)

5. Pleading

To the extent that complaint intended to assert that Medicare claims were submitted in violation of Stark, or self-referral, laws, allegations that ambulatory surgery center made kickback payments in violation of False Claims Act (FCA) failed to satisfy requirement that fraud be pleaded with particularity, given absence of requisite allegation of relationship between referring physicians and facilities. [U.S. ex rel. Barrett v. Columbia/HCA Health Care Corp., D.D.C.2003, 251 F.Supp.2d 28](#). [Federal Civil Procedure 636](#)

Complaint alleging marketing scheme involving orthopedic implant seller and medical provider sharing remunerations with provider's physicians in order to induce these physicians to help in meeting seller's prescribed volume and market share levels, and that these physicians made “prohibited referrals” for provider to provide health services for which provider then allegedly sought Medicare reimbursement stated claim under Stark Act. [U.S. ex rel. Schmidt v. Zimmer, Inc., C.A.3 \(Pa.\) 2004, 386 F.3d 235](#), on remand [2005 WL 1806502](#). [Health 533](#)

6. Persons entitled to maintain action

Association representing medical directors of outpatient dialysis facilities did not have standing to challenge validity of safe harbor provision published by Center for Medicare and Medicaid Services (CMS) as part of Stark Law regulations governing physician referrals under Medicare program identifying two methodologies as presumptively reasonable to calculate physicians' compensation levels, despite contentions that compensation figures derived by methodologies did not truly reflect fair market value of medical directors' services, and that CMS failed to provide proper notice and comment, where court had no authority to compel dialysis facilities to compensate physicians at higher rate, compliance with safe harbor methodologies was entirely voluntary, employers would be required to compensate physicians at fair market value in order to qualify for Stark Law exception, and there was no indication that alternative methods of calculating fair market value would affect compensation rates. [Renal Physicians Ass'n v. Department of Health and Human Services, D.D.C.2006, 422 F.Supp.2d 75](#). [Health 556\(4\)](#)

7. Parties

Government did not have to charge any referring physician with making prohibited referral as condition precedent to holding home health services provider (HHA) liable for having “financial relationships” with five “referring” physicians unless its relationship with those physicians met exception to statute that prohibited home health services provider (HHA) from billing Medicare program, and Medicare program from paying for services provided to patients who had been referred by physicians with whom HHA had any financial relationship. [U.S. ex rel. Roberts v. Aging Care Home Health, Inc., W.D.La.2007, 474 F.Supp.2d 810. Health 533](#)

8. Exception

Application of personal service arrangement exception was not warranted, to statute that prohibited home health services provider (HHA) from billing Medicare program, and Medicare program from paying for services provided to patients who had been referred by physicians with whom HHA had any financial relationship, where physicians did not provide any legitimate advisory services as set forth in agreements with physicians and they were compensated for providing standard care to their patients or for doing nothing, and actual services performed were not specified in agreement, not reasonably necessary, and exceeded fair market value. [U.S. ex rel. Roberts v. Aging Care Home Health, Inc., W.D.La.2007, 474 F.Supp.2d 810. Health 533](#)

9. Recovery of mistaken payments

Government was entitled to recovery of Medicare reimbursements, totaling approximately \$427,000, under theory of payment by mistake, which had been obtained by home health services provider (HHA) through prohibited relationship with referring physicians, where HHA's cost reports to Medicare program each contained express and implied certifications of compliance with governing statute that were false and material to Medicare program's decision to pay and government auditors had not approved compensation arrangements. [U.S. ex rel. Roberts v. Aging Care Home Health, Inc., W.D.La.2007, 474 F.Supp.2d 810. Health 535\(1\)](#)

10. Equitable remedies

Alternative legal remedies were not adequate, and thus they did not preclude equitable relief sought by government to recover Medicare reimbursement overpayments made to home health services provider (HHA), since Medicare provider agreements created statutory rights, not contractual rights, showing of wrongful conduct was required to establish guilt under Anti-Kickback Act or liability under False Claims Act, government was not required to pursue administrative action before seeking overpayment action, and judicial economy and legislative intent would not have been served by requiring government to pursue its legal remedies. [U.S. ex rel. Roberts v. Aging Care Home Health, Inc., W.D.La.2007, 474 F.Supp.2d 810. Health 535\(1\)](#)

11. Interest

Government was not entitled in qui tam action to prejudgment interest from date of last improper payment to each physician until date of judgment, on Medicare reimbursement overpayments obtained by home health services provider (HHA) through prohibited relationship with referring physicians, where government did not allege that Medicare statute required award of pre-judgment interest, government delayed almost 18 months in deciding whether to intervene, and legal issues involved were complex and duration of pretrial proceedings were lengthy. [U.S. ex rel. Roberts v. Aging Care Home Health, Inc., W.D.La.2007, 474 F.Supp.2d 810. United States 122](#)

42 U.S.C.A. § 1395nn, 42 USCA § 1395nn

Current through P.L. 110-133 approved 12-6-07

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