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Splitting Fees or Splitting Hairs? Fee Splitting and Health Care — The Florida Experience

*Richard O. Jacobs and Elizabeth Goodman**

INTRODUCTION

In this paper we examine fee splitting under Florida law. This evolving body of health care law is driven by administrative rule making and interpretations of statutory law aimed at prohibiting physicians and other health care professionals from paying for a patient referral. Under the current regulatory environment, there appears to be a lapse of common sense. However, experience with other applications of statutory law and rule making suggests that reason and rationalism will eventually prevail over the law of fee splitting.

For example, early court decisions under the Employee Retirement Income Security Act of 1974 (“ERISA”) denied medical plan participants damage claims against insurers withholding benefits or care for any reason.¹ The courts viewed the preemption provisions of ERISA as the basis for denying even the most egregious claims for malpractice or treatment denial damages. With time and the persistence of insured plan participants, and with the assistance of their attorneys, reason has begun to reenter the ERISA arena.

Until recently, the traditions and ethics of the learned professions universally exhibited a strong disdain for marketing and advertising. With that disdain came prohibitions against fee splitting, or paying for patient or client referrals.² However, as lines began to blur between businesses and professions, and as professionals became pressured to promote their practices, marketing freedom increasingly prevailed and the strict promotional rules of some professions have been relaxed. For example, accountants licensed in Florida are now permitted to offer insur-

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1. See 29 U.S.C. § 1001 (West 1998).

2. See MARC A. RODWIN, *MEDICINE MONEY AND MORALS* 32 (1995).

ance and investment products to their clients and are allowed to charge commissions.³ In addition, lawyers are now permitted to pay referral fees to other lawyers when the fees are disclosed to clients.⁴

For health care practitioners, however, such freedoms do not exist.⁵ Perhaps the rationale arises from the idea that because our government pays for health care, micro-management of medicine to control costs is justified. Perhaps the rationale comes from the ideology that marketing, over-utilization, and fraud and abuse are inherently linked. Perhaps the rationale is based on today's technological complexities and the difficulty in determining what is "reasonable and necessary" health care that is worth paying for.

Whatever the rationale, as managed care plans and provider networks grow, as publicly held physician practice management companies ("PPMC") consolidate practice management and promotion, as federal and state governments increase their micro-management of health care delivery, fee splitting has become a gigantic legal issue in the health care area.

In Florida, the fee-splitting issue was thrust to center stage by the Florida Board of Medicine's 1997 advisory opinion in the petition of Magan L. Bakaranian, M.D.⁶ The Medical Board advised Dr. Bakaranian that a practice management agreement between a physician group and a PPMC, PhyMatrix, violated Florida's fee-splitting statute.⁷ The management agreement provided that PhyMatrix was paid a percentage management fee in exchange for managing the practice and providing network development and other practice-enhancement services. The Board's opinion stated that the percentage management fee was an illegal fee split.

In 1998, Dr. Bakaranian's attorney requested an advisory opinion from the Office of the Inspector General ("OIG") of the Department of Health and Human Services on behalf of another physician. The OIG issued Advisory Opinion 98-4⁸ indicating that a percentage fee PPMC management contract could

3. See FLA. STAT. ANN. § 473.3205 (West 1998).

4. See FLA. STATE BAR RULE 4-1.5 (1998).

5. See, e.g., 42 U.S.C. § 1320a-7b (West 1998)

6. *In re*: Petition for Declaratory Statement of Magan L. Bakaranian, M.D., 20 F.A.L.R. 395 (1997).

7. FLA. STAT. ANN § 458.331(1)(i) (West 1998).

8. OIG Advisory Opinion No. 98-4 (last updated March 16, 1999) <<http://www.hhs.gov/progorg/oig>>.

violate the federal anti-kickback statute⁹ because percentage fees could encourage health care service over-utilization and upcoding.

I. FEE SPLITTING AND CORPORATE PRACTICE OF MEDICINE

Early writings about medical practice economics indicate that fee splitting was an ethical concern as early as the 1890s. Fee splitting arose as an issue because surgeons had developed the common practice of paying family practice physicians for patient referrals.¹⁰ In response, the American Medical Association developed an ethical prohibition against such practice.¹¹ Additionally, between 1914 and 1953, twenty-two states passed laws making fee splitting illegal.¹² Today, at least thirty-six states have laws prohibiting kickbacks or fee splits.¹³

The corporate practice of medicine doctrine generally prohibits corporations from providing professional medical services.¹⁴ The rationale behind the doctrine is that only human beings can be licensed to practice medicine and therefore corporations cannot provide medical care. Until the mid-1950s, the practice of medicine by a corporate entity was viewed as harmful to medical science, individual patients and medical practitioners. The development of the corporate practice of medicine doctrine effectively divided physicians into two camps. Most physicians opposed the corporate control of medicine, believing it would create a bidding war among physicians and would drastically decrease the level of reimbursement for physicians' services. Other physicians welcomed the stability of income they believed the corporate practice would provide.¹⁵

The courts deciding against the corporate practice of medicine reasoned that corporations were inherently incapable of practicing medicine because the corporation itself, as a legal entity, was incapable of meeting the state training and licensing requirements applicable to the practice of medicine.¹⁶ Courts ex-

9. 42 U.S.C. § 1320a-7b (West 1998).

10. See RODWIN, *supra* note 2, at 22.

11. See *id.*

12. See *id.* at 32.

13. See *id.* at 43.

14. See Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 447 (1997).

15. See *id.* at 458.

16. See 6 WILLIAM MEADE FLETCHER ET AL., FLETCHER CYCLOPEDIA OF THE LAW OF PRIVATE CORPORATIONS, § 2525 at 517 (perm. ed. rev. vol. 1996).

pressed concern that interposing the interests of a third party, the corporation, into the physician-patient relationship would cause the physician to be more interested in the needs of the corporation than in the needs of his patients. Critics also contend that this interposition results in a fee split between the corporation and the physician.¹⁷ Nonetheless, because of the growth of corporate practice of medicine, several state legislatures passed legislation limiting the practice of medicine to natural persons.¹⁸

As a corporate practice of medicine doctrine developed, both the doctrine and associated fee-splitting issues were addressed by several health care professional associations, including the American Medical Association, American Osteopathic Association, American Dental Association, American Podiatric Medical Association, state health professional boards and the courts.¹⁹

A. American Medical Association

In 1957, the House of Delegates of the American Medical Association ("AMA") approved of the practice of medicine through partnerships, associations or other lawful groups. In its resolution, the House of Delegates stated that these methods of organization were acceptable as long as the practice management and ownership duties remained in the hands of licensed physicians.²⁰ In 1961, the AMA took a leadership role on this issue. In that year, twelve states passed the first professional corporation acts based on a prototype statute drafted by the legal staff of the AMA.²¹

That same year, the AMA's Judicial Council issued a proclamation stating that "physicians may take advantage of professional association laws and may also ethically do those things, which are necessary to reap the intended and proper advantage of such legislation."²² By 1971, all states authorized physicians to organize as professional corporations, associations or partnerships.²³

17. See Andre Hampton, *Resurrection of the Prohibition on the Corporate Practice of Medicine: Teaching Old Dogs New Tricks*, 66 U. CIN. L. REV. 489, 497 (1998).

18. See 17 BERRIEN C. EATON, BUSINESS ORGANIZATIONS: PROFESSIONAL CORPORATIONS AND ASSOCIATIONS, § 8.05[1] (perm. ed. rev. vol. 1992).

19. See *id.* at § 8.05-8.07.

20. See *id.*

21. See *id.* at § 9.01.

22. See *id.* at § 8.05[1].

23. See *id.* 17B at § 19.01[2].

During 1968 and 1969, the AMA surveyed state medical societies regarding their positions on professional corporations.²⁴ This survey asked whether or not the societies favored the practice and whether or not they had promulgated rules on the issue. Five of forty-seven responding state medical societies reported ruling on the issue. Of those that ruled, one opposed professional corporations but four ruled in their favor.²⁵ However, almost half of the state societies responded in favor of the idea of permitting the corporate practice of medicine. In a follow-up survey completed in 1974, there was little change on the subject.²⁶

In 1977, the AMA Judicial Council issued Opinion 4.61, authorizing physicians to form professional service corporations and associations if formation was consistent with the laws of state in which they practiced.²⁷ Opinion 4.61 required that professional service corporations and their physician employees observe the Principles of Medical Ethics applicable to individual physicians. Finally, Opinion 4.61 required that the ownership and management of these professional corporations remain in the hands of licensed physicians.²⁸

The issue of fee splitting evolved along a concurrent path. Initially, the AMA opposed any form of fee splitting. However, between 1946 and 1963, the AMA softened its position.²⁹ At first, it took the position that the division of income among the members of a group must be associated with the services and contributions of the group's members. The AMA considered profit-sharing plans including lay employees as unethical. However, in 1964, the AMA Judicial Council modified their position as follows:

A retirement plan classified under the Internal Revenue Code which also covers lay employees and which provides that the contribution made by a solo practitioner, a group of physicians, or a professional corporation will be based on a percentage of compensation of the participants is ethically acceptable even though the contribution: (1) is limited to a percentage of net income before taxes or (2) is payable only when net income exceeds a specified amount.³⁰

24. See Eaton, *supra* note 18, at § 8.05[2].

25. See *id.*

26. See *id.*

27. See *id.* at § 8.05[1].

28. See *id.*

29. See RODWIN, *supra* note 2, at 35.

30. See Eaton, *supra* note 18.

This position is now liberally construed to mean that almost any type of pension, profit-sharing or other retirement plan is now ethically acceptable.³¹

The current position of the American Medical Association on fee splitting is expressed as follows:

Fee-splitting arrangements between physicians and other independent practitioners in which payment is made *merely for referral of patients* are unethical; State boards of medical examiners are encouraged to address this significant issue and deal appropriately with those physicians in their jurisdictions who are involved in these unethical, and often times illegal, practices.³²

This expression by the AMA is consistent with the Florida Second District Court of Appeals in *Practice Management Associates, Inc. v. Blickensderfer*, which differentiated a fee allocation based upon services from a fee split for a mere patient referral,³³ but it is inconsistent with the declaratory statements of the Florida Board of Medicine.

B. American Osteopathic Association

In 1970, the General Counsel of the American Osteopathic Association ("AOA") issued an opinion addressing the increase in the corporate practice of medicine by osteopathic physicians and other professionals. The General Counsel opined that because almost seventy percent of osteopaths engaged in a full-time general practice, as opposed to twenty-two percent of medical doctors, the trend toward group practice by osteopathic physicians would not be as great as among medical doctors.³⁴

In this opinion, the General Counsel further noted problems of unethical fee splitting in the corporate practice of medicine. The General Counsel reasoned that if the AOA Ethics Committee were called upon at that time to render an opinion, there might be some variation in opinion regarding whether additional compensation that does not reflect fees earned by the physician results in fee splitting. He opined that this disparity could have been accounted for by the Committee's varying per-

31. See *id.*

32. 1998 AMA Policy Compendium H-140.991 (Res. 89, A-86; *Reaffirmed*: CEJA Rep. A, I-88) (emphasis added).

33. See *Practice Mgmt. Assoc.'s, Inc. v. Blickensderfer*, 630 So.2d 1147, 1148 (Fla. 2nd Dist. Ct. App. 1993).

34. See Eaton, *supra* note 18, § 8.06[1].

spective concerning the increase in corporate practice by professionals and the advance of different methods of payment.³⁵

In 1972, the AOA Ethics Committee issued a ruling holding that paying a radiologist employed by a professional corporation a percentage of his fees plus his expenses did not involve improper fee splitting even though his remaining fees were distributed among the other member-employees of the professional corporation.³⁶

In 1978, the AOA Ethics Committee issued a ruling interpreting Sections nineteen through twenty-two of the AOA Code of Ethics. That document concluded that the group practice of medicine does not violate the AOA Code of Ethics if the division of income among the members is based on the relative value of the professional services and other services and contributions provided by the respective members to the group.³⁷

Today, Section twelve of the AOA Code of Ethics is consistent with that 1978 ruling. It states that any fee charged by a physician shall compensate the physician for services actually rendered and there shall be no division of professional fees for referrals of patients.³⁸ The position of the AOA is also consistent with the position of the Florida Second District Court of Appeals expressed above.³⁹

C. American Dental Association

In 1968, the Judicial Council of the American Dental Association (“ADA”) explained that *The Principles of Ethics of the American Dental Association* did not include a policy position on professional corporations, but did allow reasonable arrangements involving partnerships and office sharing.⁴⁰ Because the document failed to explicitly prohibit professional corporations, some practitioners viewed the practice as permitted. However, Section nine of the 1968 Principles of Ethics prohibited fee splitting by dentists, defining prohibited fee splitting as any fee agreement between dentists that is not disclosed to the patient.⁴¹

A survey conducted by the ADA in 1968 revealed that several state dental societies showed a significant interest in profes-

35. See *id.*

36. See *id.*

37. See *id.* at § 8.06[2].

38. See AM. OSTEOPATHIC ASS'N CODE OF ETHICS § 12 (1996).

39. See *Blickensderfer*, 630 So. 2d at 1148.

40. See *Eaton*, *supra* note 18, at § 8.07[2].

41. See *id.*

sional corporations. During those years, the Michigan, Colorado and Missouri societies issued rulings favorable to the corporate practice of dentistry, while Arizona prohibited it.⁴²

Currently, Section nine of the ADA Code of Professional Conduct states that dentists have a duty to be fair in their dealings with patients, colleagues and society. Advisory Opinion six of Section nine explicitly prohibits dentists from accepting or tendering rebates or splitting fees.⁴³

D. American Podiatric Medical Association

The Code of Ethics of the American Podiatric Association explicitly prohibits fee splitting, excluding from its definition of fee splitting the division of fees within a partnership. Section O of the Code of Ethics states:

It is unethical for a podiatrist to pay or accept commissions in any form or manner on fees for professional services, references, consultations, pathology reports, radiograms, prescriptions, or on other services or articles supplied to patients. Division of professional fees or acceptance of rebates from fees paid by patients to x-ray, clinical or other laboratories, shoe stores, or other commercial establishments is unethical. It is unethical for a podiatrist to pay for the recommendation of patients. The division of revenue in a partnership is outside the scope and application of this rule.⁴⁴

E. The Continuing Conflict

By 1971, all fifty states permitted professional corporations.⁴⁵ Today, several states, including Florida, Alaska, Connecticut, Delaware and Indiana, have no prohibition against the corporate practice of medicine regardless of whether the corporation is a professional or non-professional entity.⁴⁶ For example, in Florida, the Board of Medicine has repeatedly ruled that Florida law permits the corporate ownership of medical practices. In those rulings, the Board found it acceptable for non-physicians, including corporations, natural persons and other legal entities,

42. See *id.* at § 8.07[3].

43. See *id.* at § 8.07[2] at n.44-45.

44. AM. PODIATRIC MED. ASS'N. CODE OF ETHICS § 2(o) (1996).

45. See Eaton, *supra* note 18, at § 9.01.

46. See D. Cameron Dobbins, *Survey of Laws Relating to the Corporate Practice of Medicine*, 9 No. 5 HEALTH LAW 18 (1977).

to own medical practices and employ physicians.⁴⁷ However, a number of states, including California, Texas, Arizona, Illinois and Idaho, still prohibit the practice of medicine by “regular” non-professional corporations, partnerships and other legal entities.⁴⁸

Despite growing liberalization with regard to corporate practice and employee profit sharing, the regulatory boards continued to oppose fee splitting between a physician and a layman or between independent physicians. This position has been justified under the principle that physician judgment could be impeded by financial considerations. Many feel that fee splitting is unethical and may interfere with the physician-patient relationship.⁴⁹ Others contend that fee splitting may cause physicians to over-utilize services in order to increase fees.⁵⁰ These positions notwithstanding, in states where the corporate practice of medicine has been authorized, regulation has not prohibited non-physician corporate owners from sharing in the corporation’s earnings even though those earnings represented, at least in part, the fees generated by employed physicians.

Today, the distinction between corporate ownership of a medical practice and traditional fee splitting still confronts practitioners and regulators. The issue was recently addressed by the Florida Board of Medicine in its Answer Brief in the Board’s appeal of the *PhyMatrix Management, Inc. v. Magan L. Bakaranian* case. In describing its interpretation that a management contract paid on a percentage basis constitutes an inappropriate fee split, the Board stated:

PhyMatrix suggests to the court that its agreement is simply the corporate practice of medicine with a different ‘structure.’ It is in fact this difference in structure that distinguishes this agreement from the corporate practice of medicine. In the corporate practice of medicine, the corporation owns the medical practice and carries all the liabilities and responsibilities of ownership. The owner-corporation legally employs physicians and at the end of business retains its corporate earnings. The

47. See, e.g., Conrad Goulet, M.D., 15 F.A.L.R. 4184 (1989); John W. Lister, M.D., 9 F.A.L.R. 6299 (1987).

48. See Dobbins, *supra* note 46; but see Berlin v. Sarah Bush Lincoln Health Ctr., 179 Ill.2d 1 (1997) (recognizing that the Illinois Medical Practice Act contains no express prohibition on the corporate employment of physicians and rationalizing that hospital corporations are authorized by other laws to provide medical treatment to patients, the court ruled that licensed hospitals may directly employ physicians).

49. See Eaton, *supra* note 18, at § 8.05[1].

50. See *id.*

PhyMatrix agreement seeks to avoid ownership, but still provides PhyMatrix a share of the earnings.⁵¹

The Board draws a distinction between fee splitting among members and employees of a corporation and fee splitting between professionals and third-party contractors. Unfortunately, there is a profound lack of clarity in the definition used by the Board, which fails to distinguish between the use of fees to pay for legitimate business services from the use of fees to pay for patient referrals.

II. LACK OF CLARITY - DEFINITION

Most states have enacted legislation or rules prohibiting physician fee splitting and other payments for referrals.⁵² However, *referral* and *fee split* are rarely defined in the fee split context.

A. What is a "Patient Referral?"

Though state laws usually lack a definition of referral, the term is defined under the regulations accompanying the Social Security Act as follows:

- The request by a physician for an item or service for which payment may be made under Medicare Part B, 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].
- The request or establishment of a plan of care by a physician that includes the furnishing of designated health services.⁵³

In its 1998 proposed "Stark II" regulations, however, the Health Care Financing Administration ("HCFA") adopts the view that a referral to oneself is a referral:

Section 1877(a)(1) prohibits a physician from referring Medicare patients for the furnishing of designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. The statute encompasses any entity that provides designated health services, without qualifications or limits. We

51. Brief for Appellee, *PhyMatrix Mgmt., Inc. v. Magan L. Bakaranian, M.D.*, No. 97-4543 (Fla. 1st Dist. Ct. App. filed Apr. 17, 1998).

52. See, e.g., *State v. Abortion Info. Agency, Inc.*, 323 N.Y.S.2d 597 (N.Y. Sup. Ct. 1971); see also Robert M. McNair, Jr., *Selected Issues in Forming and Operating Health Care Joint Ventures*, 371 *PLI/Comm* 9, 58 (1985); CAL. BUS. & PROF. CODE § 650 (West 1998).

53. 63 Fed. Reg. 1659, 1690 (1998).

attempted to reflect the breadth of the concept in the August 1995 final rule at § 411.351, where we defined an “entity” as a sole proprietorship, trust, corporation, partnership, foundation, not-for-profit corporation, or unincorporated association. . . . We wish to clarify that we regard an individual physician or group of physicians as referring to an “entity” when they refer to themselves, or among themselves. The concept of a “referral” under section 1877(h)(5)(A) and (B) covers the request by a physician for an item or service under Part B, or the request or establishment of a plan of care by a physician that includes the provision of a designated health service. This statutory definition does not exclude in-office referrals, nor does it specify that a referral occurs only when a physician refers to an outside entity.⁵⁴

HCFA’s approach does little to define a prohibited “referral” for fee-split purposes. The search for a definition is also exacerbated by judicial interpretations of the federal anti-kickback statute. The courts have adopted the government’s position that the anti-kickback statute prohibits arrangements in which *any one purpose* of the remuneration is for referral of services or to induce further services.⁵⁵

B. What is a Fee Split?

Similarly lacking is a definition of fee split that distinguishes a payment for patient referrals from a payment for professional services. Under either HCFA’s definition that a self-referral is a referral, or the *one purpose rule* adopted by some courts under the federal anti-kickback statutes,⁵⁶ any payment intended to induce referrals is potentially illegal.

Consider HCFA’s view that such common business practices as hospitals providing parking for physician staff members may constitute illegal payment for referrals. The proposed Stark II regulations provide:

We have also been asked about parking spaces that a hospital provides to physicians who have privileges to treat their patients in the hospital. It is our view that, while a physician is making rounds, the parking benefits - both the hospital and its patients, rather than providing the physician with any personal benefit. Thus, we do not intend to regard parking for this pur-

54. 63 Fed. Reg. at 1685.

55. See, e.g., OIG Advisory Opinion 98-4, *supra* note 8 (citing U.S. v. Kats, 871 F.2d 105 (9th Cir. 1989).)

56. United States v. Greber, 760 F.2d 68 (3rd Cir. 1985); United States v. Kats, 871 F.2d 105 (9th Cir. 1989).

pose as remuneration furnished by the hospital to the physician, but instead as part of the physician's privileges. However, if a hospital provides parking to a physician for periods of time that do not coincide with his or her rounds, that parking could constitute remuneration.⁵⁷

With a similarly unsettling broad brush, consider Florida's Board of Medicine view that a global fee split is an illegal fee split, expressed at its April 1998 board meeting:

The Board voted to issue an opinion letter regarding certain financial arrangements between specialists and imaging centers. The Board stated that an arrangement which calls for the specialist to refer patients to an imaging center, then receive a portion of the global fee for performing the read of the study, is prohibited by law. The Board referred the matter to their Rules Committee for development of clarifying language.⁵⁸

As of the date of this writing, the Rules Committee has not issued a rule.

The Florida statute interpreted by the Board of Medicine was adopted in 1979. Section 458.331(1)(i) of the Florida Statutes provides that the Board of Medicine has the authority to discipline a physician for:

. . . paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency or person either directly or indirectly, for patients referred. . . for health care goods and services. . . .⁵⁹

Similar statutes apply to each of Florida's professional health care licensure classifications. A related Florida statute makes it a crime to:

. . . offer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage from a health care provider or health care facility.⁶⁰

Court interpretations of the Florida fee-splitting statutes are sparse. Most of the interpretations have come from the Board of Medicine and other regulatory bodies. The only cases on this subject are a series of related cases from the Florida Second District Court of Appeal. The Second District addressed fee split-

57. 63 Fed. Reg. at 1715.

58. Florida Board of Medicine Summary of Actions (last modified Oct. 13, 1998) <<http://www.fmaonline.org>>.

59. FLA. STAT. ANN. § 458.331(1)(i) (West 1998).

60. FLA. STAT. ANN. § 817.505(1) (West 1998).

ting in a series of cases relating to a Florida chiropractic practice management company, Practice Management Associates.⁶¹ However, the chiropractic fee-splitting statute is identical to the Florida fee-splitting statute applicable to physicians.⁶²

The court found that a percentage-fee arrangement in which Practice Management Associates provided services to chiropractors in Illinois and Minnesota did not violate Illinois, Minnesota or Florida law. The court interpreted “splitting fees” under the statute “. . . in the traditional meaning of dividing a professional fee with another person, professional or non-professional, for the referral of patients.”⁶³ The court held that marketing efforts of Practice Management Associates did not amount to a referral of patients; thus, there was no fee split between the company and the chiropractors.⁶⁴ The court distinguished *compensation paid for the division of services* from a *division of fees paid for mere patient referrals* in a companion case.⁶⁵ The division of fees, it held, is legal, but the payment for referrals is illegal.

In its published April 1998 board minutes referred to above, the Florida Board of Medicine did not explain the reasoning behind its holding that a division of a global fee is illegal.⁶⁶ Clearly, the Board did not follow the Second District’s distinction between a division of fees *for services performed* and fee splits for the *mere referral* of a patient. The Florida Board of Medicine clearly rejected the opinion of the Florida Second District Court of Appeals in its briefs filed in *Bakaranian*.⁶⁷

The Board’s view that a division of a global fee for services rendered is an illegal fee split overlooks business reality. For the most part, physicians have not sought global fees. Global fees have been pressed upon the health care system by managed care plans, not physicians or patients. Global fees result because of the bargaining power of managed care payers who insist on paying providers global fees with the caveat: “You

61. Practice Mgmt. Assoc.’s., Inc. v. Gully, 618 So.2d 259 (Fla. 2nd Dist. Ct. App. 1993).

62. FLA. STAT. ANN. § 460.413(1)(k) (West 1998).

63. Practice Mgmt. Assoc.’s., 618 So.2d at 260.

64. See Practice Mgmt. Assoc.’s., 618 So. 2d 259; Practice Mgmt. Assoc.’s v. Orman, 614 So. 2d 1135 (Fla. 2nd Dist. Ct. App. 1993); Practice Mgmt. Assoc.’s, Inc. v. Blickensderfer, 630 So. 2d 1147, 1148 (Fla. 2nd Dist. Ct. App. 1993).

65. See Blickensderfer at 1148.

66. See Florida Board of Medicine Summary of Actions (last modified Oct. 13, 1998) <<http://www.fmaonline.org>>.

67. Brief for Appellee, PhyMatrix Mgmt., Inc. v. Magan L. Bakaranian, M.D., No. 97-4543 (Fla. 1st Dist. Ct. App. filed Apr. 17, 1998).

provide the entire service for the global fee and you split up the fee between service providers.” The result is a fee allocation among providers and a fee split for services rendered demanded by the payers with superior bargaining power who monitor results by utilization review and quality control procedures.

Physician Practice Management Companies (“PPMC”), such as PhyMatrix or Practice Management Associates, do not refer patients. They arrange business contracts — including managed care contracts with hard-nosed, bottom-line oriented managed-care customers who insist on tough contracts monitored by utilization review and quality control systems.

Today’s rapid reorganization of *laissez-faire* medical practices into financially and professionally managed clinics is demanded by the market place. Physicians who cannot compete economically and professionally and who do not join provider networks cannot differentiate themselves from competitors and may find themselves out of business. Survival demands that professional skills be augmented with organization, capital, marketing and sophisticated management—elements not present in the typical medical practice. Contractual services like those provided by PPMCs are becoming necessary for survival. Paying for those services on a percentage basis is good business because payment is performance-based.⁶⁸

Interestingly, a RAND Journal of Economics study published almost two decades ago examined the welfare effects of fee splitting paid by one physician to another. The study concluded:

...in the principal-agent context it is possible for fee splitting to offer incentives which actually improve patient welfare. Fee splitting occurs when there is a divergence between price and the referral partner’s marginal opportunity cost. . . . It is shown that fee splitting may induce the first-contact physician to refer instead of performing a lower quality procedure himself. . . .⁶⁹

68. See JOHN W. RANSOM & JAMES J. KUMPLE, *PHYSICIAN PRACTICE MANAGEMENT: FINDING VALUE THROUGH FOCUS, CASH FLOWS, AND CAPITAL EFFICIENCY* (1998). California permits a percentage management fee based upon gross receipts. See CAL. BUS. & PROF. CODE § 650 (West 1998). New York permits fixed fees. See Edward S. Kornreich & Ellen H. Moskowitz, *Managed Care: Fee Splitting Faces Obstacles in New York*, N.Y.L.J. 5 (col. 3) (1997).

69. Mark V. Pauly, *The Ethics and Economics of Kickbacks and Fee Splitting*, 10 RAND JOURNAL OF ECONOMICS, 344-52 (1979) <http://www.rje.org/abstracts/abstracts/1979/Spring_1979>.

Thus, what is missing is a fee-splitting definition distinguishing between legitimate fee allocations and payments for services from payments for mere referrals.

III. FLORIDA BOARD OF MEDICINE ON FEE SPLITTING

The Florida Board of Medicine has issued a series of opinions related to fee splitting. However, before examining Board of Medicine decisions, it is necessary to review the scope of authority delegated by the legislature to an administrative agency charged with statutory interpretation and enforcement.

A. Florida's Administrative Agency Authority

- No agency has the authority to impose rules unless granted the authority by legislation.⁷⁰
- An agency may interpret statutes through practice, agency rules or as issued in a declaratory statement. However, the administrative interpretation of the statute must be consistent with the legislative intent of the statute:

A grant of rulemaking authority is necessary but not sufficient to allow an agency to adopt a rule; a specific law to be implemented is also required. An agency may adopt only rules that implement, interpret, or make specific the particular powers and duties granted by the enabling statute. No agency shall have authority to adopt a rule only because it is reasonably related to the purpose of the enabling legislation and is not arbitrary and capricious, nor shall an agency have the authority to implement statutory provisions setting forth general legislative intent or policy. Statutory language granting rulemaking authority or generally describing the powers and functions of an agency shall be construed to extend no further than the particular powers and duties conferred by the same statute.⁷¹

- If the legislature has granted rulemaking power to an administrative agency, that grant must be accompanied by identifiable standards governing its exercise, so that the power to make the law is not unlawfully delegated.⁷²
- Agencies are given wide discretion in the interpretation of statutes they administer. The agency's interpretation need

70. See *Department of Env'tl. Reg. v. Falls Chase Special Taxing Dist.*, 424 So. 2d 787 (Fla. 1st Dist. Ct. App. 1982).

71. FLA. STAT. ANN. § 120.536(1) (West 1998); *Cataract Surgery Ctr. v. Health Care Cost Containment Bd.*, 581 So. 2d 1359 (Fla. 1st Dist. Ct. App. 1991).

72. See *Askew v. Cross Key Waterways*, 372 So. 2d 913 (Fla. 1978).

not be the sole possible interpretation or even the most desirable one; it need only be within the range of interpretations. However, an agency's interpretation will be rejected when it "has no basis either in the statute, rules of the agency, sound business practices, or common sense."⁷³

- Although a court must follow the agency's interpretation rather than the court's preferred interpretation, the discretion of an agency is "somewhat more limited where the statute being interpreted authorizes sanctions or penalties against a person's professional license. Statutes providing for the revocation or suspension of a license to practice are deemed punitive in nature and must be strictly construed, with any ambiguity interpreted in favor of the licensee."⁷⁴
- An agency rule or interpretation cannot enlarge, modify, or contravene the provisions of law it implements, nor can it implement a statutory provision stating only general legislative intent. Implementation must be of specific statutory provisions.⁷⁵
- An agency may issue a declaratory statement only on the "applicability of a statutory provision, or of any rule or order of the agency, as it applies to the petitioner's particular set of circumstances."⁷⁶ If the declaratory statement has the potential for affecting the "substantial interests of persons other than the petitioners" it has the effect of a rule, and the declaratory statement procedure cannot be used.⁷⁷

Having described the scope of administrative authority granted to the Board of Medicine, it is important to recall the scope of this authority when evaluating the Board's various decisions. As indicated above, the Florida Board of Medicine has issued a series of opinions related to fee splitting. These opinions can be classified into five issue-based categories:

1. employment agreements;
2. independent contractor relationships;

73. *Turnberry Isle Resort & Club v. Fernandez*, 666 So. 2d 254, 256 (Fla. 2nd Dist. Ct. App. 1996).

74. *Elmariah v. Department of Prof'l Reg., Bd. of Med.*, 574 So. 2d 164, 165 (Fla. 1st Dist. Ct. App. 1990).

75. See FLA. STAT. ANN. § 120.52(8) (West 1998); see also § 120.536(1); *Cataract Surgery Ctr.*, 581 So. 2d 1359.

76. FLA. STAT. ANN. § 120.565(1) (West 1998).

77. *Florida Optometric Assoc. v. Dept. of Prof'l Reg., Board of Opticianry*, 567 So. 2d 928, 936 (Fla. 1st D.C.A. 1990). We note that this argument is made in *PhyMatrix Mgmt., Inc. v. Magan L. Bakaranian, M.D.*, Case 97-4543, filed Apr. 17, 1998, (1st D.C.A. pending) by the appellants.

3. management contracts between physicians and other entities;
4. leases; and
5. equipment and facilities ownership.

B. Employment Arrangements

The fee-split issues raised by the compensation of an employed physician were addressed by the Board of Medicine in *In re: The Petition for Declaratory Statement of C. Robert Crow, M.D.*⁷⁸ In *Crow*, a physician sold his practice to a corporation and continued to work for the corporation as an employee. He was paid on a flat salary basis. Dr. Crow sought a declaratory statement from the Board of Medicine regarding a proposed change in his compensation arrangement. Under the proposal, he would receive a base salary plus thirty-five percent of all practice revenues generated during the previous year by him or by individuals under his supervision and forty percent of all practice revenues in excess of a certain target level. The Board held that both the salary arrangement and the bonus, which was based, in part, upon fees generated from referrals by the physician for ancillary services, constituted a prohibited fee split. The Board went on to state that if the arrangement were limited solely to fees generated by the physician from his own professional services and those services provided by individuals under his own direct supervision, without reliance on fees generated from ancillary services, the arrangement would be legal.

This case was later affirmed by the Fifth District Court of Appeals in *Crow v. Agency for Health Care Administration*. In affirming the Board's ruling, the court discussed the Board's motivation in prohibiting physicians from receiving payment based on ancillary revenues, stating:

It is . . . clear that the Board was concerned with the possibility that an employee physician's medical judgment might be skewed where that physician benefits financially from over-utilization of ancillary tests and services even if performed by [the acquiring corporation].⁷⁹

A careful analysis of *Crow* raises several questions. For instance, Florida's fee-splitting statute does not define fee split-

78. *In re: Petition for Declaratory Statement of C. Robert Crow, M.D.*, 17 F.A.L.R. 2568 (1995).

79. *Crow v. Agency for Health Care Admin.*, 669 So. 2d 1160, 1162 (Fla. 5th Dist. Ct. App. 1996).

ting, and particularly, does not distinguish between fees earned from ancillary services and personal services.⁸⁰

Did the Board of Medicine exceed its authority by making new law? Did it use its declaratory statement as disguised rule making? The Fifth District Court of Appeals seemed to give deference to the Board of Medicine's interpretation because the holding does not apply to proprietors and partners. If the Board has the authority to prohibit physicians from being paid for ancillary revenues, the statute would say so and the prohibition would apply to all physicians, not just employed physicians. The Board, however, has not been granted such authority and the statute does not say so. We suggest instead that the Board's position established an unreasonable classification among business entities.

Crow provides that an employed physician can be paid productivity compensation from professional services but not from ancillary services.⁸¹ What happens to compensation for ancillary services? The compensation belongs to the owner of the practice. In Florida, the owner of the practice may be a physician — in fact *the physician rendering the ancillary services* — or any other person. Thus, if the physician practices as a proprietorship, the physician retains ancillary service revenues as proprietorship earnings. If the physician practices as a limited liability company or general partnership, the earnings are retained as partnership earnings and distributions. If the physician is the sole owner of a professional corporation, the ancillary service revenues are retained as corporate earnings or distributed as S-corporation profits. In any case, the physician is legally paid ancillary service revenues.

The Board of Medicine's approach, which has the effect of a rule, creates an unreasonable classification. It prohibits ancillary service compensation being paid to employed physicians. It cannot, and does not, deny proprietor and partner physicians the revenue from ancillary services. The deference that the Fifth District granted the Board of Medicine's concern about utilization abuse is beyond the authority granted the Board in the enabling legislation.⁸²

The Court also fails to understand the distinction in organizational form and the limits of authority of the Board of Medicine.

80. FLA. STAT. ANN. § 458.331(1)(i) (West 1998).

81. See *Crow*, 669 So. 2d 1160, 62.

82. See FLA. STAT. ANN. § 458.331(1)(i) (West 1998).

There is no statutory authority for the distinction. If statutory authority existed, it most likely would create an unreasonable classification, since a classification prohibiting compensation to employees but not partners, proprietors or owners does not necessarily have anything to do with the health, safety or welfare of the people of Florida.

For several years, the Internal Revenue Service challenged the form of business organizations, creating "corporate tests" and "non-corporate" tests to determine taxation. Recently, the IRS has come to the conclusion that form versus substance was not a game it should play. The IRS has issued its "check-a-box" regulations, providing latitude for taxpayers in determining their business form without regard to taxation effect.⁸³ The logic discovered by the IRS should be applied in health care regulation as well.

HCFA has attempted such an approach in its Stark II proposed regulations. HCFA proposes to preclude group practice physicians from being compensated for designated self-referred health services. HCFA would permit designated health service compensation when the services are performed after a referral from another physician. HCFA permits designated health service revenues to be distributed as part of the general profit share. But, alas, HCFA's regulations are limited to group practice physicians and do not deal with services performed by proprietors.⁸⁴

The *Crow* decision and HCFA's proposed Stark II regulations that prohibit ancillary service revenues to physicians discourage formation of group practices, contrary to the requirements of today's health care environment. Because, for instance, pulmonologists, radiologists and cardiologists who perform ancillary services, including designated health services, can be compensated for these services as proprietors, they have no incentive to join groups or to become employed when ancillary service compensation as an employee or group practice member is restricted. As soon as lawyers advise these specialists that they must give up their ancillary revenues when they join a group practice, their interest in such activities naturally disappears.

83. See Treas. Reg. § 301.7701-1 to § 301.7701-3 (1998); see also Terence F. Cuff, *Impact of the New Proposed and Final Check-The-Box Regulations on Partnership Tax Status*, 15 J. PARTNERSHIP TAX'N 99 (1998).

84. See 42 U.S.C. § 1395nn (West 1998); 63 Fed. Reg. 1659 (1998).

In the case *In re: Petition for Declaratory Statement of George G. Levy*, the Board addressed an arrangement under which Dr. Levy employed a radiologist on a part time basis to provide professional interpretation of MRIs conducted on Dr. Levy's patients.⁸⁵ The radiologist was paid on a "per read" basis. That payment was some amount less than the full professional service fee paid to the practice for the interpretation provided by the radiologist. The Board declared the payment to violate section 458.331(1)(i) of the Florida Statutes, stating:

The Board of Medicine finds that Dr. Levy's retention of any portion of the professional fees billed for reading and interpreting scans and studies performed on his patients, without Dr. Levy actually performing any professional services is a "split-fee" arrangement and therefore prohibited by 458.331(1)(i) Fla. Stat.⁸⁶

However, in the *Levy* case, the patients for whom services were rendered were Dr. Levy's patients and he owned the practice. In addition, the radiologist was an employee of Dr. Levy and Dr. Levy retained responsibility for the actions the radiologist, including malpractice responsibility. Furthermore, Dr. Levy owned the office space and equipment, and billed for services performed, including operational and administrative expenses.

In its ruling, the Board failed to attribute any value to these activities or to the non-professional services provided. The Board's decisions in *Crow* and *Levy* conflict with its own rulings that permit the corporate practice of medicine and conflict with cases such as *In re: The Petition for Declaratory Statement of John W. Lister*.⁸⁷ In *Lister*, the Board held that Florida law does not prohibit a duly licensed medical doctor from practicing as an employee of a corporation. Thus, it is the corporate owner, not the employed physician, who owns the practice, accepts patients, determines what fees will be charged, and sets the compensation for services rendered. The corporate owner is the party who is entitled to the profits from services rendered by its employees.

Simply put, if the medical practice, its patients and accounts receivable are owned by an employer authorized to own a medical practice, the employed physician is not splitting fees. The

85. See *In re: Petition for Declaratory Statement of George G. Levy, M.D.*, Final Order No. AHCA-97-0495 (1997).

86. *Id.*

87. *In re: Petition for Declaratory Statement of John W. Lister, M.D.*, 9 F.A.L.R. 6299 (1987).

owner already owns the fees and the physician employee is entitled to nothing but compensation for services rendered. If the physician provides unnecessary medical services, the Board of Medicine has the power to discipline him, but the payment by the corporation for legitimate services is not a fee split for the referral of patients; the fee split is a legitimate payment for services. According to the Board's own rulings, the patients belong to the practice owner, not the physician employed by the practice. If this were not true, corporate employers could not enjoin physicians from competition after employment terminates.⁸⁸

Ironically, the Board takes the position that a professional practice owner is entitled to compensation for the risks of ownership in its appellate briefs filed in the *PhyMatrix* case we noted previously.⁸⁹ The Board's position is worth noting here. *PhyMatrix* suggests to the court that its agreement is simply the corporate practice of medicine with a different 'structure.' It is in fact this difference in structure that distinguishes this agreement from the corporate practice of medicine. In the corporate practice of medicine, the corporation owns the medical practice and carries all the liabilities and responsibilities of ownership. The owner-corporation legally employs physicians and at the end of business retains its corporate earnings. The *PhyMatrix* agreement seeks to avoid ownership, but still provides *PhyMatrix* a share of the earnings.⁹⁰

Medicare recognizes that practice owners own accounts receivable for professional services rendered.⁹¹ Florida law also recognizes practice ownership, as distinguished from physician ownership, of patient charts and records.⁹² Because of the inconsistencies, the Board of Medicine decisions in *Crow* and *Levy* are contrary to logic, statutory law and its own rulings.

C. Independent Contractor Arrangements

In the case *In re: The Petition for Declaratory Statement of Edmund G. Lundy, M.D.*, the Board addressed a situation in which a physician engaged a corporation as an independent con-

88. See FLA. STAT. ANN. § 542.335 (West 1998).

89. Brief for Appellee, *PhyMatrix Mgmt., Inc. v. Magan L. Bakarania, M.D.*, No. 97-4543 (Fla. 1st Dist. Ct. App. filed Apr. 17, 1998).

90. *Id.* at 7.

91. See 42 U.S.C. § 1395(u)(b)(6) (West 1998).

92. See FLA. STAT. ANN. § 119.011 (West 1998).

tractor.⁹³ The corporation provided the physician with office space, advertising, billing and administrative services. The physician's fees were paid directly to the corporation. In exchange for the services rendered, the corporation retained forty percent of the physician's fees, paying the physician the other sixty percent. The Board of Medicine ruled that this was not a fee split but "simply a charge for services rendered," because there was no referral relationship between the company and the physician.⁹⁴

However, the Board held that an additional arrangement under which the company was to be paid a percentage of the physician's fees for the referral of patients within a network developed by the company did constitute a prohibited fee split.⁹⁵ The Board's concern over this arrangement centered on the fact that the percentage fee was only paid if both the referring physician and the receiving physician were members of the company's network. If, on the other hand, the referral came from someone out-of-network, or an in-network physician made a referral to an out-of-network specialist, no fee was due. The Board held that because of the disparity between in and out-of-network referrals, the arrangement constituted a prohibited fee split.⁹⁶

The Board also addressed the independent contractor status of a physician in *In re: Petition for Declaratory Statement of Gary R. Johnson M.D. and the Green Clinic*.⁹⁷ Under the arrangement, the Clinic provided the physician with supplies, support staff, equipment and billing services. However, the physician maintained control over his professional services and the amount of the fees charged. Compensation was divided between the physician and the Clinic, with the physician receiving forty-six percent of the fees charged and the Clinic receiving fifty-four percent. The Board found this arrangement constituted a prohibited fee split because the Clinic was to receive the fifty-four percent of billings for services performed *both* within and outside of the Clinic.⁹⁸

93. See *In re: Petition for Declaratory Statement of Edmund G. Lundy, M.D.*, 9 F.A.L.R. 6289, 6293 (1987).

94. See *id.* at 6292.

95. See *id.* at 6293-94.

96. See *id.* at 6293.

97. See *In re: Petition for Declaratory Statement of Gary R. Johnson, M.D.*, 15 F.A.L.R. 3935 (1992).

98. See *id.* at 3937.

Often organizations use revenue from various sources to measure compensation. Negotiated compensation between independent parties usually results in fair market value for services provided. Carrying the Board of Medicine's view to its logical conclusion, the Clinic could have charged sixty percent from Clinic revenues and zero percent from outside revenues, for example. This mix may have produced the same compensation as the formula found unlawful. Again, it appears the Medical Board reached beyond its statutory authority.

The petition also fails to clarify how the payment of a fee for management services is in fact a payment for referrals, which is the only issue the Board has the legal authority to regulate. The holding reflects the need for clearer statutory definition as to when a fee allocation is a fee split or a payment for services.⁹⁹

The case of *In re: The Petition for Declaratory Statement of Paul B. Speiller, M.D.*, addressed a similar arrangement.¹⁰⁰ In that case, Dr. Speiller owned a medical clinic organized to engage physicians as independent contractors. Under the independent contractor agreements, the Clinic provided consultation rooms, equipment, labs, nurses, technicians and other attendants and administrative staff. The patients receiving services at the Clinic would "belong to the Clinic" and the Clinic billed for all services provided to Clinic patients by the independent contractors both at the Clinic and at area hospitals. Unlike the *Green* case, in *Speiller* the Clinic set the fees for all services rendered and the physicians were paid a flat fee per procedure. In addition, physicians who served as independent contractors at the Clinic were allowed to maintain separate, outside independent practices, the patients of which would belong to the physician and not to the Clinic. The Board also found this arrangement constituted an improper fee split be-

99. See Department of Prof'l Reg. v. Pedro Daniel Cedre, M.D., 91-10552 (1992). The complaint alleged that the physician provided eye examinations and medical treatment at the optical shop and assigned ("signed over") his fee payments to the shop engaged in a split fee arrangement. The physician was paid 50% of fees. A consent decree was entered into in which the physician paid a fine and admitted no wrongdoing. See also *In re: Declaratory Statement of Warren L. Simmonds D.P.M.*, 10 F.A.L.R. 597 (1987) (wherein the Board of Podiatric Medicine found that a payment to a podiatric physician of \$100 for tests performed on his patients was a kick-back or fee split under FLA. STAT. ANN. § 461.013(1)(j) (1998)).

100. See *In re: Petition for Declaratory Statement of Paul B. Speiller, M.D.*, 14 F.A.L.R. 3942 (1991).

cause, as in *Green*, the Clinic sought to bill for services provided to Clinic patients both within and outside the Clinic.¹⁰¹

The Office of Inspector General considers Medicare-related compensation arrangements between contractors in a different light than compensation arrangements with employees. Giving little credence to the long-standing *respondeat superior* body of common law holding a principal responsible for an agent, the OIG views percentage contracts with independent contractors as suspect. The OIG sees independent contractors as less accountable than employees,¹⁰² but cites no authority or study for its position.

In OIG Advisory Opinion 98-10, cited above, HCFA advised that a commission payable to a manufacturer representative for sale of diapers and other items to a hospital is subject to the federal anti-kickback statute. The OIG advised it would not take action since the commission was fair market value and there was no indication of referrals. A similar result was reached by Florida's Fourth District Court of Appeals in a case involving a commission due to Medical Development Network, Inc., for its promotion of durable medical equipment sales¹⁰³ that were reimbursed by Medicare. The court held that the commission was not due and payable.¹⁰⁴

Because the anti-kickback statutes have an exception for compensation paid to employees,¹⁰⁵ the illegal result expressed in the OIG opinion and by the Florida court only occurs when the promotion is by independent contractors. As a result, one must question whether this outcome is logical.

D. Management Contracts

The Board's management contract opinions divide between those that provide for straight management services and those that provide for management services including marketing or network creation. The Board has concluded that percentage management fees under a management agreement are illegal

101. *See id.*

102. *See* 56 Fed. Reg. 35952, 35981 (1991); *see also* 54 Fed. Reg. 3088, 3093 (1989); *see also* OIG Advisory Opinion 98-10 (last updated Mar. 16, 1999) <<http://www.hhs.gov/progorg/oig>>.

103. *Medical Dev. Network, Inc. v. Professional Respiratory Care/Home Med. Equip. Serv.'s, Inc.*, 673 So. 2d 565 (Fla. 4th Dist. Ct. App. 1996).

104. *See id.* at 566.

105. *See* 53 Fed. Reg. 51856, 51860 (1988). This details the safe harbor for employment arrangements.

when the management company provides marketing, particularly network development services, for the physician or physician practice. The Board equates marketing and network development (joining health care providers into units of service under contracts with insurers and other payers) as patient-referral activity. However, the Board's rulings remain inconsistent.

In *In re: Petition for Declaratory Statement of Joseph M. Zeterberg, M.D.*, the petitioner sought Board approval for an arrangement under which a corporation bought substantially all of his practice assets and provided him with practice management services including office space, equipment, staff, practice supplies, medical transcription and other support services.¹⁰⁶ Additionally, the corporation developed a "circuit" of clinics in which the petitioner provided services. The physician signed a covenant not to compete and was paid the greater of either a floor amount or a set percentage of revenues plus expenses, with the corporation retaining the remaining revenues.

The Board of Medicine found this arrangement constituted a prohibited fee split. The Board distinguished this case from the facts in *Lundy*¹⁰⁷ because the corporation established and operated a series of offices, the "circuit." The Board found that:

. . . the contract does not cover simply an administrative charge factor, but includes the activities of the company in going out and marketing allergy care services. . . . In addition, Petitioner emphasizes that the fee received by Petitioner is not split with the clinic directly. However, the fee is split indirectly. Although none of the fees collected by the specialist would be shared with the general practitioner, they would be shared with AAC. The referral occurs by virtue of the fact that the Corporation develops the "circuit" and arranges appointments.¹⁰⁸

This contrasts with the Board's approach in *Department of Professional Regulation v. Vinger*.¹⁰⁹ In this case, the Department of Administrative Hearings reviewed and accepted an order of the Board of Medicine. The Board held that a physician who, through a wholly-owned corporation, arranged for the provision of ancillary health care services to nursing facility resi-

106. *In re: Petition for Declaratory Statement of Joseph M. Zeterberg, M.D.*, 12 F.A.L.R. 1035 (1990).

107. *In re: Petition for Declaratory Statement of Edmund G. Lundy, M.D.*, 9 F.A.L.R. 6289 (1987).

108. *In re Zeterberg*, 12 F.A.L.R. at 1038.

109. *Department of Prof'l Reg. v. Vinger*, 13 F.A.L.R. 153 (1990).

dents did not engage in an inappropriate fee-splitting arrangement.

In *Vinger*, the corporation arranged to make ancillary services available to nursing facility residents. In exchange for facilitating these services, the corporation was paid a percentage of the performing physician's earnings for the services provided. The Board found that because the nursing home made the services available to the residents on a non-exclusive basis, there was no referral to the physician. The Board ruled:

This percentage was for actual administrative services provided by Health Care Plus to the physician, including advertising the availability of services, making appointments, use of reception services, providing forms for patients and transcription services, providing assistance to the physicians at the nursing home, providing transportation for patients needing to go outside the nursing home for care, delivering reports to the nursing home for each patient seen, and other administrative services necessary to insure the operation of the program. Health Care Plus was providing valuable overhead and management services for the percentage it received.¹¹⁰

The Board made clear that one of the reasons that the arrangement did not constitute a fee split was that the company was not paid on the basis of services delivered by the participating physicians outside of the nursing facility. The Board went on:

. . .the statute does not prohibit a corporation from providing administrative services to a physician for percentage fee. To hold otherwise would be to prohibit HMOs and other similar arrangements from operating, since patients visiting HMOs necessarily see physicians working with the HMOs which advertise their services and provide administrative and support services to the physicians who care for the patients within the HMO facility. A percentage of the fee the physician is entitled to by virtue of the services he has rendered to a patient is remitted to the HMO for the administrative and overhead services provided by the corporation. On a smaller scale, the Respondent's relationship to Health Care Plus and its relationship to nursing home facilities is similar to that of an HMO, whereby the corporation advertises services, provides administrative support and collects a portion of the fee that a physician receives for patient care in order to compensate the corporation for the services it provides.¹¹¹

110. *Id.* at 158.

111. *Id.* at 160.

However, in the case *In re: Petition for Declaratory Statement of Magan L. Bakarania, M.D.*, the Board stated that a payment of a percentage management fee is an unlawful fee split under Florida law:

Although payment of a flat fee in return for the provision of management services, including practice enhancement, is appropriate and allowable under Florida law, payment of a percentage of the revenue of the management services and practice enhancement generated is not permissible.¹¹²

The PPMC in this case, PhyMatrix, provided:

- general practice management,
- relationships and affiliations with other physicians and specialists, hospitals, networks, health maintenance organizations and preferred provider organizations,
- a provider network, integrating the practice into existing networks,
- strategic planning,
- coordination of managed care relationships, and
- consultation about fee schedules and other management services.¹¹³

In addition, PhyMatrix provided the following operational services:

- billing, collections and bookkeeping,
- employing personnel, facilities and equipment, development and operation of the ancillary services, and
- financial reporting.¹¹⁴

PhyMatrix also purchased the practice assets and leased them back to the physician practice. In exchange, the physicians paid PhyMatrix the following three-tiered fee:

- an operations fee for the actual third-party expenses incurred in providing the services listed,
- a management fee of \$450,000 per year, and
- a performance fee of 30 percent of the group practice's net income per year from all revenues, including ancillary services, supplies and pharmaceuticals.¹¹⁵

The Board found:

. . .this agreement which requires petitioner or petitioner's group practice to pay a specified percentage of their net income without regard to the cost of providing services supplied

112. *In re: Petition for Declaratory Statement of Magan L. Bakarania, M.D.*, 20 F.A.L.R. 395 (1997).

113. *See id.* at 5, 12, 13.

114. *See id.* at 6, 12, 13.

115. *See id.* at 6.

by the company, and without regard to whether the income is from services performed either by petitioner or under petitioner's supervision or direction is a split fee arrangement that is in violation of Section 458.3311(i) Florida Statutes. Furthermore, payment of fees to the company, that are based upon revenue generated, at least in part, because of the referrals that the company has helped to generate is in violation of Section 817.505(1)(a) Florida Statutes.¹¹⁶

The Board further concluded that establishing networks of providers and marketing, a passive activity, is equivalent to the indirect referral of patients.¹¹⁷ Apparently, the Board sees a difference when an HMO performs the marketing and network activity, as it recognized and permitted in *Vinger*. The Board did not deal with whether or not the payment for services is reasonable or represents fair market value. Although this case was appealed, the District Court of Appeals upheld the ruling in favor the Board without comment on the basis that PhyMatrix failed to establish that the Board opinion was totally erroneous.¹¹⁸

E. Leases

In the case *In re: Petition for Declaratory Statement of Barry Zaretzky, M.D.*, the Board addressed a case in which a specialist provided services in the office of various primary care physicians, paying those physicians "rent" for the use of their office space.¹¹⁹ However, it appears from the context of the Board's opinion that the fee was paid only if Dr. Zaretzky used the space. In addition, it appears that Dr. Zaretzky only used the space if the hosting physician referred a patient to him. Consequently, the Board found that the arrangement constituted a prohibited fee split.¹²⁰

In a podiatric case, *In re: the Petition for Declaratory Statement of Robert N. Wayne D.P.M.*, the Board of Podiatric Medicine addressed an arrangement between a podiatrist and Dr. Shaw, a physician.¹²¹ The podiatrist owned a machine useable by both professionals within their practices. When a podia-

116. See *id.* at 5-6 of the original final order, attached as Exhibit A.

117. See *id.* at 13.

118. See *PhyMatrix Mgmt. Co. v. Bakarania*, 1999 WL 424411 (Fla. App. 1st Dist. 1999).

119. See *In re: Petition for Declaratory Statement of Barry Zaretzky, M.D.*, 14 F.A.L.R. 3954 (1992).

120. *Id.* at 3956.

121. See *In re: Petition for Declaratory Statement of Robert N. Wayne, D.P.M.*, 12 F.A.L.R. 4896 (1990).

trist's patient required treatment using the machine that was outside podiatry, the podiatrist referred the patient to Shaw, quoting the patient a range of fees and rental of the machine to Shaw for \$200 per hour. The Board held that as long as the podiatrist quoted a range of fees rather than Shaw's exact fee and made the machine available to others at the same price, the arrangement did not violate the fee-splitting statute. Interestingly, however, the Board did not address whether or not \$200 per hour represented a fair amount for the rent of the machine or even if the fair market value of the machine's rental was an issue in interpreting the statute.¹²²

F. Equipment and Facility Ownership

In the case of *In re: Petition for Declaratory Statement of Melbourne Health Associates, Inc. and John Lozito*, the Board examined a transaction under which a limited partnership was formed to own and operate a rehabilitation center in which physicians would be limited partners.¹²³ The Board found that the arrangement did not violate the fee-splitting provisions because the return on investment by the limited partners would be solely through participation in the profits of the partnership, based solely on the number of partnership units owned by that investor. The return on investment would not depend in any way on the number of referrals made by the investor to the entity.¹²⁴

The Board addressed the purchase of peripheral vascular study equipment in *In re: Petition for Declaratory Statement of Gene E. Myers, M.D.*¹²⁵ In this case, the physician was a shareholder in a corporation that owned the peripheral vascular study equipment. The Board found that because the return on investment was based on the overall success of the corporation and not referrals to or from the corporation by the investors, the arrangement was not a violation of the fee-splitting provisions. However, the Board held the fee-splitting provisions would be violated if "the ability of an individual physician to participate in this investment opportunity were tied in any way to his ability or willingness to make referrals to the facility or the likelihood that

122. *Id.*

123. *See In re: Petition for Declaratory Statement of Melbourne Health Assoc.'s, Inc. and John Lozito*, 9 F.A.L.R. 6295 (1987).

124. *See id.* at 6297-98.

125. *In re: Petition for Declaratory Statement of Gene E. Myers, M.D.*, 10 F.A.L.R. 6272 (1988).

he would do so."¹²⁶ Investment arrangements are now restrained under the Stark laws and under the Florida Patient Self-Referral Act.¹²⁷

IV. MARKETING ACTIVITIES AND SPLIT-FEE ARRANGEMENTS

The Board of Medicine's rulings address the fee-splitting implications for marketing and marketing-related activities. With the increasing competitiveness of the health care industry, marketing tools are necessary to generate business. The health law question is whether the fee-splitting requirements can be satisfied.

Marketing has been defined as the "analysis, planning, implementation and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives."¹²⁸ Marketing in a general sense relies heavily on designing an organization's offering, such as health care services, in terms of the target markets, needs and desires; and using effective pricing, communication and distribution to inform, motivate, and service the markets.

A distinction can be drawn between two different types of marketing: (1) direct or active marketing, and (2) indirect or passive marketing. The OIG has employed this distinction in its description of those activities that are subject to prosecution under the federal anti-kickback statute. The OIG has taken the position 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. Thus, we believe that many marketing and advertising activities may involve at least technical violations of the statute.'¹²⁹

Media advertising, for example, may be a technical violation of the anti-kickback laws, but does not warrant prosecution.

126. *Id.* at 6275; see also *In re: Petition for Declaratory Statement of William D. Ertag*, 11 F.A.L.R 4351 (1989) (pertaining to durable medical equipment).

127. See FLA. STAT. ANN. § 455.654 (West 1998) (Florida Patient Self-Referral Act); 42 U.S.C. § 1395nn (West 1998) (Stark II amendments). These statutes place significant restrictions on the ability of a physician to benefit financially from patient referrals to a third party in which that physician has an ownership interest or financial relationship.

128. PHILIP KOTLER, *MARKETING FOR NONPROFIT ORGANIZATIONS*, at 5 (1975).

129. 56 Fed. Reg. at 35952, 35974; see also OIG Advisory Opinion 98-1 (last updated Mar. 16, 1999) <<http://www.hhs.gov/progorg/oig>>.

The OIG considers passive marketing activities as those activities that do not involve direct person-to-person solicitation of Medicare and Medicaid beneficiaries or providers.¹³⁰ Despite drawing this distinction, in Advisory Opinion 98-4, the OIG concluded that a PPMC management services contract that included passive marketing duties and paid the PPMC on a percentage basis implicated the anti-kickback statute because the percentage management fee could encourage overutilization and upcoding.¹³¹

The American Bar Association (“ABA”) also distinguishes between direct or active marketing, on one hand, and indirect or passive marketing on the other, with respect to attorney advertising.¹³² The ABA defines direct marketing as selling directly through a consumer without the use of a middleman. Examples include mail orders, cold calling, telephone sales and door to door sales. Indirect marketing occurs when the potential client must initiate the contact with the law firm. Examples include brochures, published articles, billboards, and newsletters. The ABA Code of Professional Responsibility forbids direct advertising. Like the medical profession, the solicitation of business by a lawyer through direct, in-person communication with a prospective client has long been viewed as inconsistent with the profession’s ideal of an attorney-client relationship and as posing a significant potential for harm to a prospective client.¹³³

The Rules regulating the Florida Bar that define permissible advertising permit passive marketing.¹³⁴ For example, an attorney may advertise through the use of public media, such as a telephone directory, legal directory, newspaper or other periodical, billboards and other signs, radio, television, and recorded messages the public may access by dialing a telephone number, or through written communication not involving direct solicitation.¹³⁵

The Supreme Court has held that states have the power to discipline lawyers for direct client solicitation.¹³⁶ The Court ra-

130. See 56 Fed. Reg. 35952; Bruce John Shih and Barton A. Carter, *The Hidden Pitfalls of Marketing by Healthcare Providers*, 10 No. 1 HEALTH LAW 8, 11 (1997); see also OIG Advisory Opinion 98-1, *supra* note 129.

131. See OIG Advisory Opinion 98-4, *supra* note 8.

132. See MODEL RULES OF PROFESSIONAL CONDUCT RULE 7.3 (1995).

133. See MODEL CODE OF PROFESSIONAL RESPONSIBILITY, DR 2-104(A) (1980); see also MODEL RULES OF PROFESSIONAL CONDUCT RULE 7.3 (1995).

134. See FLA. ST. BAR RULE 4-7.2 (1996).

135. See *id.*

136. See *Ohralik v. Ohio State Bar Ass’n*, 436 U.S. 447 (1978).

tionalized that active, in-person solicitation differs substantially from passive advertising. Additionally, states have a stronger interest in prohibiting "pressure-laden," in-person solicitation than they do in prohibiting passive advertising of routine legal services. The difference between public or indirect advertising and in-person or direct advertising is the requirement that the recipient make an immediate decision about representation without time to compare the "availability, nature, and prices" of other legal providers. Direct solicitation is a one-sided process because it allows an attorney, trained in persuasion, the opportunity to manipulate an uninformed lay person. Therefore, because in-person attorney solicitation is usually done in private, it is not subject to the public scrutiny that advertising receives. The Court concluded that state solicitation regulations are preventative measures. These regulations "reduce the likelihood of overreaching and the exertion of undue influence on lay persons, . . . protect the privacy of individuals, and . . . avoid situations where the lawyer's exercise of judgment on behalf of the client will be clouded by his own pecuniary self-interest."¹³⁷

The Board of Medicine has not distinguished between active and passive marketing with the clarity expressed by the Florida Bar. Although the OIG has acknowledged the difference, OIG Advisory Opinion 98-4 raises concerns that the difference is not clearly recognized.¹³⁸ An argument can and should be made that the distinction is applicable in fee-splitting cases. A percentage payment for marketing services should not universally be viewed as a fee split regardless of the services provided.

The direct result of such a broad pronouncement is to preclude incentive-based payments to entities providing services as basic to a successful medical practice as managed care contracting and passive marketing materials such as brochures and print advertisements. This distinction goes well beyond a reasoned understanding of the intent of the fee-splitting and patient-brokering statutes designed to preclude physicians and others from actively soliciting patients and referrals.

The restraints imposed by the approach of the Board of Medicine and the OIG may also be unconstitutional infringements on free speech. A 1998 decision from the U.S. District Court for the Northern District of Florida declared unconstitutional a Florida statute prohibiting dentists from advertising

137. *Id.* at 461.

138. See OIG Advisory Opinion 98-4, *supra* note 8.

membership in or specialty recognition by an organization not recognized or accredited by the American Dental Association.¹³⁹ The Court confirmed that commercial speech enjoys First Amendment protection. Only commercial speech that is false, deceptive or misleading can be prohibited. The Court held that the Florida Board of Dentistry “may not rely on speculation or conjecture but must produce specific evidence to demonstrate that the harms. . . are real and substantial.”¹⁴⁰ The Board failed to meet that standard.

The Federal Trade Commission position on professional advertising is similar. The FTC held that the California Dental Association’s ethical advertising restraints violate the Sherman Act because the rules restrained truthful, nondeceptive advertising. The U.S. Supreme Court decided September 29, 1998, to consider, among other issues, whether or not the Dental Association ethical restraint violates the Sherman Act.¹⁴¹

Certainly neither the Board of Medicine nor OIG considered the constitutional implications of its decisions in regard to marketing activities by a PPMC. If a dentist or a physician has the constitutional right to engage in commercial advertising, then the dentist or physician has the constitutional right to employ professionals skilled in commercial free speech to assist them. Engaging professionals, including PPMCs, should be constitutionally protected, as should fair market value compensation.

V. THE MINNESOTA APPROACH

Upon careful examination of the Board of Medicine approach, one can easily argue that the Board has exceeded its interpretive authority. One can also easily argue that the courts have paid unusual deference to the Board’s interpretations without careful analysis. Unfortunately, such arguments, without legislative or further court support, leave well-meaning physicians exposed to discipline, fines and penalties. What appears to be necessary is a statutory revision providing clear guidance. For example, Minnesota law provides:

- (p) Fee splitting, includes without limitation:
 - (1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or

139. See *Borgner v. Cook*, 33 F. Supp. 2d 1327 (N.D. Fla. 1998).

140. *Id.* at 1331.

141. See *California Dental Ass’n v. FTC*, 128 F.3d 720 (9th Cir., 1997), *cert. granted*, 119 S. Ct. 29 (U.S. Sept. 29, 1998) (No. 97-1625).

- indirectly, primarily for the referral of patients or the prescription of drugs or devices;
- (2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the service provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;
- (3) referring a patient to any health care provider in which the referring physician has a significant financial interest unless the physician has disclosed the physician's own profit interest; and
- (4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest.¹⁴²

The Minnesota Rules on the division of fees provide a simple guide for the Board of Medicine:

In reviewing a division of fees . . . the board may consider, but is not limited to, the following factors regarding the reasonableness of the proportional division of fees:

- A. the value of the professional services;
- B. overhead costs;
- C. time and distance traveled; and
- D. the availability of the service or the product elsewhere in the local trade area.¹⁴³

CONCLUSION

Lost on the Board of Medicine has been the clean, crisp holding of the Florida Second District Court of Appeals that illegal fee splitting involves direct, patient-specific activity rather than business activity. In reaching its decision, the court said:

Such an interpretation recognizes the complexities of marketing and management of professional services in today's competitive business environment without compromising the public policy behind legislation prohibiting or regulating the division of professional fees.¹⁴⁴

Sadly, even if the percentage fee management contract used by PhyMatrix had been validated on appeal, reversing the Board of Medicine in *Bakaranian*, unresolved issues remain because of *Crow*, *Levy* and other Board decisions.

142. MINN. STAT. ANN. § 147.091(p) (West 1998).

143. MINN. R. 5620.0160 (1998).

144. Practice Mgmt. Assoc.'s v. Orman, 614 So. 2d 1135 (Fla. 2nd Dist. Ct. App. 1993); see also Practice Mgmt. Assoc.'s, Inc. v. Blickensderfer, 630 So. 2d 1147, 1148 (Fla. 2nd Dist. Ct. App. 1993).

The Minnesota statute cited above prohibits fee splitting when compensation is paid “primarily for the referral of patients or the prescription of drugs or devices.” This approach is similar to the AMA’s ethical rules defining fee splitting:

Fee splitting arrangements between physicians and other independent practitioners in which payment is made *merely for referral of patients* are unethical. . . .¹⁴⁵

The statute reaches a result similar to the Florida Second District Court of Appeals holding that limits fee splitting to payments made for the “mere referral” of patients.¹⁴⁶ The reference to “primarily” or “merely” reflects the reality and requirements of medicine today.

Minnesota also permits physicians to divide fees for services rendered, solving the global fee requirements of managed care. This is helpful because the complexity of the managed care environment requires patient referrals, often among providers in exclusive networks who must share global fees. The market’s insistence on global fees demands that fees be split and shared among those who do the work. The market has the ability to dictate how those fees will be shared. PPMCs providing management, passive marketing and network organization may be survival necessities. Statistics are abundantly available to those charged with managing the system.

Guidance on the distinction between payment for a “mere referral” and for goods and services is provided in the Real Estate Settlement Procedures Act (“RESPA”). RESPA prohibits kickbacks in connection with a real estate settlement service related to a federally funded loan.¹⁴⁷ An exception to the definition of kickback is provided for fees for goods and services actually furnished.¹⁴⁸ Kickbacks are resolved under RESPA by determining whether or not goods and services were furnished and whether or not fair market value was charged for the services.¹⁴⁹ The Board of Medicine, at least in dicta, has on occasions noted that percentage fees exceed costs, but does not address the value of the services.¹⁵⁰ Cost and value are not necessarily related, as any person in business can attest. Percentage fees, a form of

145. 1998 AMA Policy Compendium H-140.991 (emphasis added).

146. *See Orman*, 614 So. 2d 1135; *see also Blickensderfer*, 630 So. 2d 1147.

147. *See* 12 U.S.C. § 2601(b)(2) (West 1998).

148. *See id.* § 2607(c).

149. *See Taylor, III v. Flagstar Bank, FSB*, 181 F.R.D. 509 (M.D. Ala. 1998).

150. The cost discussion appears in many of the Board of Medicine determinations cited, including the pending *Bakarania* Declaratory Statement; *see supra* note 6.

productivity compensation, are often the fair market value for the services rendered. Percentage fees and productivity compensation are the norm in almost every business today.

Any legislation intended to fairly deal with kickbacks and referral fees should include an exception for goods and services provided at fair market value, as does RESPA. Unstated in the Minnesota law is whether kickbacks occur between employer and employee.

In contrast, the federal anti-kickback statute provides an employee exemption and excepts from the kickback law "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 services."¹⁵¹ A similar provision should be part of any fee-split legislation.

With the variety of today's business organizations, selected for tax and other reasons unrelated to health care regulation, the employee exception should be expanded to encompass limited liability company members and partners. Logic also indicates that independent contractors paid fair market value compensation for other legitimate services should also be excluded, as recognized in OIG Advisory Opinion 98-10.¹⁵²

Related is the issue of disclosure. Disclosure of interrelationships and compensation arrangements has been an integral element of securities offerings since the Securities Act of 1933 became law.¹⁵³ Disclosure allows patients and buyers of health care services to make informed decisions and set appropriate contractual terms for relationships. Most states have adopted requirements that physicians disclose investment interests in health care facilities to patients. Minnesota requires disclosure as part of its fee-split statute. Publicity stigmatizes inappropriate behavior.¹⁵⁴ The requirement for disclosure should be a part of fee-split regulation.

The Florida Board of Medicine has approached fee splitting in an arbitrary fashion, as if the idea exists in a vacuum. Its decisions lack practicality, and, as we have noted, may well exceed the Board's statutory and constitutional authority. Fee splitting demands definition and revision to fit today's environment.

151. 42 U.S.C. § 1320a-7b (West 1998).

152. See OIG Advisory Opinion 98-10, *supra* note 102.

153. See 15 U.S.C. § 77a (West 1998).

154. See RODWIN, *supra* note 2, at 212.