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An Examination of Fee-Splitting Statutes in the Context of Value-Based Health-Care

BY MARK USTIN AND CAROL BRASS

One of the goals of the Affordable Care Act is to align incentives among provider communities and their patients and partners. This effort to create communities of common interest with mutually beneficial incentives is now a key driver of many innovations in the health-care business environment.

However, some states still have in place antiquated statutory prohibitions that hamper positive attempts to promote legitimate business arrangements that promote efficiency and quality. A key example is the state prohibition against fee-splitting.

Fee-splitting prohibitions, adopted in approximately two-thirds of the states, are aimed primarily at situations where a health-care professional, in order to generate patient referrals from other licensed or unlicensed persons, splits part of the professional fee earned from treating the referred patient with the source of the referral.

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In response to this legitimate concern, states adopted prohibitions against fee-splitting. However, some of these prohibitions reach far broader than necessary to deter this behavior, and instead prohibit appropriate business relationships with entities that are not health-care providers, such as billing agencies or management companies.

Although there are some legitimate concerns regarding overbilling or overutilization of care, fee-splitting prohibitions which broadly prohibit legitimate, non-fraudulent relationships are not the appropriate tool with which to address these concerns.

This article will examine the current status of fee-splitting prohibitions in the states, with an emphasis on highlighting differing legislative approaches to facilitating and promoting desirable business arrangements, and a particular emphasis on billing arrangements.

At one end of the spectrum is New York, where fee-splitting laws prohibit the compensation of any practice management and billing entities based on a percentage of reimbursement collection, meaning that New York health-care professionals, either knowingly or unknowingly, run the risk of being charged with professional misconduct by entering into agreements with national practice management, professional billing and health information technology vendors whose customary pricing practices are not consistent with the unique New York limitations.

At the other end of the spectrum, some states, including California, have adopted statutory amendments to explicitly permit and sanction such arrangements. In between are a range of approaches to fee-splitting, including explicit statutory provisions more limited in scope than New York, prohibitions imposed by case law rather than statute, and states that have not addressed this issue at all.

The article will provide a general survey of the legal landscape and alert readers to the need to investigate such laws prior to entering into potentially violative relationships.

Historical Context for Fee-Splitting Prohibitions

The medical profession historically has recognized an ethical prohibition against physicians paying their professional peers for referrals. One form this takes is the prohibition against fee-splitting. Fee-splitting developed as a way for physicians to generate compensation from referrals to specialists such as surgeons or laboratories. The specialist would divide a portion of the fee recovered by the specialist to generate these referrals.[1]

In other words, fee-splitting occurs when a physician, to generate referrals from other physicians, splits part of the professional fee earned from treating the referred patient with the referring physician.

There are various harms that might arise from fee-splitting, including unnecessary operation and procedures, incompetent specialists, and dishonest orientation by the general practitioner and the specialist.[2] However, where patients are not harmed (namely, where they are charged the same price they would otherwise have been charged, and are referred to the same specialist they would have been referred to absent the incentive), it was traditionally acknowledged that no ethical violation occurred.[3]

Given the historical development of the fee-splitting prohibition, it is not surprising that the American Medical Association's Opinion No. 6.02 on fee-splitting provides that ''payment by or to a physician solely for the referral of a patient is fee splitting and is unethical. A physician may not accept payment of any kind, in any form, from any source . . . for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referral and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.''

The purpose of the prohibition on fee-splitting is to ensure that the patient's referral to a particular specialist is not tainted by an improper remuneration incentive. Outside the context of patient referrals, then, the fee-splitting prohibition would have no useful effect.

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Similarly, the American Society for Clinical Pathology's Policy Statement on ''Self-Referral, Markups, Fee Splitting, and Related Practices,'' Policy No. 04-03, states that it supports prohibitions designed to ''prevent clinical providers from profiting on their patient referrals for anatomic pathology and clinical laboratory services. . . . Profiting on patient referrals can cause a host of problems. . . . Abusive billing practices, such as markups, fee splitting and kickbacks, distort rational medical decisions as a result of an economic incentive to overutilize testing services.''

By the same logic as above, the aim of the prohibition is to ensure ethical referrals amongst providers; the concern is not prompted by the fact that fees are shared, but rather with whom and for what intent and effect those fees are shared.

Survey of State Legislation Regarding Fee-Splitting

A significant number of states have not adopted generally applicable fee-splitting statutes *per se* (17 states).[4]

The remaining two-thirds of the states have enacted prohibitions on fee-splitting in some form.[5] Most of these statutes are fairly broad, rarely interpreted, and could be used by a Board as the basis for a claim of professional misconduct against a physician utilizing a percentage-based management or billing arrangement.[6]

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[1] ''Concierge Medicine: Something Old, Something New,'' by Leila M. Hover (2008), at 36.

[2] *Id.*

[3] *Id.*

[4] There are no statutory or regulatory fee-splitting prohibitions in the following states: Alaska, Arkansas, Connecticut, Indiana, Iowa, Louisiana, Maine, Massachusetts, Mississippi, Missouri, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, South Carolina, and Wyoming. However, it is possible that similar prohibitions may be found in case law, attorney general opinions, or other sources of legal authority.

[5] Note that some states have fee-splitting prohibitions limited to certain categories of services which are particularly prone to abuse, such as:

- New Jersey (clinical laboratory services, at N.J. Stat. Ann 45:9-42.42);
- South Carolina (physical therapy services, at S.C. Code Ann. § 40-45-110(A)(1));
- Georgia (optometry, at Ga. Comp. R. & Regs. § 430-4.01(3)); and
- Missouri (dentistry, at Mo. Rev. Stat. 332.321.2(18)).

In these cases, the fee-splitting statutes are typically limited by their terms to referrals made for those specialized services.

[6] Note that some states, including Arizona, Delaware, Michigan, Minnesota, Nevada, Ohio, and Virginia, have fee-splitting statutes that only prohibit fee-splitting among professionals (e.g., physicians).

This form of prohibition more closely tracks the historical concerns discussed above, and would not implicate arrangements between physicians and non-professional entities such as billing companies.

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For example, Idaho's statute is representative of many of these statutes, which define the grounds upon which the board may discipline physicians to include the ''[d]ivision of fees or gifts or agreement to split or divide fees or gifts received for professional services with any person, institution or corporation in exchange for referral.''[7] On its face, the statute could be interpreted to prohibit a broad variety of arrangements, including percentage-based billing or management arrangements. Because virtually all billing companies and some management companies utilize percentage-based billing arrangements, many physicians may unknowingly and inadvertently be in violation of such prohibitions.

This exposes them to legal risk, and exposes their partner entities to uncertainty, because in the event that the physician wishes to exit from a contractual arrangement with the partner, the physician can allege that the underlying contract is void because it is contrary to law.

Four states (Florida, New York, North Carolina, and Tennessee) have notably broad prohibitions against fee-splitting, where case law and/or statute indicate that percentage-based billing arrangements and/or management company arrangements are legally risky.[8]

Of these, only New York has explicitly stated that percentage-based agreements with billing companies are impermissible. In both Florida and Tennessee, courts have expressed some concern over percentage-based arrangements with management companies, but not with companies whose sole function is billing.

Management companies have a significantly higher degree of involvement with and control over the physician practices with which they contract. As such, there is a heightened concern in these instances regarding the amount of control that these companies are able to exert over practices, which may be driving the unfavorable attorney general opinions and/or case law in these states.

These cases therefore do not necessarily indicate that percentage-based billing arrangements would be deemed inappropriate.

North Carolina is somewhat anomalous as well, in that its Board of Medicine has publicly posted an online warning related to fee-splitting[9] (although not specifically related to billing companies), but there are no posted records of disciplinary action taken against licensees for fee-splitting that might provide more context as to what the Board deems impermissible fee-splitting.

Finally, two states (California and Illinois) have statutes prohibiting fee-splitting but specifically authorizing percentage-based billing arrangements.

[7] Idaho Stat. Ann. § 54-1814.

[8] The states are Florida, New York, North Carolina, and Tennessee. In such states, management or billing services are generally expected to be provided on a flat fee or per-claim basis, respectively. A per-claim arrangement (where a billing company's fee is tied to the number of claims submitted rather than the reimbursement collected) carries some of the concerns of a percentage-of-reimbursement arrangement, since the billing company is incentivized to increase the number of claims; however, there is no particular incentive to increase the value of such claims.

[9] ''It is the position of the Board that a physician cannot share revenue on a percentage basis with a non-physician. To do so is fee splitting and is grounds for disciplinary action.''

While fee-splitting is generally prohibited in California, the state legislature has enacted a statute specifically permitting the payment of consideration for services other than the referral of patients which is based on a percentage of gross revenue or other similar types of contractual arrangement 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.[10]

In other words, California has recognized and taken proactive legislative action to protect arrangements which it recognizes as lawful, efficient, and presenting a reasonably low likelihood of abuse. The requirement that fair market value compensation be paid for the billing or management services provides a reasonable check against abusive relationships.

Another state of particular interest is Illinois. Illinois courts originally interpreted the Illinois fee-splitting statute to prohibit any percentage-based compensation arrangements with outside contractors. However, these interpretations were overridden by legislation in 2009 to permit percentage-based fair market value billing, administrative preparation of claims, or collection services.[11]

The Illinois law permits physicians to pay a fair market value fee to an entity performing billing, administrative preparation of claims, or collection services based upon a percentage of professional service fees billed or collected, a flat fee, or any other arrangement that directly or indirectly divides professional fees, so long as the physician or physician's practice at all times controls the amount of fees charged and collected and all charges collected are paid directly to the licensee or put in an appropriate trust account.

Note, interestingly, that the Illinois law even permits a percentage-based fee calculated on service fees ''billed''; this is even broader than the California statute, which only permits such arrangements to be based on fees ''collected.'' The potential for abuse is much greater if the percentage is calculated based on the percentage billed, since billing companies arguably have a higher degree of control over what is billed rather than what is collected.

Nevertheless, Illinois still deemed the fair market value requirement to be a sufficient check against abusive behaviors in billing, administrative preparation of claims, or collection services arrangements.

Percentage-Based Billing and Management Company Arrangements

In this context, it would seem to be anomalous to target percentage-based billing and management arrangements under applicable fee-splitting prohibitions. This is particularly true in the billing company context.

There is no 'tainted referral,' because there is no referral at all. The potential harm is to the payer (or to the patient) in the form of fraud and abuse committed by the billing company (e.g., upcoding or abusive billing practices). The likelihood of such harm, however, is only marginally greater using percentage-based billing arrangements than it is using per-claim billing arrangements.

[10] Cal. Bus. & Prof. Code § 650.

[11] 225 Ill. Comp. Stat. 60/22.2(d).

Rather, the preference for the latter type of arrangement is a relic of a system whose driving principle was volume rather than value. Alignment of incentives and shared savings arrangements require that providers and their supporting organizations be able to accurately and fairly share costs amongst themselves. Legal prohibitions which prevent these organizations from utilizing accurate, non-abusive means to reach that end are undesirable.

The performance of billing functions by a third party, rather than by the provider itself, increases efficiency in the health care system. Billing companies have significantly greater expertise and resources with which to train their employees and support them in billing complex claims. Utilizing billing companies is more cost-efficient for providers, who are able to take advantage of savings achieved via the economies of scale leveraged by the billing company.

Claims are also more likely to be billed accurately by a billing company with experience than by an office manager whose range of expertise likely extends to no more than thirty or forty ICD-9 codes. Moreover, given the general consensus that health care costs should increasingly be driven by considerations of quality, value, and payment for performance, it follows that payments to billing companies should track those principles, as well.

Guaranteed payments to billing companies (which might take the form of fixed fees or payment on a per-claim basis) that apply regardless of the biller's success in achieving outcomes are contrary to these principles and unfair to providers, who are left to bear the brunt of two separate risks: the risk of nonpayment on their claims, as well as the risk that their billing company will not pursue payment on their claims.

In both instances, a percentage-based billing arrangement (but not a fixed-fee or per-claim billing arrangement) enables the provider to share risk with the billing company, which is a more equitable outcome given that the billing company has a greater degree of control over success.

Overall, then, compensation of billing companies on a percentage basis provides a net savings to the health care system and creates efficiencies that should be utilized by providers.

The remaining issue, then, is whether such an arrangement increases the likelihood of fraud and abuse. One clear indication that a billing method is susceptible to abuse is where the compensation paid by the provider to the biller is not commensurate with the fair market value of the services provided by the biller. Measured on this scale, flat fee billing is far more susceptible to abuse than percentage-based billing.

When a provider pays a flat fee to a billing company, neither the provider nor the billing company can predict whether the fee paid will accurately reflect or wildly differ from the actual cost of the billing company's efforts to obtain collections for the provider.

Consider two physicians who pay a flat fee of $10,000 each to a billing company to process 1,000 claims. Based on errors in claims processing and adjudication by the billing company and/or insurance companies, differing success rates in claims appeals, and different patient populations, the success rate of the billing company may differ significantly for each physician.

For example, the insurance company might recover on 55 percent of one physician's claims and 70 percent of the other physician's claims. Even under a per-claim arrangement, the billing company has no incentive to pursue additional efforts to recover reimbursement for the physician with a lower collections rate, which renders this arrangement inefficient for this physician.

Viewed from this angle, it is both inequitable and inefficient that both physicians should pay the insurance company the same compensation amount. A percentage-based billing arrangement ensures that the billing company retains an adequate incentive to encourage it to pursue claims for as long as efficiently possible.

Further, it more fairly allocates cost to physicians, in that they only pay for claims which were successfully recovered by the billing company. On both metrics of fairness and efficiency, the percentage-based billing arrangement is superior.

Conclusion

In any situation where bills are submitted to payers—whether personally by a provider or by a third-party biller—there is always a potential for abuse or fraud if the submitter has an improper motive.

This is true regardless of the methodology for calculating payments; while some argue that contracting with third-party billers on a percentage-based basis incentivizes upcoding, it also can be said that per-claim billing arrangements incentivize duplicate billing and submission of multiple claims.

The dispositive factor as to whether abuse is likely to occur is whether the biller has an abusive motive, not whether a physician pays the biller on a flat-fee or percentage basis.

Given the efficiencies and fairness associated with percentage-based billing, the equity considerations in terms of apportioning risk fairly amongst interested parties, and the growing recognition amongst the states that these billing practices are innocuous, states with outmoded fee splitting prohibitions should—and, in at least some cases, likely will—update these statutes to account for the realities of today's modern health care system.

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