

**SELF-REFERRAL 101:
A GUIDE TO UNDERSTANDING THE IN-OFFICE
ANCILLARY SERVICES EXCEPTION**




American Physical Therapy Association.



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THE PROMOTING INTEGRITY IN MEDICARE ACT (H.R. 2914)

POSITION

The American Physical Therapy Association (APTA) strongly supports the Promoting Integrity in Medicare Act of 2013 (H.R. 2914), which would exclude physical therapy services from the in-office ancillary services (IOAS) exception under the physician self-referral prohibition (commonly referred to as the Stark Law). H.R. 2914 was introduced by Representative Jackie Speier on August 1, 2013.

The expansive use of the IOAS exception by physicians in a manner not originally intended by the law undercuts the purpose of the law and substantially increases costs to the Medicare program and its beneficiaries. APTA believes that this issue should be addressed as part of any fundamental delivery system reform and that the resulting cost savings could help support reform.

CURB MEDICARE ABUSE AND MISALIGNED INCENTIVES

The Stark Law provisions relating to self-referral generally prohibit physicians from referring Medicare patients to entities in which they have a financial interest. The law seeks to ensure that medical decisions are made in the best interest of the patient on the basis of quality, diagnostic capability, turnaround time, and cost without consideration of any financial gain that could be realized by the treating physician through self-referral. The IOAS exception was originally created to allow physicians to self-refer and bill the Medicare program for typical same day services such as x-rays. Unfortunately, abuse of the IOAS exception has substantially diluted the self-referral law and its policy objectives, making it simple for physicians to avoid the law's prohibitions by structuring arrangements that meet the technical requirements but circumvent the intent of the exception.

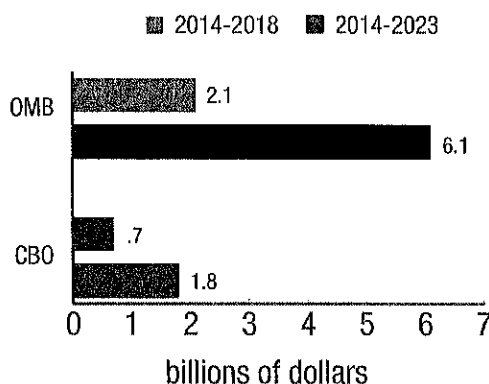
H.R. 2914 removes the health care services most susceptible to overutilization and abuse from the IOAS exception, while preserving the ability of robust, integrated, and collaborative multi-specialty group practices to offer these services.

RESTORE INTEGRITY

Inappropriate use of the IOAS exception relating to physical therapy services should be addressed by Congress. Physical therapy does not meet the intended use of the IOAS exception, as patients must return for physical therapy treatments in subsequent visits. According to the Medicare Payment Advisory Commission (MedPAC), in 2008 only 3% of outpatient therapy services were provided on the same day as an office visit. 9% were provided within 7 days after a visit, and 14% within 14 days after a visit. MedPAC has also cited research that found physicians with a financial interest in physical therapy initiated therapy for patients with musculoskeletal injuries more frequently than other physicians and that physical therapy clinics with physician ownership provided more visits per patient than non-physician-owned clinics. This inappropriate utilization drives up costs in the Medicare program and depletes a patient's trust in our health care system.

Other entities such as the Office of Management and Budget, the Congressional Budget Office, and the Government Accountability Office have also looked at outpatient therapy, advanced imaging, radiation oncology, and pathology as areas where abuse of the IOAS exception is occurring.

Estimated savings from eliminating certain services from IOASE



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Co-sponsor H.R. 2914 Today!

For additional information, contact the American Physical Therapy Association's Government Affairs Department at 703/706-8533 or advocacy@apta.org.

OVERVIEW OF THE IN-OFFICE ANCILLARY SERVICES (IOAS) EXCEPTION

The 1989, the Ethics in Patient Referrals Act, also known as the self-referral law or “Stark” law (after then-Rep Pete Stark of California), generally prohibited physicians from referring Medicare patients for “designated health services” (DHS) to entities in which they have a financial interest. The legislation was intended to ensure medical decisions are made in the best interest of the patient on the basis of quality, diagnostic capability, turnaround time, and cost without providing the treating physician with any incentive for financial gain.

The law included an “in-office ancillary services” (IOAS) exception that permitted physicians to bill the Medicare program for some self-referred services. The intent was to make it convenient for patients to get routine, in-office services such as x-rays and blood work.

In 1993, what is known as the “Stark II” law passed, expanding the in-office ancillary services exception. Physical therapy was added to the exception at that time. Unfortunately, Stark II made it easier for physicians to circumvent the intent of the exception. More and more evidence shows that physician self-referral leads to increased utilization of ancillary services that may not be medically necessary, pose a potential risk of harm to patients, and costs the health care system millions of dollars each year.

APTA supports excluding physical therapy from the IOAS exception. There has been an explosion in physician practices’ use of this exception to hire physical therapists and then bill these providers’ services to the practice itself. This abuse violates the spirit of Stark II, which was for patient convenience. Physical therapy services are rarely provided while the patient is “in the waiting room.” According to the Medicare Payment Advisory Commission (MedPAC), in 2008 only 3% of outpatient therapy services were provided on the same day as an office visit. Furthermore, this practice undercuts the original purpose of the original self-referral law, which was to ban referral-for-profit altogether.

In recent years, the arguments against this loophole have begun to garner attention. One important development was the formation of the Alliance for Integrity in Medicare (AIM). This coalition, of which APTA is a founding member, brought together various provider groups and organizations that seek to address the abuse of the IOAS exception. AIM has been able to increase awareness in Congress, obtain a congressional request for studies from the Government Accountability Office, and introduce legislation to eliminate physical therapy and other services from the exception. What might prove to be most important is AIM’s willingness to stand up against groups that want nothing to change. Opposition is powerful, and without groups like APTA and AIM, this issue would continue to plague our profession.



THE ALLIANCE FOR INTEGRITY IN MEDICARE

The Alliance for Integrity in Medicare, or AIM, was formed to remove certain services from the in-office ancillary services (IOAS) exception. In the past, APTA and the other involved organizations were fighting the self-referral issue on separate fronts. Together, these organizations can speak with one voice, better distribute workload and use resources, and wield more clout on Capitol Hill.

As a founding member of AIM, APTA adds its formidable membership and Capitol Hill presence to the coalition, which also includes the American College of Radiology (ACR), the American Society of Radiation Oncology (ASTRO), the College of American Pathology (CAP), the American Clinical Laboratory Association (ACLA), the Association for Quality Imaging (AQI), the American Society for Clinical Pathology (ASCP), and the Radiology Business Management Association (RBMA).

AIM brings together these organizations in a united effort to fight not only self-referral but also the organizations that support the flawed policy. Self-referral has been a flashpoint for several years, and it is essential for AIM to advocate on Capitol Hill. It is just as important for members in every organization within AIM to get involved.

In 2013, AIM was approached by Rep Jackie Speier (D-CA) for support on a bill to remove certain services from the IOAS exception. In past Congresses, Rep Speier had introduced legislation to remove advanced imaging from the IOAS exception. Together with Rep Speier's office, AIM saw its expanded legislative language become a bill, H.R. 2419.

COORDINATED CARE

Those who oppose the removal of physical therapy, advanced imaging, anatomic pathology, and radiation oncology will claim that closing the self-referral loophole will harm coordinated care. This could not be further from the truth, and it is important to remember that self-referral is *not* the same as coordinated care. The only thing that will end is the incentive to refer patients to entities in which there is a financial self-interest. Physical therapists enjoy excellent relationships with physicians and other health care providers and are leaders in promoting access to coordinated care across all facilities and settings.

The services that AIM supports removing from the IOAS exception are rarely same-day services. For example, the Medicare Payment Advisory Commission (MedPAC) found that only 3% of outpatient therapy services were provided on the same day as an office visit.

What's worse is that patients may not even know they can look elsewhere for care, limiting their choices. There are legitimate safeguards that prevent this legislation from interfering with truly integrated care models. For example, rural settings are exempted, since there is a high chance of a health care provider shortage in these areas.

COST SAVINGS: REPORTS AND ESTIMATES THAT SUPPORT CLOSING THE SELF-REFERRAL LOOPHOLE

GAO REPORTS

- **Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions**

On October 31, 2012, the Government Accountability Office (GAO) issued this report that found self-referred magnetic resonance imaging (MRI) services increased by approximately 84% from 2004 to 2010, whereas non-self-referred MRI services only increased by roughly 12%. For computed tomography (CT) over the same time period, the number of services performed by self-referrers increased by approximately 107%, in contrast to an increase of roughly 30% by non-self-referrers.

GAO also found that in 2010 "providers who self-referred made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring." As a result, GAO concluded that "financial incentives for self-referring providers were likely a major factor driving the increase in referrals." GAO estimated the fiscal impact of the 400,000 improper referrals on the Medicare program to be more than \$100 million just in 2010. GAO also highlighted the "unacceptable risks for beneficiaries" resulting from additional radiation exposure, particularly in the case of CT services, associated with these unnecessary referrals.

- **Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer**

On July 15, 2013, this report from the Government Accountability Office (GAO) concluded that when physicians performed biopsies in their own facilities instead of referring the service to an outside lab, the number of procedures increased, and costs went up.

Among the findings are that self-referred services more than doubled, while services referred externally increased far less (116% vs 38%), and spending was higher for self-referrals than for non-self-referral services (164% vs 57%). GAO estimated that the higher rate of procedures and higher number of services per biopsy by self-referrers cost Medicare \$69 million.

- **Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrants Scrutiny**

On August 1, 2013, the Government Accountability Office (GAO) concluded in this report that when physicians provide certain services in their own facilities instead of referring the service to an outside lab, the number of procedures increases, and costs go up.

This report covered prostate cancer-related intensity-modulated radiation therapy (IMRT) services between 2006 and 2010. Among the findings are that self-referred services grew by 46% annually, from 80,000 in 2006 to 366,000 in 2010, while non-self-referred services decreased by 1% each year, from 490,000 to 466,000. In 2009, providers who self-referred Medicare patients with prostate cancer were 53% more likely to refer the patients for IMRT than for other less costly treatments. GAO estimated that, even including a \$91 million decrease in expenditures by the non-self-referring provider groups, the higher rate of IMRT by self-referrers led to an overall increase in IMRT Medicare costs of \$47 million between 2006 and 2010. The report also suggested that financial interest in one type of treatment over other less costly procedures may negatively affect a provider's decision-making process and, ultimately, patient care.

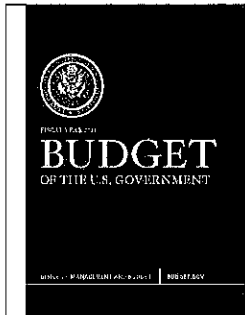
- **Physical Therapy – Report expected in Fall of 2013**

Bipartisan Groups Support Closing Self-Referral Loophole

Momentum is mounting to end self-referral abuse in Medicare. AIM's proposed solution to close the self-referral loophole has gained recent endorsements from bipartisan groups and President Obama.

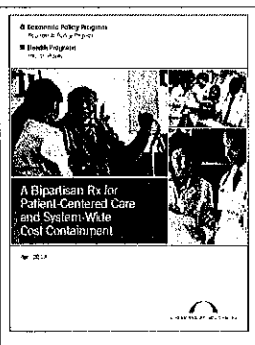
April 2013: President Obama's 2014 budget proposal.

"Exclude Certain Services from the In-Office Ancillary Services Exception: The in-office ancillary services exception was intended to allow physicians to self-refer quick turnaround services. While there are many appropriate uses for this exception, certain services, such as advanced imaging and outpatient therapy, are rarely performed on the same day as the related physician office visit. Additionally, evidence suggests that this exception



may have resulted in overutilization and rapid growth of certain services. Effective calendar year 2015, this proposal would seek to encourage more appropriate use of select services by excluding radiation therapy, therapy services and advanced imaging from the in-office ancillary services exception to the prohibition against physician self-referrals (Stark law), except in cases where a practice meets certain accountability standards, as defined by the Secretary. **[\$6.1 billion in savings over 10 years]**"

April 2013: The Bipartisan Policy Group, Former Senate Majority Leaders Tom Daschle (D-SD) and Bill Frist (R-TN), former Senator Pete Domenici (R-NM), and former White House and Congressional Budget Office Director Dr. Alice Rivlin.



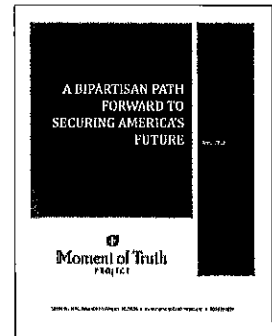
in which providers are accountable for cost and quality, is in alignment with our overall vision for health-system reform."

"5. LIMIT THE IN-OFFICE EXCEPTION TO THE PHYSICIAN SELF-REFERRAL LAW (FY2014-2023 Budget Savings: \$6.1 Billion)

The president's FY 2014 budget included a proposal to limit the in-office exception to providers who meet accountability standards. We are supportive of this approach. Limiting self-referral for imaging and other tests to providers who participate in advanced payment models,

April 2013: Erskine Bowles and Alan Simpson, Moment of Truth Project.

"Physician self-referrals should be further restricted and better monitored, including narrowing the ancillary service exception."

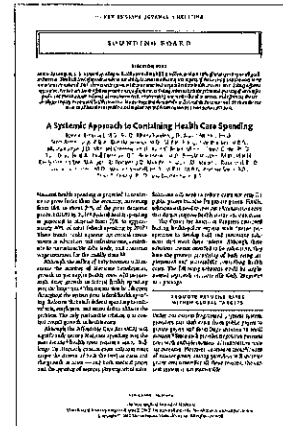


August 2012: New England Journal of Medicine

"A Systemic Approach to Containing Medicare Spending," was written by former high ranking administration officials and premier health policy experts.

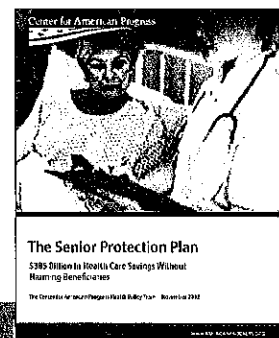
"Expand the Medicare Ban on Physician Self-Referrals

We believe that the Stark law should be expanded to prohibit physician self-referrals for services that are paid for by private insurers. In addition, the loopholes for in-office imaging, pathology laboratories, and radiation therapy should be closed. Physicians who use alternatives to fee-for-service payment should be exempted because these methods reduce incentives to increase volume."



November 2012: The Center for American Progress, Senior Protection Plan.

"Expand Medicare's ban on physician self-referrals The Stark law should be expanded to prohibit physician self-referrals for services that are paid for by private insurers. Within three years, the loopholes for in-office imaging, pathology laboratories and radiation therapy should be closed. An exception should apply to physicians who use alternatives to fee-for-service payment, which reduce incentives to increase the volume of services."



LEGISLATIVE OUTLOOK

On August 1, 2013, Rep Jackie Speier (D-CA) introduced the Promoting Integrity in Medicare Act, H.R. 2914. This was an important step in the elimination of physical therapy from the IOAS exception. The introduction was preceded by three GAO reports, on anatomic pathology, radiation oncology, and advanced imaging, all of which showed increased utilization of ancillary services under the exception. The GAO report on physical therapy is expected this fall.

NEXT STEPS

Legislatively, the next steps on this policy issue will be difficult. The opposition to this policy is strong, and allies in Congress can be difficult to find. APTA and AIM have been educating Members of Congress on the policy merits for over two years, specifically those on Committees that will consider legislation such as H.R. 2914.

The most likely scenario is that the legislative language of H.R. 2914 is used as part of a larger health bill. Since, according to the CBO, this policy change would save money, APTA is hopeful that it will be used to offset a fix to the sustainable growth rate (SGR) or therapy cap repeal. With Congress looking for every penny, this cost-saving change remains attractive to policy makers.

APTA and AIM will continue to lobby the Hill and rally support for H.R. 2914, either as a standalone bill or as an offset to be included in broader health legislation.

ADVOCACY

APTA and AIM have launched an aggressive grassroots campaign. The coalition has shared all relevant GAO reports with their membership and continued the campaign with Action Alerts when H.R. 2914 was introduced. APTA will continue grassroots efforts throughout the fall, keeping membership informed of new developments, creating resources, updating the website, and coordinating site visits with members of Congress.

WHAT CAN YOU DO?

As an APTA member, you can get involved in many ways. First and foremost, be informed on the policy. APTA has posted, and will continue to post, many resources for you to use—this member toolkit being one. Keep informed of events by subscribing to PTeam and APTA's legislative e-mail alerts, and checking the APTA website, www.apta.org, frequently.

You can also visit the Legislative Action Center and write or call your member of Congress. You will be provided with a sample letter, but we need your information and your personal touch to make it as strong as possible. If you've been impacted in some way by a self-referral arrangement, include how it hurt your patients or your ability to serve your patients. APTA's advocacy web page will have information on how to speak to your member of Congress' office via phone to set up a meeting face to face with your representative, or a staff member.

Finally, one of your patients may be able to best illustrate the impact of self-referral arrangements. Ask your patients if they'd like to get involved by letting their member of Congress know how self-referral impacted their treatment. APTA has a Patient Action Center, similar to the Legislative Action Center, that patients can use to take action.

The issue of self-referral has been stirring up debate among specialty groups for 20 years. It is an extremely controversial issue, and your help will be essential to end this abuse of Medicare and patients. If you have any questions on how you can help, don't hesitate to contact APTA at advocacy@apta.org.

FACTS ABOUT PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS



WHO WE ARE

Physical therapists (PTs) are health care professionals who diagnose and treat individuals of all ages, from newborns to the very old, who have medical problems or other health related conditions that limit their ability to move and perform functional activities in their daily lives. PTs also work with individuals to prevent the loss of mobility before it occurs by developing fitness- and wellness-oriented programs for healthier and more active lifestyles.

Physical therapist assistants (PTAs) provide selective physical therapy interventions under the direction and supervision of physical therapists.

WHAT WE DO

PTs examine each individual and develop a plan of care using treatment techniques to promote the ability to move, reduce pain, restore function, and prevent disability. Under the direction and supervision of the PT, PTAs provide selective physical therapy interventions based on the developed plan of care.

WHERE WE PRACTICE

PTs and PTAs provide care for people in a variety of settings, including outpatient clinics or offices; inpatient rehabilitation facilities; skilled nursing, extended care, or subacute facilities; education or research centers; schools; hospices; industrial, workplace, or other occupational environments; and fitness centers and sports training facilities.

EDUCATION & LICENSURE

All PTs must receive a graduate degree from an accredited physical therapist program before taking a national licensure examination that permits them to practice. The majority of programs offer the doctor of physical therapy (DPT) degree. State licensure is required in each state in which a PT practices. PTAs must complete a 2-year associate's degree and are licensed, certified, or registered in most states.

AMERICAN PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association (www.apta.org) is a national organization representing more than 85,000 physical therapists, physical therapist assistants, and students nationwide. Its goal is to foster advancements in physical therapist education, practice, and research.

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