

Is it fee-splitting for medical doctors to share revenues with non-medical business owners?

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"I provide medical (or acupuncture, chiropractic, osteopathic, massage) services on an hourly basis and get paid a percentage of revenues in return." Is that fee-splitting? The fee-splitting question is a typical one that clients bring to our firm. The client may be the venture owner / entrepreneur, the medical director for a medical group, or a practitioner who is a medical doctor or osteopathic physician, or a chiropractor, acupuncturist, homeopath, massage therapist, or other clinical care provider.

The answer to the fee-splitting question depends both on the kind of provider, and on state law – and the other underlying circumstances, such as whether the healthcare provider is an employee or independent contractor.

For example, some statutes do not apply **fee-splitting** prohibitions to massage therapists, but do apply the prohibitions to medical doctors, chiropractors, and acupuncturists. It's important to read the rules carefully and apply them to the facts.

Let's first talk about federal **Stark** and **anti-kickback legal rules**.

Federal Law – Stark, Anti-Kickback Law

Let's assume for now that the provider is a healthcare licensee and that no Medicare or Medicaid reimbursement is involved.

If the healthcare provider submits claims for reimbursement to Medicare or Medicaid (or in California, Medi-Cal), then our healthcare lawyers would do a Stark and anti-kickback analysis under federal law. (See [Federal Self-Referral \(Stark\) and Anti-Kickback Analysis for Integrative Care Center](#), for a summary of federal self-referral and anti-kickback law, and its application in particular to **integrative medicine**).

We would first analyze compensation arrangements. We would look, among other things, to:

- Corporate practice of medicine and unlicensed medical practice concerns.
- Scope of practice rules for each practitioner.
- State laws prohibiting kickbacks, fee-splitting, self-referral, and exploitation of patients for financial gain.

If Medicare or Medicaid are not involved, then we look only to state law.

Let's look at **New York** for a sample of what's in store under state law.

Corporate Practice of Medicine

Some states have a “weak” **corporate practice of medicine** rule. This means they typically prohibit non-clinicians from practicing medicine or intruding into clinical practice. But they do not prohibit laypersons from employing physicians, so long as the layperson has no **actual control** over the practice of medicine.

By contrast, New York State has a “strong” corporate practice of medicine prohibition. (See [New York’s Strong Corporate Practice of Medicine Requires a Professional Corporation for Professional Services](#)). Laypersons cannot hire physicians, period (with very limited exceptions).

Under this rule, medical service organizations (MSOs) must be structured properly as they can blur the distinction between professional judgment and administrative services.

California, Texas, and various other states similar have a **strong corporate practice of medicine legal prohibition**.

In New York, a corollary of this strong corporate practice of medicine, is the rule requiring separation of activities between **professional medical corporations** and **general business corporations**. All *professional services* can only be offered within a *professional service corporation* (“PC”), or a *professional limited liability company* (“PLLC”). *Business services* have to be performed with a *simple LLC* or *general business corporation*, but the MSO cannot perform professional services.

So, for example, who hires the nurse? The professional medical corporation. Who hires the front desk person? The general corporation. Can the MSO handle the payroll for the nurse, physician assistant, and other clinical providers? The MSO can administer payroll, but it cannot be the employer, as the employer has supervisory responsibilities and clinical control over dependent practitioners’ activities.

Scope of Practice

The next issue is legally authorized scope of practice; scope of practice rules require that non-medical practitioners (such as licensed acupuncturists) remain within the practice boundaries specified by their licensed statute, as clarified by any subsequent regulations promulgated by the state acupuncture board.

See, for example, [Legal Rules Restrict Scope of Practice Boundaries in Acupuncture](#).

Practicing beyond the scope of practice can:

- Put the healthcare practitioner at risk of **unlicensed practice of medicine**.
- Put the organization at risk of **aiding and abetting unlicensed practice of medicine**.

Both are criminal violations.

Additional risks include **professional discipline**, and, **vicarious liability** for the negligence of others.

Two things our healthcare lawyers do, in addition to researching the legally authorized scope of practice for each clinician, are:

- Draft **contract language** that **limits the clinician’s activities to appropriate practice boundaries**.
- Implement a **strong credentialing scheme** before hiring. This helps reduce risk of vicarious liability—liability for the actions of others. Note that this can at the same time create a risk of liability for negligent credentialing should patient injury ensue, so there are pros and cons to being a **directory only** an organization that credentials providers.

Self-Referral and Fee-Splitting

New York has several rules addressing **self-referral** and **kickbacks / fee-splitting**. It's worth citing some of these specifically, because they provide a more extensive web of regulation than exist in many states.

New York State Education Law, Section 6509-a

Within Title VIII, the general provisions of Article 130 are applicable to all the health care professions. (See [NYS Health Care Provider Licensing Laws Spell Out Who Can Practice](#)). This is important, because we'll want to know which clinical care practitioners are within the regulatory umbrella.

Subarticle 3 (Section 6509 of NYS Education Law) contains a list of activities that constitute **professional misconduct**. Professional misconduct includes such conduct as:

- Practicing the profession fraudulently, beyond its authorized scope, with gross incompetence, with gross negligence on a particular occasion or negligence or incompetence on more than one occasion.
- Permitting, aiding or abetting an unlicensed person to perform activities requiring a license.
- Committing unprofessional conduct, as defined by the Board of Regents in *its*

Note that these definitions pick up the ideas articulated earlier about **scope of practice** and **unlicensed practice**.

Section 6509-a of NYS Education Law contains the following additional definition of professional misconduct:

That any person subject to the above enumerated articles, has directly or indirectly requested, received or participated in the **division, transference, assignment, rebate, splitting or refunding of a fee** for, or has directly requested, received or profited by means of a credit or other valuable consideration as a commission, discount or gratuity in connection with the furnishing of professional care, or service...

Here note the language, "**directly or indirectly**." Clients sometimes ask, "does it matter if the money goes first to X and then Y?" The money could flow through a hole in the Earth to China, but "directly or indirectly" is pretty clear.

Also, Section 6509-a applies to *some* of the licensed health care professionals under Title VIII (including chiropractors, nurses, and physical therapists), but the list does not include providers such as acupuncturists (see [Group 6509 to Kickback Prohibition Under State Law](#)). Again, it's important to see who is included and who is not included.

However, there still could be fee-splitting provisions in the licensing laws governing the professions not covered by 6509-a. Further, such professionals would likely be covered the Rules of the Board of Regents (below). This is why it's important to have your **healthcare lawyers** look at all the rules that could potentially apply to a **fee-splitting** question. Just because one rule doesn't apply, does not mean there aren't others (if you follow both double negatives; put another way, there are lots of rules that could conceivably apply!).

Even though 6509-a does not, by its terms, apply to acupuncturists, 6509-a does have an exception that becomes important in light of other provisions of law covered further below:

Nothing contained in this section shall prohibit such persons from practicing as partners, in groups or as a professional corporation or as a university faculty practice corporation nor from pooling fees and moneys received, either by the partnerships, professional corporations, university faculty practice corporations or groups by the individual members thereof, for professional services furnished by any individual professional member, or employee of such partnership, corporation or group, nor shall the professionals constituting the partnerships, corporations or groups be prohibited from sharing, dividing or apportioning the fees and moneys received by them or by the partnership, corporation or group in accordance with a

partnership or other agreement....

We will describe the “group” exception in more detail later.

Kickbacks, Fee-Splitting, and Exploitation of Patients (Rule 29b-1 of the Rules of the Board of Regents)

Unlike 6509-a, Section 29.1b applies to “any profession licensed, certified or registered” under Title VIII. This is big. Each of those professions is included.

Section 29.1b contains three different prohibitions:

- **Exercising undue influence on the patient** or client, including the promotion of the sale of services, goods, appliances or drugs in such manner as to **exploit the patient or client for the financial gain** of the practitioner or of a third party.
- **Directly or indirectly** offering, giving, soliciting, or receiving or agreeing to receive, **any fee** or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services;
- **Permitting any person to share in the fees for professional services**, other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice the same profession, or a legally authorized trainee practicing under the supervision of a licensed practitioner. This prohibition shall include any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a professional licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice.....

These rules are a handful. First, exploiting patients is prohibited, but what does that mean? Does selling dietary supplements in-office constitute exploiting patients for financial gain?

Second, there is the language again about “directly or indirectly” agreeing to give or receive a fee in exchange for a referral.

Third is a powerful prohibition against “**permitting any person to share in the fees for professional services**.” This expresses a strong disfavor for **any** percentage-based arrangement.

Whereas in California, an MSO can accept a percentage of gross revenues of the medical practice at fair market value, in exchange for designated management services (Business & Professions Code Section 650(b)), in New York, the above rule appears to prohibit percentage-based MSO fees.

The rule contains an exception for a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice the same profession, to share fees.

Again, **California Business & Professions Code Section 650(b)**, provides a **fair market value** safe harbor to the anti-kickback and fee-splitting prohibition in **California Business & Professions Code Section 650(a)**. **New York** appears to knock out this potential safe harbor with a broader prohibition against **revenue shares**, except where a partner, employee, associate is concerned.

And, even with a partner, employee, associate, we also have to think about New York’s Rule 29.2a-7, which prohibits “ordering excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient.” One never knows how enforcement authorities will view a given arrangement. The goal is to create as defensible a position as possible.

Self-Referral (NYS Public Health Law Section 238-a; NYCRR)

NYS Public Health Law Section 238-a prohibits referral of certain designated health services to an entity (or an immediate family member) with which the practitioner has a financial relationship. Those services include: clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services.

The rule contains a complicated number of exceptions (including for a group practice, and for a lease at fair market value for over a year). (See [Mini-Stark Statute Addresses Self-Referral Issues](#)). The prohibition in 238-a is a New York State version of Stark. (That's mini-Stark, not mini-Me).

However, the so-called designated health care services must be involved, for the rule to be triggered in the first place.

In addition to 238-a, Part 34, Chapter II, the Administrative Rules and Regulations of the NYS Codes, Rules & Regulations ("NYCRR"), Title 10, deals with [Health Care Practitioner Referrals](#) (as well as [Laboratory Business Practices](#), among other topics). (See [Health Care Referrals for Designated Health Services Raise State Law Issues](#)). So here is yet one more legal rule to reckon with.

Section 34-1.5 (Disclosure: other health or health related items or services) provides that:

(a) With respect to referrals for health or health related items or services other than clinical laboratory services, pharmacy services, radiation therapy services, or x-ray or imaging services, and except as provided in subdivision (c) of this section, a practitioner may not make a referral to a health care provider for the furnishing of health or health related items or services where such practitioner or immediate family member of such practitioner has any of the following financial relationships without disclosing to the patient such financial relationship (emphasis added):

(1) an ownership or investment interest with such health care provider; or

(2) a compensation arrangement with such health care provider which is in excess of fair market value, or which provides for compensation that varies directly or indirectly based on the volume or value of any referrals of business between the parties.

(b) The disclosure shall provide notice of any such financial relationship and shall also inform the patient of his or her right to utilize a specifically identified alternative health care provider if any such provider is reasonably available, and shall be in the form specified in section 34-1.6 of this Subpart. Such form shall also be posted prominently in the practitioner's office. (emphasis added)

(d) A practitioner shall maintain documentation of each instance of disclosure to a patient pursuant to this section.

Section 34-1.6 provides a sample disclosure form (See [Sample Disclosure Form for Self-Referrals](#)).

The answer doesn't stop with an analysis of the earlier fee-splitting rules.

More New York Anti-Kickback and Fee-Splitting Law

One thing that can be helpful in interpreting this maze of legal rules, is to look for court cases interpreting the self-referral, anti-kickback, and fee-splitting rules. Fortunately, New York has a number of cases.

In these cases, New York courts frequently invoke § 6509-a, Rule 29.1b, and §238-a together, making it difficult to determine the contours of the "group" exception and the limits of permissible arrangements (See [Do Percentage-based, Revenue-sharing arrangements Between a Clinic and its Health Care Practitioners Violate Stark, Antikickback and Fee-splitting Laws?](#))

Moreover, New York courts are rather mixed in their assessment as whether different percentage-based arrangements fall within relevant legal boundaries, or are prohibited by the various statutes and rules referenced above. On balance, the courts disfavor revenue-sharing arrangements involving MSO services for medical groups and practices.

For example, New York courts have found a variety of fee-splitting arrangements to violate § 6509-a. Cases include:

- *Sachs, Toffler*—arrangements in which dentists remitted a percentage of revenues to landlords.

- *Katz*—arrangement wherein MD would pay technicians a percentage of test fees.
- *Bell*—arrangement whereby dentist paid a non-dentist a commission to garner patients.
- *LoMagno*—fee-splitting arrangement.
- *Necula*—payment by radiologist of a percentage of receipts for billing services.

Splitting fees between clinicians and MSOs were explicitly disapproved and disallowed in several cases:

- *Calendar*—remission by physicians of a percentage of their gross earnings to a corporation constituted both illegal fee-splitting and the corporate practice of medicine.
- *Mukendi*—sharing of a percentage of net receivables or of collected receivables from a clinic, and the clinic was illegal.

This may be somewhat shocking to the person who wants to create a **medical spa**, for example, and **revenue share** with physicians based on the argument that “everyone is doing it.”

As noted, the rules themselves are drafted broadly, suggesting any percentage-based payment creates some potential enforcement risk, even if the practice is defensible in theory. Some portion of “everyone” gets investigated by undercover agents posing as patients (while collecting evidence).

“Mall Model” vs. “Center Model” and MSO Arrangements

Every situation has to be analyzed separately to see how it meets the symphony of legal rules about self-referral, kickbacks and fee-splitting,

Percentage-based, revenue share arrangements in the healthcare environment often require a detailed written analysis.

In New York, some of the more useful exceptions are:

- Revenue-sharing arrangements in a properly constituted “group,” as defined by relevant rules, and embodied in appropriate contract language; and
- Compensation to an employee that reflects (and does not grossly exceed) fair market value for services actually rendered.

A properly constituted “**group**” in New York has to meet not only legal rules governing self-referral, kickbacks and fee-splitting, but also corporate practice of medicine concerns. So, for example, the group:

- Requires an appropriate entity (i.e., corporation/PC, LLC/PLLC or partnership/PLLP with bylaws or other appropriate agreement binding the shareholders, members or partners).
- Cannot include non-professionals (non-clinicians) (per *Okere*).
- Can include licensed professionals (who can also be employees) (per *Rubin*).
- Can allow revenue-sharing among its members, assuming the above argument succeeds; **but cannot share revenues with the MSO.**

Further, under the corporate practice of medicine doctrine, as we’ve read the rules at one point, the “group:”

- Can include practitioners from different disciplines, subject to the caveat that the corporate practice of medicine doctrine requires that professions of medicine, dentistry, veterinary medicine, licensed clinical social work, mental health counseling,

psychoanalysis, creative arts therapy, or marriage and family therapy be placed in their own professional corporations.

- The “group” entity may not serve as a management services corporation.

With many of our clients who are seeking to implement a revenue-sharing arrangement between their centers and practitioners, we sometimes recommend the “Mall Model” or the “Center” models as possible ways to structure compensation without running afoul of relevant kickback and fee-splitting rules. Of course, as noted, there is never any guarantee that a proposed arrangement will not be investigated or subject to enforcement action; nonetheless, we have attempted to design structures that take account of legal roadblocks and attempt to create a flow of payments that respect existing legal rules.

In a nutshell, in the Mall Model, the flow of payments is from the patient to the practice for health care services, and from the practice to the Clinic for management, administrative and marketing services. The argument is that this does not involve kickbacks or fee-splitting, because there is no unearned fee going to either the practitioner or the Clinic in exchange for patient referrals. The Mall Model is preferred in a **strong corporate practice of medicine** state such as New York or California.

In the mall model, the lease should be a separate written contract. Lease payments will have to be for the market value of the lease, and not be tied to the volume of patients the practitioner sees or refers to the Clinic. However, in order to accommodate ramp-up time in the practice, the lease can establish a rising amortization payment over time. In addition:

- The practitioner is an independent contractor, with independent medical (or other professional) judgment, to see its own patients at the Clinic.
- The medical records are owned and maintained by the practitioner, although the practitioner can give the Clinic a right to a copy of those records.
- The practitioner pays the Clinic a monthly management or administrative fee.
- The patient makes payment out to the practice.
- The Clinic can serve as the billing and collecting agent for the practice, and be authorized to: deposit payments directly into the practitioner's account for services rendered to the patient by the practitioner; and withdraw its administrative or management fee from the account it maintains for the practitioner.

In the Center Model, the flow of payments is from the patient to the Clinic for health care services, and from the Clinic to the practitioner for services rendered to the patient. The argument is that this does not involve kickbacks or fee-splitting, because there is no unearned fee going to either the practitioner or the Clinic in exchange for patient referrals. But this argument is more difficult in a strong corporate practice of medicine state.

Among other things, the agreement between Clinic and practitioner specifies that:

- The practitioner is an independent contractor, with independent medical (or other professional) judgment, to see the Clinic's patients.
- If the state has a strong corporate practice of medicine doctrine and the practitioner is a medical doctor, then the medical records should be owned and maintained by the practitioner, although the practitioner can give the Clinic a right to a copy of those records. Otherwise records can be shared among practitioners or a central (i.e., electronic) record can be created, with each having the right to contemporaneous access and copies upon termination. Patients should be required to execute a consent authorizing access by multiple caregivers within the Clinic.
- The Clinic can serve as the billing and collecting agent for the practice (or farm this out to a third-party MSO or medical billing & collections service).
- The patient makes payment out to the Clinic.
- The Clinic pays the practitioner, typically a flat fee such as \$X per Botox injection, \$Y per hour of medical services, or \$Z per month. To avoid the appearance of a kickback, it is better if the payment from the Clinic to the practitioner is a flat fee and

not a percentage, because regulators can always view a percentage-based arrangement as suspiciously looking like a kickback (or in addition, in states prohibiting fee-splitting, like a fee split). The argument that can be made to try to defend a revenue-sharing arrangement is that the percentage fee is earned by the practitioner's production. If the percentage also reflect referrals by the practitioner to other health care providers within the Clinic, this can potentially involve a second level of kickback and fee-splitting analysis, and one must look to "group practice," "ancillary services," and other potential exceptions and safe harbors.

In either case, there could be an MSO that contracts with the professional corporation to act for it as a management service organization, which can provide claims management, accounting, marketing, and other management services, and even hold assets. For example: an MSO would provide office space through leasing arrangements to the group, as well as front desk, patient scheduling, claims submission and collections, accounting, marketing, and other non-clinical services.

Conclusion

The combination of fee-splitting prohibitions and the corporate practice of medicine rule can be daunting to the entrepreneur in the health care industry who wants to own and operate an enterprise that involves medical diagnosis and treatment—whether it's a **medical group**, **medical spa**, or even a **mobile medical app** or **Web-based platform** that provides **telehealth** or other online or mobile healthcare services.

Our healthcare lawyers can craft ways to handle these imposing legal rules, but this requires creativity and savvy, and a strong working knowledge of all the various law and regulations, and how they work together.

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