Final Order No. DOH-02-0673-DS-MQA
FILED DATE - 5/6/02
Department of Health
By: Vicki A. Kenon
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

IN RE: THE PETITION
FOR DECLARATORY
STATEMENT OF

JOHN SOKOLOWICZ, MD
_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (hereinafter "the Board") pursuant to §120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code, at a duly-noticed public meeting in Ft. Lauderdale, Florida on April 7, 2002, for the purpose of considering the Petition for Declaratory Statement (attached as Exhibit A) filed on behalf of JOHN SOKOLOWICZ, MD (hereinafter Petitioner). Having considered the petition, the arguments of counsel for Petitioner, and being otherwise fully advised in the premises, the Board makes the following findings and conclusions.

FINDINGS OF FACT

1. This petition was noticed by the Board in Vol. 28, No. 13, dated March 29, 2002, of the Florida Administrative Weekly. These findings of fact are those pled by Petitioner in his petition.

2. Petitioner, JOHN SOKOLOWICZ MD, is an allopathic physician licensed to practice medicine in the State of Florida.

3. Petitioner and Dean Heller, MD ("Heller") are the sole shareholders of Sokolowicz and Heller, MD, PA (hereinafter "the PA").

4. Petitioner and Heller provide medical services to patients as employees of the PA.

5. The PA currently has a contract with Humana, Inc. to provide Diagnostic Tests to a certain panel of subscribers, referred to as "Panel A Subscribers," on a reduced fee-for-service basis of 70% of Medicare allowable.

6. Humana, Inc. is proposing a separate contract with the PA to provide diagnostic tests to a different panel of subscribers, referred to as "Panel B Subscribers," on a reduced fee-for-service basis of 60% of Medicare allowable.

7. Humana, Inc. does not permit a provider to have different contracts with different rates for reduced fee-for-service reimbursement and requires any provider with contracts having different reimbursement rates to accept reimbursement at the lowest rate provided in the contracts.

8. As a result of Humana, Inc.'s policy, if the PA entered into the new contract regarding the Panel B Subscribers, Humana, Inc. would reduce the fees payable under the current contract to 60% of Medicare allowable.

9. Humana, Inc. will continue to pay the current fee of 70% of Medicare allowable under the current contract, if the PA can use a different taxpayer identification number ("TIN") for the new contract for Panel B Subscribers.

10. The PA can obtain a different TIN for the purposes of the new contract by forming a wholly-owned subsidiary with its own TIN.

11. The PA plans to form a wholly-owned subsidiary limited liability company to hold the new contract. The subsidiary will not provide services or have employees.

12. Petitioner will be required to be a party to the new contract as an affiliated physician.

13. Petitioner and Heller will provide the full range of health care services for which the subsidiary will contract through the joint use of share office space, facilities, equipment and personnel of the PA, as part of the relationship between the PA and the subsidiary. Substantially all of the services of Petitioner and Heller are billed in the name of the PA, and amounts received are treated as receipts of the PA. The overhead expenses of and the income from the PA are distributed in accordance with methods previously determined by Petitioner and Heller.

CONCLUSIONS OF LAW

14. The Board has jurisdiction over this matter pursuant to Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code.

15. The petition filed in this cause is in substantial compliance with the provisions of Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code.

16. In his petition, Petitioner requested the Board to interpret Section 456.053, Florida Statutes, and to advise whether the provision of medical services by the PA under the new contract between the PA's subsidiary and Humana, Inc. would constitute a violation of that provision.

17. Regardless of which panel an individual patient subscribes to, the PA will be providing the medical services for which Humana, Inc. has contracted, and will receive a fee only for those medical services. Under these circumstances, the proposed

arrangement between the PA and the subsidiary does not violate Section 458.053, Florida Statutes.

18. This Final Order responds only to the specific facts set forth and specific questions set forth by Petitioner in his Petition for Declaratory Statement. The conclusions of the Board are with regard to the specific statutory provision addressed, and should not be interpreted as commenting on whether the facts in the petition may or may not violate any other provisions of Chapters 458 or 456, Florida Statutes, or other related obligations placed on physicians in Florida. Furthermore, this Declaratory Statement is not a ruling on the legal validity or enforceability of any contract described in the petition.

WHEREFORE, the Board hereby finds that under the specific facts of the petition, as set forth above, the proposed contractual arrangement does not constitute prohibited patient self-referral.

DONE AND ORDERED this 1 day of MAY, 2002.

BOARD OF MEDICINE

Larry McPherson, Executive Director
for Zachariah P. Zachariah, MD, Chair

NOTICE TO PARTIES

Pursuant to Section 120.569, Florida Statutes, the parties are hereby notified that they may appeal this Final Order by filing one copy of a notice of appeal with the

Clerk of the Department of Health and one copy of a notice of appeal and the filing fee with the District Court of Appeal within 30 days of the date this Final Order is filed.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. Mail to Keith J. Blum, Esquire, Zack Kosnitsky, PA, 100 SE 2nd Street, Suite 2800, Miami FL 33131 this 6th day of May, 2002.

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March 12, 2002

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VIA FEDERAL EXPRESS AND
VIA E-MAIL: cheryl_graham@doh.state.fl.us

Ms. Cheryl Graham
Board of Medicine
4052 Bald Cypress Way, Bin-C03
Tallahassee, Florida 32399

Re: Petition For Declaratory Statement
In Re: John Sokolowicz, M.D.

Dear Ms. Graham:

Enclosed please find John Sokolowicz, M.D.'s Petition For Declaratory Statement for submission to the Board of Medicine. We are submitting this Petition to be heard at the April 5-6, 2002, full board meeting to be held at Weston, 400 Corporate Drive, Ft. Lauderdale, Florida.

Please confirm your receipt of our Petition by returning to us, by mail, a stamped signed copy of the Petition.

I am available for any questions or comments you may have with respect to this matter. Thank you for your assistance and cooperation.

Very truly yours,

Keith J. Blum

KJB/hc
Enclosures
cc: Lee Ann Gustafson, Esq. (FedEx & e-mail: Lee_Ann_Gustafson@oag.state.fl.us) 4579 6747 2858
John Sokolowicz, M.D.

Doc.#: 151266v1 03-12-2002; 11:49:06

STATE OF FLORIDA, DEPARTMENT OF HEALTH
BOARD OF MEDICINE

Case No. _____

IN RE: PETITION FOR DECLARATORY STATEMENT BY:

JOHN SOKOLOWICZ, M.D.
_____/

PETITION FOR DECLARATORY STATEMENT PURSUANT TO SECTION 120.565, FLORIDA STATUTES, AND RULES 64B 28-1.003 AND 28-4.001, FLORIDA ADMINISTRATIVE CODE

Petitioner, John Sokolowicz, M.D. ("Petitioner") by and through undersigned counsel, petitions the Board of Medicine for a Declaratory Statement and states the following:

INTRODUCTION

1. Petitioner, John Sokolowicz, M.D, ("Sokolowicz"), is licensed to practice medicine in the State of Florida.

2. The agency affected by this Petition is the Department of Health, Board of Medicine (the "Board").

3. The activities of Petitioner are subject to regulation under Section 456.053, Florida Statute (a/k/a known as the Patient Self-Referral Act of 1992) (the "Self-Referral Act"), a copy of which is attached hereto as Exhibit "A".

4. Petitioner is contemplating entering into a contract with Humana, Inc., or its subsidiaries or affiliates ("Humana"), to provide thallium stress tests and other similar diagnostic tests, some of which are considered "designated health services" under the Self-Referral Act, (collectively, the "Diagnostic Tests") on a reduced fee-for-service basis.

SHORT QUESTION

STATEMENT OF FACTS

5. Sokolowicz is a shareholder of Sokolowicz and Heller, M.D., P.A. (the "P.A.")

6. Sokolowicz provides medical services on behalf of the P.A. as an employee of the P.A.

7. The P.A. currently has a contract with Humana to provide Diagnostic Tests to a certain panel of subscribers ("Panel A Subscribers") on a reduced fee-for-service basis of seventy (70%) percent of Medicare allowable (the "Existing Contract").

8. Humana would like to enter into a separate contract with the P.A. to provide Diagnostic Tests to a different panel of subscribers, other than the Panel A Subscribers ("Panel B Subscribers"), on a reduced fee-for-service basis of sixty (60%) percent of Medicare allowable (the "New Contract").

9. Humana does not permit a provider to have different contracts with different rates for reduced fee-for-service reimbursement, and requires any provider with contracts with different reimbursement rates to accept reimbursement at the lowest rate provided in the contracts.

10. As such, if the P.A. were to enter into the New Contract with Humana, the P.A. would be required to accept a sixty (60%) percent reimbursement rate under the Existing Contract, in addition to the sixty (60%) percent reimbursement rate under the New Contract.

11. The P.A. will not enter into the New Contract with Humana if required to accept a reduction in the reimbursement rate under the Existing Contract to a sixty (60%) percent reimbursement rate from a seventy (70%) percent reimbursement rate.

12. Humana will permit the P.A. to enter into the New Contract and maintain the seventy (70%) percent reimbursement rate under the Existing Contract if the P.A. can use a taxpayer identification number ("TIN") different from that of the P.A.'s TIN.

13. The only way for the P.A. to obtain a different TIN, so as to enter into the New Contract without having the reimbursement rate under the Existing Contract reduced, is for the P.A. to form a wholly owned subsidiary entity and apply for a separate TIN from the Internal Revenue Service (the "IRS"). Individual entities may not have more than one TIN or else the P.A. would apply to the IRS for its own new TIN.

14. The P.A. is contemplating forming a wholly owned subsidiary limited liability company (the "Subsidiary LLC") with its own TIN to enter into the New Contract with Humana.

15. A wholly owned subsidiary limited liability company is considered a disregarded entity for federal and state tax purposes. That is, for tax purposes it is deemed not to exist and all of the income and expenses of such subsidiary limited liability company are deemed to be the income and expenses of its parent. In our case, all of the income and expenses of the Subsidiary LLC would be deemed to be the income and expenses of the P.A. and the Subsidiary LLC would not be required to file any tax returns, but will be able to obtain a new TIN.

16. The Subsidiary LLC's only function will be to hold the New Contract; it will not provide services or have employees.

17. However, Sokolowicz will also be required to be a party to the New Contract as an affiliated physician.

18. The Diagnostic Tests provided for under the New Contract will be provided by the P.A. as part of the relationship between the P.A. and the Subsidiary LLC, in that the Subsidiary LLC has no employees and its sole purpose is to hold the New Contract as a method for the P.A. to get the New Contract without having a corresponding reduction in the reimbursement rate under the Existing Contract.

19. The sole purpose of this structure is to obtain a different TIN so as to permit the P.A. to maintain the Existing Contract with its seventy (70%) percent reimbursement rate and also enter into the New Contract with the sixty (60%) percent reimbursement rate, without losing the seventy (70%) reimbursement rate of the Existing Contract.

GENERAL REQUEST FOR DECLARATORY STATEMENT

20. This Petition seeks, in general, guidance as to whether the structure as contemplated above, whereby the P.A. will provide the Diagnostic Tests under the New Contract to which the Subsidiary LLC (the P.A.'s wholly owned subsidiary) is a party, will constitute a violation of the Florida Patient Self-Referral Act.

21. Pursuant to the Self-Referral Act and based on assuming the accuracy and completeness of the Statement of Facts set forth above, Sokolowicz is requesting a written declaratory statement from the Board of Medicine that the above described relationship will not result in prohibited referrals under the Self-Referral Act.

ANALYSIS OF THE LAW

22. For purposes of this analysis and the Petition, the critical question is whether there will "prohibited referrals" under the Self-Referral Act as a result of the relationship by and between the P.A. and the Subsidiary LLC.

23. The Self-Referral Act prohibits the referral by a physician for the furnishing of "Designated Health Services" to an entity in which the physician is an investor. Section 455.654(5)(a), Florida Statutes. As discussed above, certain of the Diagnostic Tests are Designated Health Services.

24. The Self Referral Act defines "referral" as, in general, any referral of a patient by a physician for health care services. Section 455.654(3)(o), Florida Statutes.

25. "Referral" as defined under the Self-Referral Act contemplates that: (i) the forwarding of a patient by a physician to another physician or to an entity which provides or supplies designated health services or any other health care item or service; or (ii) the request or establish of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

26. In our case, a referral could be deemed to occur as a result of the P.A. providing Diagnostic Tests under the New Contract in that since the Subsidiary LLC is a party to the New

Contract and not the P.A. Sokolowicz, as the affiliated physician of the Subsidiary LLC, could be deemed to be referring the Panel B Subscribers to the P.A. for the provision of Diagnostic Tests in that, technically, under the New Contract the Subsidiary LLC is contractually obligated to provide the services under the New Contract. However, since the Subsidiary LLC has no employees and was only formed to obtain a new TIN so that the P.A. would not lose its seventy (70%) percent reimbursement rate under its Existing Contract, the Subsidiary is unable to, and it was never contemplated that it would, provide the Diagnostic Tests under the New Contract. The sole purpose of the relationship between the P.A. and the Subsidiary LLC was for administrative convenience so that the P.A. could obtain the 60% contract without losing the 70% contracts.

27. As such, there is no "referral" in connection with the above contemplated structure that would implicate the Self-Referral Act.

28. However, even if the relationship between the P.A. and the Subsidiary LLC were deemed to be considered a "referral" within the meaning of the Self-Referral Act, the Self-Referral Act provides for certain exceptions for referrals of professional services provided within a group practice.

29. Pursuant to Section 456.053(3)(o)3.f., Florida Statutes, an order, recommendation or plan of care **will not constitute a referral** "[b]y a ... member of a group practice for designated health services ... that are prescribed or provided solely for such ... group practice's own patients..."

30. Section 456.053(3)(h), Florida Statutes, defines "group practice", as a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:

> (a) In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;

(b) For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

(c) In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

31. The P.A., including the Subsidiary LLC which is the P.A.'s wholly owned limited liability company, meets the requirements of a "group practice" in that (i) Sokolowicz and Dean Heller, M.D. ("Heller") are the sole shareholders of the P.A. and the P.A. is the sole owner of the Subsidiary and, therefore, they are two health care providers legally organized as an association consisting of the P.A. and its wholly owned subsidiary the Subsidiary LLC, (ii) each Sokolowicz and Heller provide the full range of health care services they routinely provide through the joint use of shared office space, facilities, equipment, and personnel of the P.A.; (iii) substantially all of the services of Sokolowicz and Heller are provided through the P.A. and are billed in the name of the P.A. and amounts so received are treated as receipts of the P.A., and (iv) the overhead expenses of and the income from the P.A. are distributed in accordance with methods previously determined Sokolowicz and Heller.

32. Therefore, assuming the relationship between the P.A. and the Subsidiary LLC creates a "referral" within the meaning of the Self-Referral Act, such "referral" would be an exception to the prohibition of referral under the Self-Referral Act as a result of the "group practice" exception for the reasons discussed above

33. Specific Request for Declaratory Statements.

(a) Whether the relationship by and between the P.A. and the Subsidiary LLC with respect to the provision of Diagnostic Tests under the New Contract results in a referral for health care service subject to the Self Referral Act.

(b) Assuming the relationship between the P.A. and the Subsidiary LLC is deemed to create a referral of health care services subject to the Self-Referral Act,

whether such referral results in a violation of the Self-Referral Act, not subject to the group practice exception.

ZACK KOSNITZKY, P.A.
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Bank of America Tower, Suite 2800
100 Southeast 2nd Street
Miami, Florida 33131
Phone: 305-539-8400

BY: _____
KEITH J. BLUM, ESQ.
Florida Bar #0879185

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of the foregoing was furnished on March 12, 2002 by e-mail and overnight courier to Cheryl Graham, Board of Medicine, 4052 Bald Cypress Way, Bin-C03, Tallahassee, Florida 32399, Cheryl_Graham@doh.state.fl.us and to Lee Ann Gustafson, Esq., Assistant Attorney General, Office of Attorney General, Room 324, Collins Building, 107 West Gaines, Tallahassee, Florida 32301, Lee_Ann_Gustafson@oag.state.fl.us.

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BY:_____
KEITH J. BLUM, ESQ.
Florida Bar #0879185

The 2000 Florida Statutes

Title XXXII	Chapter 456	View Entire Chapter
REGULATION OF PROFESSIONS AND OCCUPATIONS	Health Professions And Occupations: General Provisions	

[1]456.053 Financial arrangements between referring health care providers and providers of health care services.--

(1) SHORT TITLE.--This section may be cited as the "Patient Self-Referral Act of 1992."

(2) LEGISLATIVE INTENT.--It is recognized by the Legislature that the referral of a patient by a health care provider to a provider of health care services in which the referring health care provider has an investment interest represents a potential conflict of interest. The Legislature finds these referral practices may limit or eliminate competitive alternatives in the health care services market, may result in overutilization of health care services, may increase costs to the health care system, and may adversely affect the quality of health care. The Legislature also recognizes, however, that it may be appropriate for providers to own entities providing health care services, and to refer patients to such entities, as long as certain safeguards are present in the arrangement. It is the intent of the Legislature to provide guidance to health care providers regarding prohibited patient referrals between health care providers and entities providing health care services and to protect the people of Florida from unnecessary and costly health care expenditures.

(3) DEFINITIONS.--For the purpose of this section, the word, phrase, or term:

(a) "Board" means any of the following boards relating to the respective professions: the Board of Medicine as created in s. 458.307; the Board of Osteopathic Medicine as created in s. 459.004; the Board of Chiropractic Medicine as created in s. 460.404; the Board of Podiatric Medicine as created in s. 461.004; the Board of Optometry as created in s. 463.003; the Board of Pharmacy as created in s. 465.004; and the Board of Dentistry as created in s. 466.004.

(b) "Comprehensive rehabilitation services" means services that are provided by health care professionals licensed under part I or part III of chapter 468 or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.

(c) "Designated health services" means, for purposes of this section, clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic-imaging services, and radiation therapy services.

(d) "Diagnostic imaging services" means magnetic resonance imaging, nuclear medicine, angiography, arteriography, computed tomography, positron emission tomography, digital vascular imaging, bronchography, lymphangiography, splenography, ultrasound, EEG, EKG, nerve conduction studies, and evoked potentials.

(e) "Direct supervision" means supervision by a physician who is present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed.

(f) "Entity" means any individual, partnership, firm, corporation, or other business entity.

(g) "Fair market value" means value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use, and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(h) "Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:

1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;

2. For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

3. In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

(i) "Health care provider" means any physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or any health care provider licensed under chapter 463 or chapter 466.

(j) "Immediate family member" means a health care provider's spouse, child, child's spouse, grandchild, grandchild's spouse, parent, parent-in-law, or sibling.

(k) "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments. The following investment interests shall be excepted from this definition:

1. An investment interest in an entity that is the sole provider of designated health services in a rural area;

2. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides designated health services, as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the notes, bonds, debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996.

3. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or

4. An investment interest in an entity which owns or leases and operates a hospital licensed under chapter 395 or a nursing home facility licensed under chapter 400.

(l) "Investor" means a person or entity owning a legal or beneficial ownership or investment interest, directly or indirectly, including, without limitation, through an immediate family member, trust, or another entity related to the investor within the meaning of 42 C.F.R. s. 413.17, in an entity.

(m) "Outside referral for diagnostic imaging services" means a referral of a patient to a group practice or sole provider for diagnostic imaging services by a physician who is not a member of the group practice or of the sole provider's practice and who does not have an investment interest in

the group practice or sole provider's practice, for which the group practice or sole provider billed for both the technical and the professional fee for the patient, and the patient did not become a patient of the group practice or sole provider's practice.

(n) "Patient of a group practice" or "patient of a sole provider" means a patient who receives a physical examination, evaluation, diagnosis, and development of a treatment plan if medically necessary by a physician who is a member of the group practice or the sole provider's practice.

(o) "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. The following orders, recommendations, or plans of care shall not constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, that effective July 1, 1999, a physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461 may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more that 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

h. By a health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis.

i. By a urologist for lithotripsy services.

j. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

k. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

l. By a nephrologist for renal dialysis services and supplies.

(p) "Present in the office suite" means that the physician is actually physically present; provided, however, that the health care provider is considered physically present during brief unexpected absences as well as during routine absences of a short duration if the absences occur during time periods in which the health care provider is otherwise scheduled and ordinarily expected to be present and the absences do not conflict with any other requirement in the Medicare program for a particular level of health care provider supervision.

(q) "Rural area" means a county with a population density of no greater than 100 persons per square mile, as defined by the United States Census.

(r) "Sole provider" means one health care provider licensed under chapter 458, chapter 459, chapter 460, or chapter 461, who maintains a separate medical office and a medical practice separate from any other health care provider and who bills for his or her services separately from the services provided by any other health care provider. A sole provider shall not share overhead expenses or professional income with any other person or group practice.

(4) REQUIREMENTS FOR ACCEPTING OUTSIDE REFERRALS FOR DIAGNOSTIC IMAGING.—

(a) A group practice or sole provider accepting outside referrals for diagnostic imaging services is required to comply with the following conditions:

1. Diagnostic imaging services must be provided exclusively by a group practice physician or by a full-time or part-time employee of the group practice or of the sole provider's practice.

2. All equity in the group practice or sole provider's practice accepting outside referrals for diagnostic imaging must be held by the physicians comprising the group practice or the sole provider's practice, each of whom must provide at least 75 percent of his or her professional services to the group. Alternatively, the group must be incorporated under chapter 617 and must be exempt under the provisions of s. 501(c)(3) of the Internal Revenue Code and be part of a foundation in existence prior to January 1, 1999, that is created for the purpose of patient care, medical education, and research.

3. A group practice or sole provider may not enter into, extend or renew any contract with a practice management company that provides any financial incentives, directly or indirectly, based on an increase in outside referrals for diagnostic imaging services from any group or sole provider managed by the same practice management company.

4. The group practice or sole provider accepting outside referrals for diagnostic imaging services must bill for both the professional and technical component of the service on behalf of the patient, and no portion of the payment, or any type of consideration, either directly or indirectly, may be shared with the referring physician.

5. Group practices or sole providers that have a Medicaid provider agreement with the Agency for Health Care Administration must furnish diagnostic imaging services to their Medicaid patients and may not refer a Medicaid recipient to a hospital for outpatient diagnostic imaging services unless the physician furnishes the hospital with documentation demonstrating the medical necessity for such a referral. If necessary, the Agency for Health Care Administration may apply for a federal waiver to implement this subparagraph.

6. All group practices and sole providers accepting outside referrals for diagnostic imaging shall

report annually to the Agency for Health Care Administration providing the number of outside referrals accepted for diagnostic imaging services and the total number of all patients receiving diagnostic imaging services.

(b) If a group practice or sole provider accepts an outside referral for diagnostic imaging services in violation of this subsection or if a group practice or sole provider accepts outside referrals for diagnostic imaging services in excess of the percentage limitation established in subparagraph (a) 2., the group practice or the sole provider shall be subject to the penalties in subsection (5).

(c) Each managing physician member of a group practice and each sole provider who accepts outside referrals for diagnostic imaging services shall submit an annual attestation signed under oath to the Agency for Health Care Administration which shall include the annual report required under subparagraph (a)6. and which shall further confirm that each group practice or sole provider is in compliance with the percentage limitations for accepting outside referrals and the requirements for accepting outside referrals listed in paragraph (a). The agency may verify the report submitted by group practices and sole providers.

(5) PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.--Except as provided in this section:

(a) A health care provider may not refer a patient for the provision of designated health services to an entity in which the health care provider is an investor or has an investment interest.

(b) A health care provider may not refer a patient for the provision of any other health care item or service to an entity in which the health care provider is an investor unless:

1. The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation:

a. Whose shares are traded on a national exchange or on the over-the-counter market; and

b. Whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million; or

2. With respect to an entity other than a publicly held corporation described in subparagraph 1., and a referring provider's investment interest in such entity, each of the following requirements are met:

a. No more than 50 percent of the value of the investment interests are held by investors who are in a position to make referrals to the entity.

b. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are no different from the terms offered to investors who are not in a position to make such referrals.

c. The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are not related to the previous or expected volume of referrals from that investor to the entity.

d. There is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor.

3. With respect to either such entity or publicly held corporation:

a. The entity or corporation does not loan funds to or guarantee a loan for an investor who is in a position to make referrals to the entity or corporation if the investor uses any part of such loan to obtain the investment interest.

b. The amount distributed to an investor representing a return on the investment interest is directly proportional to the amount of the capital investment, including the fair market value of any preoperational services rendered, invested in the entity or corporation by that investor.

4. Each board and, in the case of hospitals, the Agency for Health Care Administration, shall encourage the use by licensees of the declaratory statement procedure to determine the applicability of this section or any rule adopted pursuant to this section as it applies solely to the licensee. Boards shall submit to the Agency for Health Care Administration the name of any entity in which a provider investment interest has been approved pursuant to this section, and the Agency for Health Care Administration shall adopt rules providing for periodic quality assurance and utilization review of such entities.

(c) No claim for payment may be presented by an entity to any individual, third-party payor, or other entity for a service furnished pursuant to a referral prohibited under this section.

(d) If an entity collects any amount that was billed in violation of this section, the entity shall refund such amount on a timely basis to the payor or individual, whichever is applicable.

(e) Any person that presents or causes to be presented a bill or a claim for service that such person knows or should know is for a service for which payment may not be made under paragraph (c), or for which a refund has not been made under paragraph (d), shall be subject to a civil penalty of not more than $15,000 for each such service to be imposed and collected by the appropriate board.

(f) Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil penalty of not more than $100,000 for each such circumvention arrangement or scheme to be imposed and collected by the appropriate board.

(g) A violation of this section by a health care provider shall constitute grounds for disciplinary action to be taken by the applicable board pursuant to s. 458.331(2), s. 459.015(2), s. 460.413 (2), s. 461.013(2), s. 463.016(2), or s. 466.028(2). Any hospital licensed under chapter 395 found in violation of this section shall be subject to the rules adopted by the Agency for Health Care Administration pursuant to s. 395.0185(2).

(h) Any hospital licensed under chapter 395 that discriminates against or otherwise penalizes a health care provider for compliance with this act.

(i) The provision of paragraph (a) shall not apply to referrals to the offices of radiation therapy centers managed by an entity or subsidiary or general partner thereof, which performed radiation therapy services at those same offices prior to April 1, 1991, and shall not apply also to referrals for radiation therapy to be performed at no more than one additional office of any entity qualifying for the foregoing exception which, prior to February 1, 1992, had a binding purchase contract on and a nonrefundable deposit paid for a linear accelerator to be used at the additional office. The physical site of the radiation treatment centers effected by this provision may be relocated as a result of the following factors: acts of God; fire; strike; accident; war; eminent domain actions by any governmental body; or refusal by the lessor to renew a lease. A relocation for the foregoing reasons is limited to relocation of an existing facility to a replacement location within the county of the existing facility upon written notification to the Office of Licensure and Certification.

(j) A health care provider who meets the requirements of paragraphs (b) and (i) must disclose his or her investment interest to his or her patients as provided in s. 456.052.

History.--s. 7, ch. 92-178; s. 89, ch. 94-218; s. 60, ch. 95-144; s. 35, ch. 95-146; s. 8, ch. 96-296; s. 1083, ch. 97-103; s. 78, ch. 97-261; s. 70, ch. 97-264; s. 263, ch. 98-166; s. 62, ch. 98-171; s. 1, ch. 99-356; s. 10, ch. 2000-159; s. 77, ch. 2000-160.

[1]**Note.**--Section 2, ch. 99-356, provides that "[t]he agency shall require registration by all group practices providing diagnostic imaging services, regardless of ownership. Registration information must include the medical specialty of each physician; address and phone number of the group; UPIN numbers for the group and each group member; and Medicare, Medicaid, and commercial billing numbers for the group. The agency shall complete the registration by December 31, 1999."

Note.--Former s. 455.236; s. 455.654.

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