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Complete Healthcare Compliance Manual 2024
Physician Compensation: Managing Relationships and Conflicts of Interest

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What Are Physician Relationships and Conflicts of Interest?

Physicians establish a variety of financial relationships with their employers, health systems, ancillary services, insurance companies, medical technology firms, and other entities. These relationships can occur with employed physicians as well as with physician-owners in private practice. Some of these arrangements include direct and/or indirect compensation to the physician. Some of the direct methods may include compensation through speaking/consulting fees, supplies or services, business-related travel, meal expenses, research payments, and/or royalty agreements, while some of the indirect means occur based on the physician's position and influence to sway purchasing decisions to entities where they and/or family members have a financial interest.

While these arrangements, as well as physicians having decision-making power, are commonplace, they carry a risk for a potential conflict of interest. A conflict of interest occurs when a physician puts his/her interest, financial or otherwise, above the interest of the health system, medical staff colleagues, or patients. These conflicts arise often in the areas of daily practice, research, graduate medical education, etc. Given the numerous regulations and severe penalties for engaging in activities that result in conflicts of interest, it is critical for health systems to manage these relationships to ensure compliance.

Risk Area Governance

Physician relationships and potential conflicts of interest are highly regulated by federal law, a variety of state-specific fraud and abuse statutes, and government agencies. The activities and transactions of most physicians in private practice and those employed by health systems are impacted by these regulations. The primary laws governing physician relationships include the Physician Payments Sunshine Act (PPSA), the Stark Law, the Anti-Kickback Statute (AKS), the False Claims Act (FCA), and a variety of government agencies.

Physician Payments Sunshine Act, 42 U.S.C. § 1320a-7h

PPSA was enacted in 2010 with the Affordable Care Act and requires medical manufacturing companies to disclose to the Centers for Medicare & Medicaid (CMS) any payments or "transfer of value" made between them and physicians or academic medical systems.[2][3] The transfer of value is categorized based on the following:

- Meals, travel, or consulting fees
- Research payments
- Personal or family member ownership interest in the manufacturing company

Maximum payments allowed without reporting can be up to $10 per item or $100 per year in total.

Stark Law (Physician Self-Referral Law), 42 U.S.C. § 1395nn

The Stark Law has undergone several phases to its rules, regulations, and exceptions since its introduction; however, at its core, the law "prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless an exception applies; and prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those referred services."[4][5]

Table 1. Designated Health Service[6]
• Clinical laboratory services
• Physical therapy, occupational therapy, and outpatient speech-language pathology services
• Radiology and certain other imaging services
• Radiation therapy services and supplies
• Durable medical equipment and supplies
• Parenteral and enteral nutrients, equipment, and supplies
• Prosthetics, orthotics, and prosthetic devices and supplies
• Home health services
• Outpatient prescription drugs
• Inpatient and outpatient hospital services

In limited circumstances, the Stark Law does allow for certain exceptions. All exceptions must still comply with CMS, the AKS, and any other applicable federal and state regulations. Exceptions are noted for specific healthcare services as well as specific healthcare entities, such as academic medical centers (AMCs), ambulatory surgery centers (ASCs), and federally qualified health centers (FQHCs). The most notable exceptions to the law include the following:

- Employment relationships
- In-office ancillary services
- Group practice arrangements
- Fair market value exception
- Physician services
- Provider recruitment
- Risk sharing agreements
- Equipment and space leases
- Indirect compensation arrangements
- Nonmonetary exception[7]

Anti-Kickback Statute, 42 U.S.C. § 1320a-7b

The AKS is a federal fraud and abuse law that prevents those who knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business payable by Medicare and Medicaid unless certain safe harbors are satisfied.[8] The AKS applies to all persons on all healthcare services, not solely physicians or hospitals. The intent of the law is to prevent overutilization of services through prohibiting incentive compensation to induce referrals.

In limited circumstances, the AKS does allow for certain safe harbors. All safe harbors must still comply with CMS, the Stark Law, and any other applicable federal and state regulations. The most notable safe harbors to the law include the following:

- Bona fide employment relationships
- Personal services arrangements
- Group purchasing organizations
- Referral services
- Fair market value exception[9]

False Claims Act, 31 U.S.C. §§ 3729-3733

The FCA was first enacted in 1863 as a result of contractors/suppliers defrauding the US government during the US Civil War.[10] The law states that "any person who knowingly presents . . . a false or fraudulent claim for payment . . . or knowingly makes . . . a false record or statement material to a false or fraudulent claim, . . . is liable to the U.S. government for a civil penalty."[11] Claims made against Medicare, Medicaid, and various other federal and state health insurance plans may potentially fall under the FCA.

Examples of common fraud and abuse behaviors that fall under the FCA include but are not limited to the following:

- Kickbacks
- Services not rendered
- Lack of medical necessity
- Coding irregularities (upcoding or unbundling)

Government Agencies

Many federal and state government agencies provide regulatory oversight to physicians and health systems. These include the CMS, accrediting agencies, the Office of Civil Rights, the Federal Trade Commission, the Internal Revenue Service, and various state-level agencies, medical boards, and courts. In addition, health systems conducting research need to maintain compliance with respect to the funding source (i.e., National Institutes of Health (NIH)).[12]