

Quick Summary of Federal “Stark” Self-Referral & Anti-Kickback Law and California Self-Referral and Fee-Splitting Prohibitions

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Here is a quick summary of federal self-referral (“Stark law”) and anti-kickback law, and California self-referral and anti-kickback / fee-splitting rules. Each state has its own laws, of course.

This is only a summary; if you have a **Stark**, **anti-kickback**, or **fee-splitting** issue, [contact](#) our attorneys.

A. Federal Concerns

1. Federal Self-Referral (“Stark”)

The federal self-referral statute (“Stark”)^[1] provides that if a physician (or immediate family member)^[2] has a *financial relationship* with an entity, then, unless the arrangement qualifies for a specific exception:

- The physician may not refer^[3] patients to the entity for “designated health services” (“DHS”)^[4] payable by federal health care programs (including Medicare, Medicaid or CHAMPUS, and in California, Medi-Cal), and
- Where DHS are involved and the referral is prohibited, the physician may not present a claim to any third-payer for the same.^[5]

Penalties for violation of Stark can be significant. In a recent case, a large health system agreed to pay more than \$25 million to resolve self-disclosed allegations that it illegally paid bonuses to doctors based on how much the system earned from their patient referrals. According to an article in Modernhealthcare.com entitled, Intermountain to pay \$25.5 million to settle Stark case, the health system reportedly “characterized the violations as ‘technical in nature’ and said they arose partly because of the 300 pages of federal regulations and commentary that govern financial relationships between hospitals and physicians. “

Note the following definitions under Stark:

- The financial relationship can be an *ownership or investment interest* in the entity, or a *compensation arrangement* between the physician (or immediate family member) and the entity.^[6]
- A *compensation arrangement* is any arrangement involving *remuneration* between a physician (or an immediate family member) and an entity.^[7]

- The Stark regulations define a physician as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.^[8]

In general, “remuneration” means “any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.”^[9]

A first step is to determine whether DHS is involved. DHS within Stark include:^[10]

- clinical laboratory services;
- physical therapy services;
- occupational therapy services;
- outpatient speech-language pathology services;
- radiology services, including nuclear medicine, MRI, CAT scans, and ultrasound 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; and
- inpatient and outpatient hospitalization services

With regard to the first six categories of DHS, the Stark regulations identify the specific insurance billing codes in each category, which are considered to constitute DHS. These are updated annually by CMS.^[11] The remaining six categories of DHS are defined in the Stark regulatory text.

If DHS is involved, then proposed arrangements must be structured to fit an exception.^[12]

[At this juncture we have omitted discussion of exceptions.]

2. Federal Anti-Kickback

The federal anti-kickback statute^[13] prohibits the knowing and willful offer or receipt of remuneration^[14] to induce the referral of business or services covered by a federal health care program, including Medicare. Even in the presence of other legitimate purposes, the courts have interpreted the statute to cover any arrangement where *one purpose* of the payment or offer of payment (albeit not the only purpose) was to obtain money for the referral of services or to induce further referrals.^[15]

Federal anti-kickback law can apply to all practitioners, not just physicians, where federal reimbursement monies are involved. Practitioners may benefit from cross-referrals and be induced by the financial benefit to cross-refer to Medicare-reimbursed practitioners, irrespective of medical benefit.

Among other dangers, enforcement authorities can potentially view an arrangement as a disguised kickback scheme. One of the ways this could be expressed is an unlawful joint venture between the two entities. The Office of the Inspector General (“OIG”) has expressed concern about joint ventures violating federal anti-kickback law.

In order to protect beneficial arrangements, the federal Centers for Medicare and Medicaid Services (“CMS”) has published certain statutory safe harbor regulations that define practices that are not subject to the anti-kickback statute. If the conditions

in the safe harbors are met, neither party will be prosecuted or sanctioned for the arrangement. Fitting into an exception under Stark is mandatory, whereas under anti-kickback law, if an arrangement does not meet every element of a safe harbor, it is not necessarily unlawful, but rather, is at risk of scrutiny by the OIG.

In the preamble to the 1991 final safe harbor rules, ^[16] the OIG explained that the anti-kickback statute “on its face prohibits offering or acceptance of remuneration, inter alia, for the purposes of ‘arranging for or recommending purchasing, leasing, or ordering any . . . service or item’ payable under Medicare or Medicaid.” The OIG has also observed that “many marketing and advertising activities may involve at least technical violations of the statute.”^[17] As a result, it is critical to scrutinize payments for marketing activity involving physicians for the risk of falling within the anti-kickback prohibition.

If a proposed arrangement fully complies with all the detailed requirements of the safe harbor, the arrangement is not subject to enforcement under the anti-kickback statute; but practices that do not fit within a safe harbor are not necessarily illegal. The arrangement must be carefully scrutinized. The OIG will “evaluate both the form and substance of arrangements,”^[18] and take enforcement action against arrangements that are merely disguised kickbacks.

Potential safe harbors^[19] to many healthcare transactions include:

- Bona Fide Employees
- Personal services and management contracts

These have to be analyzed individually.

Although federal anti-kickback law only applies where federal reimbursement monies are involved, out of an abundance of precaution, a venture may wish to ensure that any contracts with practitioners comply with one or more available safe harbors.

(a) Bona Fide Employee

The bona fide employee safe harbor applies to “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services,” for which payment may be made under Medicare, Medicaid or another federal health care program.

Compensation must be:

- Reasonable;
- Fair Market Value;
- Arm’s Length Negotiations; and
- Not based upon number or value of referrals.

The individual must be an employee, not an independent contractor.

All referrals must meet the above criteria.

(b) Personal Services and Management Contracts

This safe harbor applies only if all of the following standards are met:

- The agency agreement is set out in writing and signed by the parties.
- The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and

specifies the services to be provided by the agent.

- If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.
- The term of the agreement is for not less than one year.
- The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.
- The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.
- The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

Note that unlike in the Stark exception, there is a reference to “aggregate compensation,” and that there is language regarding services to be provided on a part-time basis.

In addition, note the language regarding what must be set forth if services are to be part-time.

B. California Concerns

1. Self-Referral (“PORA”)

California law contains prohibitions against self-referral in the Physician Ownership and Referral Act of 1993 (“PORA”),^[20] as well as California Labor Code Section 139.3 (workers compensation). PORA applies to healthcare licensees. Under PORA:

- A “financial interest” includes “any ... compensation,” whether direct or indirect.^[21] In other words, a physician need not have a stock ownership in the entity to which the physician is referring, in order for PORA to apply. Spouses are considered an immediate family member under PORA.^[22]
- Unlike the Stark law, PORA applies to designated health care services regardless of the source of payment, *i.e.* for private insurers and cash patients.

California’s definition of “physician” is broader than that under federal law, and includes, for example, acupuncturists. For purposes of PORA, under section 650(b)(4), the term “licensee” means “a physician as defined in Section 3209.3 of the Labor Code.”^[23] Under section 3209.3(2) of the Labor Code, the term “physician” “includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.”

The PORA prohibition on referrals only applies if the services provided are those designated as health services triggering the prohibition by PORA, Section 650.01(a) (laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services).

In connection with PORA, a physician must report to the California Medical Board of any “financial interest” in a “health-related facility.”^[24] The term “financial interest” is broadly defined to include, among other things:^[25]

Any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution,

subsidy, or other form of direct or indirect payment, whether in money or otherwise, to a licensee or the licensee's immediate family from a health-related facility.

The term "health-related facility:"^[26]

shall include a facility for clinical laboratory services, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, and outpatient surgery centers. "Diagnostic imaging" shall include, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services. (emphasis added).

If any of designated health services in PORA apply, then we must look to a PORA exception, such as the following:^[27]

The prohibition of Section 650.01 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a licensee's office, or the office of a group practice.

Further, the provisions of Section 650.01 shall not alter, limit, or expand a licensee's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice.

PORA defines "licensee's office," and also has a more extensive definition of "office of a group practice" which would need to be analyzed to the extent PORA indeed applies.^[28]

More notably, there is also a personal services arrangement exception in 650.02(b)(6):

(6) A personal services arrangement between a licensee or an immediate family member of the licensee and the recipient of the referral if the arrangement meets all of the following requirements:(A) It is set out in writing and is signed by the parties.(B) It specifies all of the services to be provided by the licensee or an immediate family member of the licensee.(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.(D) A person who is referred by a licensee or an immediate family member of the licensee is informed in writing of the personal services arrangement that includes information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee.(E) The term of the arrangement is for at least one year.(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, 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.(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

Disclosure of Financial Interest

If none of the designated health services in the statute are being provided, then the prohibition is inapplicable; however, a disclosure of the financial interest must be provided to patients at the time of the referral.^[29] Thus a disclosure of financial interest by the principals to the patients is advised.

California Business & Professions Code Section 650.02(d) provides:

(c) (1) A licensee may refer a person to a health facility, as defined in Section 1250 of the Health and Safety Code, or to any facility owned or leased by a health facility, if the recipient of the referral does not compensate the licensee for the patient referral, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a licensee solely because the licensee has an ownership or

leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A licensee may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code.

(4) A licensee may refer a person to any organization that owns or leases a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code if the licensee is not compensated for the patient referral, the licensee does not receive any payment from the recipient of the referral that is based or determined on the number or value of any patient referrals, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b). For purposes of this paragraph, the ownership may be through stock or membership, and may be represented by a parent holding company that solely owns or controls both the health facility organization and the affiliated organization.

2. California Law – Anti-Kickback

With respect to potential kickbacks, California Business & Professions 650 provides:^[30]

(a) the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

Section 650(b) is often used to justify payment of the management fee based on a percentage of gross revenues at fair market value.

The California Attorney General (“AG”) has interpreted the term “referral” very broadly; for example, according to the AG, “in selecting a particular medical device for use by his or her patient, a physician is ‘referring’ the patient to the company that supplies the device.”^[31]

In addition, California Health & Safety Code, Section (“H&S”) 445, prohibits any person from profiting from referring patients to a physician or clinic for care; California Business & Professions Code, Section 2273(a) prohibits “the employment of runners, cappers, steerers, or other persons to procure patients.” The California Attorney General opinions sometimes reference H&S 445 in connection with B&P 650(a) opinions. And, as suggested, Section 13408.5 of the California Corporations Code prohibits the formation of a professional corporation to cause any violation of law, including prohibitions against fee-splitting and kickbacks.

Kickbacks and fee-splitting are closely related, in that a “kickback” involves the payment to or from a physician in exchange for a referral, while fee-splitting involves splitting the physician’s fee to the patient between the physician and a third-party. B&P 650 prohibits both.^[32] Fee-splitting often implicates CPM concerns. Thus, whether the financial arrangements constitute excessive involvement and effective “control” over the physicians would also be scrutinized by the medical board in investigating a possible B&P 650 violation.

As noted, state regulators are often influenced by opinions and publications of the OIG. In addition to flagging statutory prohibitions on kickbacks, the OIG states that “many marketing and advertising activities may involve at least technical

violations of the statute.”^[33]

As a result, it is critical to scrutinize payments for marketing activity involving physicians for the risk of falling within the anti-kickback prohibition.

California Attorney General Opinions (Business & Professions Code Section 650)

Several opinions California Attorney General interpret the notion of “referral” very broadly, and prohibit various arrangements that have some similarity to your proposed arrangement. Among these:

- **Cal. Atty. Gen. Op. No. 00-1002 (February 1, 2001)**^[34]: The AG opined that B&P 650 prohibits chiropractors from participating in an Internet marketing plan in which they agree to promote the naturopathic products of an Internet company and to refer their patients to the company’s website in exchange for fees equaling 20 percent of the price of the products purchased by their patients from the company.
- **Cal. Atty. Gen. Op. No. 99-611 (December 16, 1999)**^[35]: The AG opined that a physician may not enter into an agreement with a group of licensed and certified professionals to perform working hardening and rehabilitation services for patients, where the physician would control the scope of the services by prescription, obtain payment from a workers’ compensation insurance carrier for the services, and retain a portion of the fee after compensating the group. The AG determined that the physician would be receiving a “discount” from the group, and would be keeping a “rebate” in retaining a portion of the fee after compensating the group.
- **Cal. Atty. Gen. Op. No. 98-611 (January 20, 1999)**^[36]: The AG opined that a corporate entity licensed as a health care service plan may not enter into an agreement with a network of providers of cosmetic medical services, a specialty not covered by any of the entity’s health benefit plans, according to the terms of which the entity would: (1) refer its enrollees to a participating provider, or to a provider selected by the enrollee from a directory of participating providers, for medical services at a discounted rate, and (2) collect and forward to the provider the fees for such services after deducting an “administrative fee.” The AG rejected the argument that B&P 650 would be inapplicable simply because the proposed arrangement would allow the enrollee to select from a list of professionals.
- **Cal. Atty. Gen. Op. No. 93-807 (June 30, 1994)**^[37]: The AG opined that a podiatry referral service for profit may not direct callers on the following basis: (1) to a service subscriber who pays \$500 monthly for a nonexclusive listing according to geographic proximity; (2) to a service subscriber who pays \$750 monthly for a semi- exclusive listing within a five-mile radius; and (3) to a service subscriber who pays \$1000 monthly for an exclusive listing within a five-mile radius, where the caller may, during the call, request and select an alternative referral.

The AG concluded that the proposed referral plan for podiatrists “comes squarely under our 1982 dental referral opinion,” and that the legislative enactment of express authorization for dental referral services (B&P 650.2) and chiropractic referral services (B&P 650.3) is subject to “strict limitations,” and supports the conclusion that a referral plan for *podiatrists* violates B&P 650. The AG emphasized that the proposed plan would constitute “consideration ... as compensation or inducement for referring patients” to the podiatrist.

- **Cal. Atty. Gen. Op. No. 90-304 (October 25, 1990)**^[38]: The AG opined that where a group of radiologists contracts with physicians to provide imaging services for the patients of the physicians, and the agreement provides that (1) the group will charge each patient a fee for the services, (2) the fees collected will be transmitted to the physicians, (3) the physicians will pay stipulated amounts to the group for the services, and (4) the total amounts paid by the physicians will be independent of but increase proportionately less than the total fees collected from the patients, performance of the agreement would violate B&P 650.

The AG broke down B&P 650 into five elements:

- (1) An offer, delivery, receipt or acceptance
- (2) by any person licensed under this division (the healing arts provisions)
- (3) of consideration to any person
- (4) as compensation or inducement for
- (5) referral of patients, clients or customers.

The AG also noted that: “With each referral, the referring physician will receive an economic benefit that is not based solely upon the imaging services rendered the patient. An increment of the consideration will be tied exclusively to the referral itself in that the physician will receive a proportionately greater share of the payments by increasing the number of referrals.

Cases

Some of the key California cases on kickbacks and fee-splitting include the following:

- Defendant paid for “referrals,” in violation of B&P 650, in hiring marketers to hand out cards offering defendant’s services and drive patients to defendant’s office, and paying the marketers \$20 for each referred patient who was qualified to enroll, and who did enroll, in the Family Planning Access Care and Treatment (Family PACT) or Child Health and Disability Prevention Program (CHDP), even though defendant did not pay for patients who were not qualified to enroll in those programs.^[39]
- Contract between medical doctor and lay hospital administrator whereby the administrator was to contact fellow hospital administrators on behalf of the medical doctor in an effort to persuade them to contract for their emergency room services with the medical doctor and under which the administrator was to receive \$250 per month for each hospital client successfully referred by administrator was void in that it violated B&P 650, inasmuch as the referred hospitals became the “clients” or “customers” of the medical doctor and, in turn, the emergency room patients of the hospitals contracted with became referred “patients.”^[40]
- Clinical laboratory’s practice of offering discounted payments to certain patients was not illegal; payment of sales commissions to independent contractor who marketed laboratory’s services to *physicians* (not patients) did not violate B&P 650, but it did violate the Medi-Cal statute’s prohibition on kickbacks, which is broader and includes referrals of “individuals” to “persons” for the furnishing of “services” which may be paid for by Medi-Cal.^[41]
- The bona fide employee exception to the anti-kickback prohibition regarding Medi-Cal, subsumes the common law definition of “employee,” and excludes independent contractors.^[42]

The bottom line is that **California** is a state that takes **anti-kickback** and **fee-splitting prohibitions**, very seriously. The term “referral” is interpreted broadly, and there are cases and Attorney General opinions that provide grounds for legal caution when entering into a healthcare venture that may trigger these rules. If you have any questions, contact an attorney experienced in self-referral, anti-kickback, and fee-splitting legal issues.

Footnotes

^[1] 42 USC §1395nn(a)(1); Section 1128B(b) of the Social Security Act. The Centers for Medicare and Medicaid (“CMS”) has issued a series of regulations interpreting the federal self-referral prohibition and the exceptions. See 42 CFR Sections 411.350-411.361.

^[2] The term “immediate family member” is defined broadly to mean a husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or

sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

[3] The request by a physician for an 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.” 42 USC §1395nn(h)(5).

[4] See below for discussion of DHS.

[5] The penalties for violating the Stark law include denial of payment, refunding of payments received, and imposition of significant civil monetary penalties ranging from \$15,000 to \$100,000, and exclusion from participation in federal health care programs, including Medicare.

[6] 42 USC §1395nn(a)(2); 42 CFR §354(a).

[7] 42 USC §1395nn(h)(1)(A); 42 CFR §411.354(c).

[8] 42 CFR §411.351.

[9] 42 USC §1395nn(h)(1)(B); 42 CFR §411.351. There are various exceptions under Stark, some of which are relevant to the MSO model.

[10] See the summary at Centers for Medicare & Medicaid Services (“CMS”), [Physician Self-Referral: Overview](#). The physician self-referral law can be found in section 1877 of the Social Security Act (42 U.S.C. 1395nn). The regulations are located in Title 42 of the Code of Federal Regulations §411.350 – §411.389.

[11] See CMS, [Physician Self-Referral: Code List for Certain Designated Health Services](#); 42 CFR §411.351 (defining DHS categories without reference to the Code List). The code list includes x-rays, ultrasound, CT, MRI, nuclear medicine, and other imaging services.

[12] See [42 CFR Part 411](#).

[13] 42 U.S.C. §1320a-7b(b); Section 1128B(b) of the Social Security Act. Violation of this statute is a felony punishable by a fine, imprisonment, automatic exclusion from Medicare and Medi-Cal, and civil monetary penalties.

[14] For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

[15] *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985). The statute ascribes liability to both sides of an impermissible “kickback” transaction.

[16] 56 Fed. Reg. 35952 (July 29, 1991).

[17] See 56 Fed. Reg. 35974.

[18] 64 Fed. Reg. 63518, 63530 (Nov. 19, 1999).

[19] 42 C.F.R. §1001.952. With respect to the discount safe harbor, according to the OIG Special Advisory Bulletin on Contractual joint Ventures: “Simply put, the discount safe harbor does not protect—and has never protected—prices offered by a seller to a buyer in connection with a common enterprise. To be protected under the discount safe harbor, a price reduction must be based on an *arms length transaction*.”

[20] Cal. Bus. & Prof. Code §650.01.

[21] Calif. Bus. & Prof. Code §650.01(b)(2).

[22] Calif. Bus. & Prof. Code §650.01(a)(3).

[23] Calif. Bus. & Prof. Code §650.01(b)(4).

[24] Calif. Bus. & Prof. Code §2426(a). See also the California Medical Board's webpage on [Financial Interest Statement](#).

[25] Cal. Bus. & Prof. Code, §2426(b)(1).

[26] Cal. Bus. & Prof. Code §2426(b)(6).

[27] Cal. Bus. & Prof. Code §650.02.

[28] Cal. Bus. & Prof. Code §650.01(b)(5)-(6).

[29] Cal. Bus. Prof. Code §650.01(f). *See also* AG Opin. No. 05-614 (Feb. 27, 2006) (physician may refer a patient “to a company in which he or she has an ownership interest as long as the referral is for a medical device that is not covered by section 6501.01, subdivision (a).”

[30] In addition, California Health & Safety Code, Section 445, prohibits any person from profiting from referring patients to a physician or clinic for care; California Business & Professions Code, Section 2273(a) prohibits “the employment of runners, cappers, steerers, or other persons to procure patients.” And Section 13408.5 of the California Corporations Code prohibits the formation of a professional corporation to cause any violation of law, including prohibitions against fee-splitting and kickbacks.

[31] Cal. Atty. Gen. Op. No. 05-614 (February 27, 2006) (citing *People v. Duz-Mor Diagnostic Laboratory Inc.* (1998) 68 Cal.App.4th 654, 664). *See also* [Major California Attorney General Opinions Involving Business & Professions Code Section 650](#).

[32] As well, the OIG [Special Fraud Alert on Joint Ventures](#) cautions against arrangements where the joint venture is a “shell” intended to induce referrals.

[33] See 56 Fed. Reg. 35974.

[34] 84 Ops. Cal. Atty. Gen. 25 (Cal.A.G.), 2001 WL 117913.

[35] 82 Ops. Cal. Atty. Gen. 225 (Cal.A.G.), 1999 WL 1213591.

[36] 82 Ops. Cal. Atty. Gen. 1 (Cal.A.G.), 1999 WL 26906.

[37] 77 Ops. Cal. Atty. Gen. 143 (Cal.A.G.), 1994 WL 287652.

[38] 73 Ops. Cal. Atty. Gen. 321 (Cal.A.G.), 1990 WL 484782.

[39] *People v. Guimelon* (App. 2 Dist. 2012) 140 Cal.Rptr.3d 584, 205 Cal.App.4th 383, review denied, certiorari denied 133 S.Ct. 547, 184 L.Ed.2d 343/

[40] *Mason v. Hosta* (App. 2 Dist. 1984) 199 Cal.Rptr. 859, 152 Cal.App.3d 980.

[41] *People v. Duz-Mor Diagnostic Laboratory, Inc.* (App. 2 Dist. 1998) 80 Cal.Rptr.2d 419, 68 Cal.App.4th 654, as modified, review denied.

[42] *People v. Palma*, 40 Cal. App. 4th 1559 (1995).

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Contact our healthcare law and FDA attorneys for legal advice relevant to your healthcare venture.