The Michigan Business Law JOURNAL

Volume 42
Issue 2
Summer 2022

CONTENTS

Section Matters

From the Desk of the Chairperson 1
Officers and Council Members 3
Committees and Directorships 4

Columns

Taking Care of Business: Business Identity Theft
Alexis Lupo 6
Tax Matters: IRS Budget and Staffing Woes Continue— New Warnings to Taxpayers
Eric M. Nemeth 8
Technology Corner: It's All Meta in the Metaverse and the World of NFTs
Jennifer A. Dukarski and Maya Smith 9
Touring the Business Courts
Douglas L. Toering, Fatima M. Bolyea, and Brian P. Markham 12

Articles

The Stark Reality: Stark Law Changes for Physician Group Practice Compensation Arrangements and How These Affect Business Lawyers
Theresamarie Mantese, Douglas L. Toering, and M. Jennifer Chaves 15

Case Digests 24

Index of Articles 26
ICLE Resources for Business Lawyers 32

Published by THE BUSINESS LAW SECTION, State Bar of Michigan

*The Stark Reality: Stark Law Changes for Physician Group Practice Compensation Arrangements and How These Affect Business Lawyers**

By Theresamarie Mantese, Douglas L. Toering, and M. Jennifer Chaves

Introduction

The reach of health care laws extends far beyond the treatment of patients and proper billing procedures. Health care laws directly and indirectly regulate nearly every aspect of a health care provider's practice. The federal Physician Self-Referral Act, or "Stark Law," governs compensation arrangements and referrals between physicians and health service providers. Stark's broad scope and detail-laden exceptions place complex restrictions on matters otherwise categorized as employment or business law.

This article first highlights why business lawyers should care about health care laws. We provide a brief overview of the federal and Michigan-specific laws that regulate the health care profession.

Our discussion will then review the Stark Law and several of its heavily relied-upon exceptions that are of particular application to business lawyers who serve health care providers. These set out the required elements of various arrangements to avoid being deemed impermissible referrals. In this review, our primary goals are twofold. First, we aim to explain how the recent change to Stark's in-office ancillary services exception affects physician compensation models in group practices. Our second goal is to demonstrate how the Stark Law restricts a health care provider's business transactions.

Changes to Stark's in-office ancillary services (IOAS) exception took effect January 1, 2022.[1] The requirements to qualify as a group practice and utilize this exception are complex. Stark's amended group practice requirements now prohibit distributions of profits from designated health services on a service-by-service basis. Such distribution arrangements are sometimes called "split-pooling" of profits. Our discussion of the IOAS exception includes an explanation of acceptable profit distribution models under the new law. We briefly conclude with the intersection of business transactions and the Stark Law.

Why Business Lawyers Should Care About Health Care Laws

The health care profession is regulated at both the federal and state level. Every business lawyer who represents health care clients needs a working understanding of health care statutes. This is true even when the attorney limits his or her representation to business matters and carefully avoids giving legal advice on health care topics. While some health care laws apply only to health care providers, many apply more broadly.

There are a few key federal and state laws that commonly restrict business transactions of health care providers. Primarily, these are the Stark Law, the federal Anti-Kickback Statute, and state laws on the corporate practice of medicine and fee-splitting. Examples of business transactions that are commonly impacted by these laws include employment contracts, transfers of business interests, sale of a health care entity, leases of office space or equipment, affiliate marketing agreements, marketing to and solicitation of patients, and vendor service and supply contracts. Although these transactions may appear routine, they should be scrutinized for conformity to applicable health care laws.

Violating health care laws can lead to a provider's Medicare and Medicaid exclusion, licensure issues, hefty civil penalties, and possibly criminal liability. Even where

**The authors would like to thank Gregory G. Drutchas and Richard J. Joppich of Kitch Drutchas Wagner Valitutti & Sherbrook for their thorough review and edits.*

no violation has occurred, the mere appearance of unlawful conduct can trigger onerous fraud investigations. These investigations are often costly and can continue for years—consequences that most clients are obviously eager to avoid.

Some health care laws extend beyond health care providers to vendors and other economic players on the periphery of the health care profession. Anytime the client's transactions intersect with the health care field, business lawyers should use care. With research and thoughtful planning, most transactions can be structured to mitigate risk to the client.

Every business lawyer who represents health care clients needs a working understanding of health care statutes.

Overview of Health Care Regulation

As mentioned, federal statutes impose a myriad of complex requirements on health care providers that affect nearly every aspect of their practices. This article is limited to a focus on, and practical implications of, the Stark Law.[2] However, the wary lawyer should consider the many other federal statutes that govern health care practice. These include the False Claims Act,[3] the Anti-Kickback Statute,[4] the Civil Monetary Penalties Law,[5] the Health Insurance Portability and Accountability Act (HIPAA),[6] the Emergency Medical Treatment and Labor Act (EMTALA),[7] the Health Information Technology for Economic and Clinical Health Act (HITECH Act),[8] and the Health Care Quality Improvement Act (HCQIA).[9] Federal administrative agencies further affect the regulatory landscape with interpretive rules, fraud alerts, and advisory opinions. Also, some health care providers must pay special attention to antitrust laws when engaging in business transactions.

Additionally, Michigan has its own laws on physician licensure,[10] fee-splitting and anti-kickback,[11] false claims,[12] and the corporate practice of medicine.[13] Importantly, some of these state laws apply more broadly than their federal counterparts. Michigan's fee-splitting statute, for example, applies to all medical treatments, procedures, and services, not only those billed to a government payor.

What Is the Stark Law?

The Stark Law aims to minimize financial incentives for physicians who recommend unnecessary tests, services, and procedures at the government's expense. To accomplish this, the statute limits the circumstances under which a physician may refer a patient for certain health services, called "designated health services" (DHS). When a physician has a financial relationship with an entity that provides such services, Stark prohibits the physician from referring patients to the entity for DHS if the DHS are payable by Medicare—unless an exception applies.[14] If such a referral for DHS is made (and no exception applies), the entity may not bill Medicare and must refund any payment received from Medicare.

The Stark Law's prohibitions reach broadly. Many common medical tests, procedures, and services fall under the definition of designated health services. Examples of DHS include laboratory services, physical therapy, occupational therapy, outpatient prescription drugs, home health services, prosthetics, hospital procedures and services, speech-language pathology services, and some equipment and supplies.[15] Every year the Centers for Medicare and Medicaid Services (CMS) publish an updated list of medical billing codes that qualify as designated health services.[16]

The term "referral" is similarly broad. It covers not only designated health services requested by the physician, but also DHS requested by another physician if the initial physician referred the patient to the second physician. A referral also includes DHS furnished by another physician within the referring physician's own practice.[17] Additionally, the term "physician" includes doctors of medicine or osteopathy that are legally authorized to practice medicine and surgery by the state and other specialized health care providers, such as dentists, chiropractors, optometrists, and podiatrists.[18]

Most notably, the broad definition of "financial relationship" encompasses nearly all economic activities, from ownership or investment interests to direct or indirect compensation arrangements, between a referring physician or his or her immediate family members and a DHS provider. Physician salaries, equipment and office leases by physician-owned entities, and even nonmonetary benefits that physicians receive from hospitals or vendors create a financial relationship between the parties for purposes of the Stark Law. Stark also extends to indirect financial arrangements, such as physician ownership of a legal entity that owns shares in a DHS provider to which the physician makes re-

ferrals.[19] Furthermore, the Stark Law defines immediate family members to include many relations that common parlance would instead categorize as extended family members. Brothers-in-law, sisters-in-law, the spouses of grandparents, and the spouses of grandchildren are all deemed immediate family members under Stark.[20]

However, it is not only Stark's expansive definitions that make it so potent. The Stark Law is what is known as a strict liability statute. That is because physicians can be held liable for violating its prohibitions, even absent an intent to do so. Stark imposes a $15,000 penalty for each billing and refund violation, and penalties up to $10,000 per day for certain reporting failures. A $100,000 penalty applies to indirect referral schemes designed to circumvent the statute.[21] The U.S. Department of Justice typically enforces the Stark Law through the False Claims Act, which can trigger both civil and criminal liability. Additionally, the Office of the Inspector General has authority to exclude Stark violators from participation in all federal health care programs. Consequently, violators risk significant loss of future revenue from Medicare, Medicaid, and other government-payor health care programs.[22]

Stark Law Exceptions

Despite such heavy penalties, there are many examples of routine practices in the health care profession that may appear to violate the Stark Law. These are allowed because Stark provides a multitude of exceptions that permit physicians to make otherwise-prohibited referrals. Nearly all customary referral and compensation arrangements between physicians and DHS providers operate under a Stark Law exception. Several common exceptions are described below.

In-Office Ancillary Services (IOAS) Exception

Many physicians refer patients for designated health services that are provided within the physician's own practice. In the case of a group practice, these are mostly diagnostic testing, but also include some therapy services. Physicians typically refer these services to internal units in their own practice under the exception for IOAS. The IOAS exception specifies who must provide the DHS, where the DHS must be provided, and who can bill for the service.[23]

Stark limits this exception to medical groups that qualify as a group practice and solo practitioners.[24] CMS amended the definition of a group practice with its recent changes to the Stark Law. We reserve discussion of those changes for later in this article.

Under the IOAS exception, the DHS may be provided only by the referring physician, another physician in the group practice, an individual who is supervised by the referring physician, or by another physician in the same group practice. The referring physician must be present and order the DHS during a patient visit or must be present while the DHS is furnished. Further, the patient receiving the DHS must usually receive care from the referring physician or a member of the physician's group practice.

The IOAS exception demonstrates Stark's far-reaching effects on business transactions. In addition to other requirements, it requires the DHS to be provided at one of a few specified locations.[25] Under the first location option, DHS may be provided in the same building as the physician's or medical group's office, if all the following criteria are met:

- the office is normally open to patients for medical services at least 35 hours per week;
- a physician or another member of the group regularly practices medicine and provides physician services to patients at least 30 hours per week; and
- that physician provides some services to patients that are unrelated to provision of DHS.

Another location option under the IOAS exception speaks of a centralized building. The centralized building may be all or part of a building, including a mobile vehicle or trailer, that is owned or leased on a full-time basis by a group practice (24 hours a day, 7 days per week for no less than six months) and that is used exclusively by the group practice. However, the definition of centralized building excludes space shared with a third party.[26] Thus, the Stark IOAS exception affects employment practices such as physician work hours, business hours, and even property leases.

Billing for IOAS must be by (1) the physician performing or supervising the service, (2) the group practice of the performing or supervising physician under the group practice's billing number, (3) an entity that is

The Stark Law aims to minimize financial incentives for physicians who recommend unnecessary tests, services, and procedures at the government's expense.

wholly owned by the performing or supervising physician or that physician's group practice, or (4) a third-party billing company acting as an agent of the physician or group practice, or the wholly owned entity.

Although these are some of the key elements to be aware of for a properly designed IOAS arrangement, additional specific rules apply for certain, durable medical equipment, home care physicians, MRI, CT, and PET scans, Academic Medical Centers, Ambulatory Surgical Centers, and other situations, which extend beyond the scope of this article. However, careful review of the statute and regulations is imperative for application to any proposed IOAS arrangement.

Overall, the Stark Law dictates many aspects of a physician's practice, including compensation arrangements, sales, leases, and financial investments.

Bona Fide Employment Relationships Exception

Another Stark exception that authorizes familiar health care referral arrangements is the bona fide employment relationships exception.[27] A physician who refers patients to his or her employer for DHS typically does so pursuant to this exception. To fall within the exception, the parties must have an employment agreement for specific, identifiable services. The physician's compensation cannot be determined in any way that accounts for the volume or value of physician referrals made to the employer unless the compensation or formula for determining the compensation is set in advance for the duration of the arrangement, and patient choice is maintained. The employer must pay fair market value for the physician's services, and the physician's compensation under the agreement must be commercially reasonable even if the physician makes no referrals to the employer. Other requirements also apply. As with the IOAS exception, here again the Stark Law reaches beyond health care law into employment and transactional matters.

Personal Service Arrangements Exception

Stark also provides an exception for work performed for a DHS provider by a non-employee physician. This exception allows a DHS provider to compensate a referring physician for personal services he or she provides to the DHS provider under contract.[28] Although this exception fits many different types of work arrangements, Stark limits its scope to services that are "reasonable and necessary for the legitimate business purposes of the arrangement(s)." The arrangement must be set out in a writing, which includes the services to be provided by the physician, and the compensation must be consistent with fair market value. Other than for certain qualified types of incentive plans, the compensation in such arrangements must not be based on the volume or value of referrals or other business generated between the parties. The arrangement must be for no less than one year; and if canceled during the initial year, it cannot be renewed on the same or substantially the same terms during the remainder of the one-year term.

Office Space and Equipment Lease Exceptions

Stark offers separate exceptions for leases and rentals of office space and equipment.[29] Both exceptions contain similar requirements. Most notably, the rent payments must be set in advance, must not take into account the volume or value of referrals between the parties, must be consistent with fair market value, and cannot exceed what is reasonable and necessary for the legitimate business purpose of the lease. These exceptions also require, among other things, a written lease agreement that specifically describes the leased property for exclusive use by the lessee. Careful analysis by the attorney is imperative to avoid running afoul of these exceptions. Of particular note, care is needed to avoid the lessor or another tenant using the leased property or equipment during periods of exclusive use by the lessee under the lease.

Fair Market Value Compensation Exception

The fair market value compensation exception enables DHS providers and physicians to buy, sell, or lease items, services, and even office space and equipment to each other at fair market value without the requirements of a one-year term or exclusivity of use, if applied appropriately.[30] Among other requirements, the parties' agreement must be in writing, signed, and must be commercially reasonable even if no referrals were made between the parties. Moreover, the compensation amount cannot be tied to the volume or value of referrals or other business generated by the parties, with limited exceptions.

Other Exceptions

The Stark Law provides several other exceptions that enable desirable economic relations among physicians and DHS providers. For example, referring physicians may invest

in publicly traded securities of large corporations that provide DHS.[31] They may also invest in a hospital, if they are authorized to perform services there, or in a rural DHS provider.[32] The one-time sale of property or a medical practice is permitted.[33] Furthermore, hospitals may provide certain benefits to medical staff, and DHS providers may give low-value, noncash gifts of appreciation to referring physicians.[34] As with the other Stark exceptions, the exceptions covering these transactions are subject to very specific requirements.

Overall, the Stark Law dictates many aspects of a physician's practice, including compensation arrangements, sales, leases, and financial investments. The law's detail-laden exceptions and sprawling restrictions create an intricate web of acceptable conduct. Counsel and clients must navigate Stark's prohibitions attentively.

Recent Changes for Group Practices

CMS recently amended and interpreted the Stark Law as it relates to group practices.[35] As mentioned earlier, medical groups relying on Stark's in-office ancillary services (IOAS) exception must meet the definition of a group practice. The Stark Law enumerates eight very specific requirements, all of which must be met to qualify as a group practice.[36] CMS's new regulations narrow and clarify the seventh requirement of a group practice, as discussed below.

Requirements to Qualify as a Group Practice

Of the eight requirements to qualify as a group practice under the IOAS exception, two relate to the group practice's corporate form and governance. Four requirements relate to the medical group's physician-members or the services they provide, and the final two restrict compensation, profit sharing, and distribution arrangements.

Single Legal Entity

To qualify as a group practice, the medical group must consist of a single legal entity that operates as a physician group. In limited situations, the single legal entity may consist of multiple legal entities in contiguous states.

Unified Business Test

The medical group must also meet the unified business test. That is, it must have consolidated billing, accounting, and financial reporting. Additionally, the medical group must have a "body representative" that performs centralized decision-making and maintains effective control over the group's assets and liabilities. The unified business test is intended to prevent loose confederations of physicians from joining together primarily to capture the profits from referrals.[37] Business attorneys who assist medical groups with corporate documents must understand these restrictions if the group utilizes the IOAS exception.

Members and Services

A group practice must have at least two physicians who are members. Independent contractors do not count as members, but owners and employees do. Physician-members of the group practice must personally perform at least 75 percent of the group practice's "physician-patient encounters." Also, each physician-member must furnish substantially the full range of patient care services that the referring physician routinely furnishes through the group practice.

Substantially All

In addition, "substantially all" (at least 75 percent) of the physician-members' total patient care services must be furnished through the group and billed under the group practice's billing number. Amounts received for these services must be treated as receipts of the group. Although there is flexibility in determining how to measure patient care services for the purpose of this "substantially all" (75 percent) requirement, records must be kept and made available to the Secretary of the Department of Health and Human Services[38] upon request. Stark provides an exception to the "substantially all" requirement for services provided in areas designated by CMS as having a shortage of health care professionals.

Compensation and Profit Sharing

A group practice must determine how it will distribute income and overhead expenses before payments are received. Additionally, physician-members may not be compensated based on the volume or value of their DHS referrals, directly or indirectly. However, special rules permit productivity bonuses and certain DHS profit-sharing arrangements. A physician in the group may be paid a share of "overall profits" from DHS that is not directly related to the volume or value of

Of the eight requirements to qualify as a group practice under the IOAS exception, two relate to the group practice's corporate form and governance.

his or her referrals. Many medical groups utilize these special rules to lawfully engage in various profit-sharing arrangements.

Split-Pooling Under the Special Rules for DHS Profit Sharing

Earlier Definition of "Overall Profits"

CMS amended the definition of "overall profits" related to DHS profit sharing in these special rules for physician compensation. Prior to this change, "overall profits" meant either "the group's entire profits derived from [DHS]" or "the profits derived from [DHS] of any component of the group practice that consists of at least five physicians."[39]

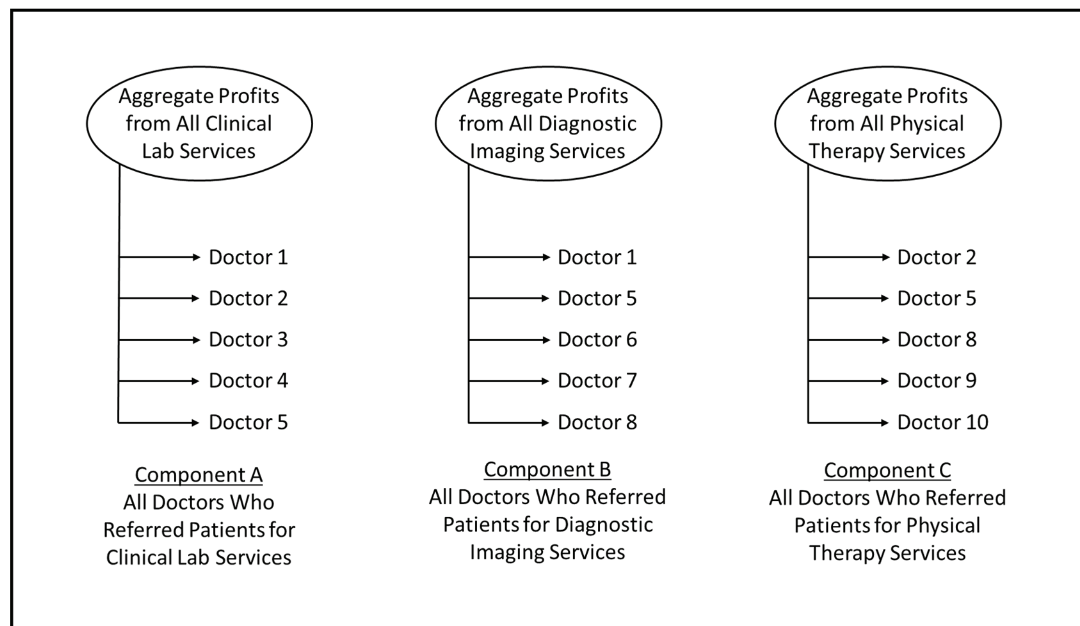
Interpretation of Earlier Definition (Split-Pooling Model)

Some medical groups utilizing the IOAS exception interpreted this earlier definition to allow distributions of DHS profits on a service-by-service basis, sometimes called split-pooling. Under that distribution model, medical groups formed components based on DHS. Typically, a medical group would form components so that each DHS category corresponded to one component, such as one component for clinical laboratory services and one component for diagnostic imaging services. All profits from each DHS category (which are all profits within that particular component) would be aggregated and then distributed to all physicians in the medical group who, by circumstance, happened to refer patients to receive that corresponding DHS.

Figure 1 illustrates split-pooling using clinical laboratory services, diagnostic imaging services, and physical therapy services, all of which are DHS. For example, in Figure 1, all profits from clinical laboratory services would be aggregated into the corresponding clinical laboratory services component and then distributed to the physicians who referred patients to receive clinical laboratory services (Doctors 1-5). Those referring physicians would then become the physicians in that component and, under a split-pooling model, those physicians would receive profits from the clinical laboratory services component. Thus, using a split-pooling model, the kind of referrals alone caused physicians to be placed into components. The earlier definition of "overall profits" further complicated the split-pooling distribution model by requiring a minimum of five physicians per component.

The Stark Law's detailed provisions require vigilance from counsel when handling business transactions or litigation for health care providers.

Figure 1. DHS Profit Aggregation & Distribution by Service (Split-Pooling)



When using a split-pooling model, a single physician could have been (and often was) a member of multiple components. In Figure 1, Doctor 5 is a member of all three components, because he or she refers patients for clinical laboratory services, diagnostic imaging services, and physical therapy services. As the name split-pooling implies, the profits from Doctor 5's various DHS referrals are thus split among three different pools (components).

Under a split-pooling model, profits from a specific DHS were distributed to all physicians who referred patients for that particular DHS. However, because of Stark's restrictions, the profits were not distributed according to the volume or value of referrals. For example, the amount of total profits from diagnostic imaging services, after aggregating, could *not* be distributed pro rata according to the value of each physician's diagnostic imaging referrals. Per capita distribution (20 percent for each of five physicians), however, would have been an acceptable distribution method.

Recent Changes to the Special Rules for DHS Profit Sharing

Amended Definition of "Overall Profits"

CMS revised the definition of "overall profits" in the special rules of the IOAS exception's group practice definition. The new definition of "overall profits" adds the words "all the" immediately before "designated health services," among other changes. It now reads:

> Overall profits means the profits derived from *all the* designated health services of any component of the group that consists of at least five physicians, which may include all physicians in the group. If there are fewer than five physicians in the group, overall profits means the profits derived from *all the* designated health services of the group.[40] (Emphasis added.)

CMS implemented this change to the special rules specifically to prohibit the split-pooling distribution model.[41]

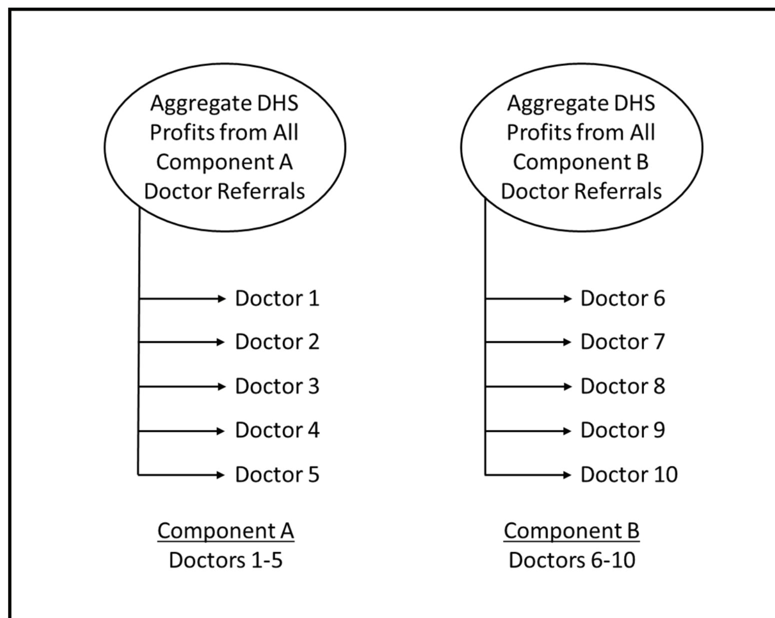
Interpretation of New Definition (Physician Group Model)

The new definition leaves many aspects of acceptable DHS profit-sharing models unchanged. As before, a medical group may still aggregate DHS profits within each component and distribute them to that component's physicians, assuming it has enough physicians to do so. The five-physician minimum per component also remains unchanged.

What has changed is the process of assigning physicians to a component. If a medical group is using components to aggregate and distribute DHS profits, it may no longer form components on a service-by-service basis (split-pooling). Instead, it must intentionally place each physician in a *single component*, thereby creating components that are best described as physician groups. Although no physician may be placed in more than one component, different physicians may be separated into different components, as shown in Figure 2.

When a DHS provider gives anything of value to a referring physician (for any reason), the transaction must comply with one of Stark's exceptions.

Figure 2. DHS Profit Aggregation & Distribution by Physician Group



The restriction that each physician may join only one component results from the new definition. "Overall profits" are "profits derived from *all the* designated health services of any component." If a single physician were to be placed in two components, then neither of those two components would be able to aggregate profits from *all the* DHS of the physicians in that particular component. Rather, the DHS profits from the physician in two components would have to be split between those two components (split-pooling), which is now prohibited.

Forming Components under the New Physician Group Model

In its commentary on the new definition, CMS explained that physicians may be placed in components based on any criteria that does not directly relate to the volume or value of DHS referrals.[42] Acceptable criteria for placing physicians in components include similar practice patterns, similar practice locations, similar years of experience, and similar years of tenure with the medical group.

Distributing DHS Profits under the New Physician Group Model

A component's *aggregate* DHS profits may be distributed to the component's physicians using any method that does not directly relate to the volume or value of DHS referrals. Different distribution methods may be used for different components. The definition of "overall profits" explicitly permits per capita distributions and distributions based on a physician's personal productivity.[43] Some medical groups choose to distribute profits according to ownership interests.

Furthermore, a medical group may treat different components differently when it comes to the decision to distribute DHS profits.[44] For example, a medical group may choose to distribute all aggregated DHS profits from Component A to the Component A physicians, but choose not to distribute any Component B DHS profits, or choose to distribute only a portion of the Component B profits to the Component B physicians.

Eligibility to Receive DHS Profits under the New Physician Group Model

Under Stark's IOAS exception and its special rules on DHS profit sharing, all physicians in a component may receive DHS profits. That is, owners, employees, and independent contractors in a component are all eligible to receive a share of the aggregated profits from that component.[45] However, a medical group may establish its own eligibility standards that restrict some physicians from receiving profits, provided, of course, that those standards do not relate to the volume or value of DHS referrals. Eligibility could be premised on considerations such as length of time with the medical group, whether the physician is an owner, employee, or independent contractor, or the number of hours the physician typically works.[46]

Record Keeping

The definition of "overall profits" in the special rules requires careful bookkeeping. Medical groups utilizing the IOAS exception must maintain records of their profit share calculations and supporting documentation.[47]

Stark Affects Business Transactions and Disputes

The Stark Law's detailed provisions require vigilance from counsel when handling business transactions or litigation for health care providers. In general, a good place to begin is to identify whether the Stark Law applies, and then if so, determine whether a Stark exception, if any, applies.

For medical groups and physicians, employment agreements and contracts for personal services are directly impacted by the Stark Law, although other types of transactions can also be impacted and other health care laws can restrict business transactions. The contents of the employment agreement will vary depending on the needs of the practice and the applicable Stark exception. If the physician's referrals will fall under the IOAS exception, the agreement should incorporate Stark's business practice requirements and describe a compliant physician-compensation arrangement.

As for litigation, claims of minority owner oppression[48] between physicians in a group practice may give rise to scenarios with restricted settlement options. In the event a dispute is settled, counsel must verify that any payment to a health care provider does not run afoul of Stark. Counsel should also consider Stark's restrictions when developing damages models.

Conclusion

Health care providers do business in a complex regulatory setting. Some health care laws apply even to entities that do not them-

selves provide health care services. Business attorneys who represent these clients should have a general understanding of the statutes that govern the practice of medicine.

The Stark Law is a complex federal statute that significantly limits many aspects of health care practice. When a DHS provider gives anything of value to a referring physician (for any reason), the transaction must comply with one of Stark's exceptions. Health care providers should consider potential Stark restrictions before engaging in business transactions, generally, and physician compensation arrangements, in particular.

CMS recently changed the definition of "overall profits" in Stark's IOAS exception. Medical groups relying on this exception may no longer aggregate profits from a specific DHS category. Overall, the Stark Law affects many aspects of a health care provider's practice. Business attorneys who represent health care providers or those who do business with health care providers should be familiar with how Stark affects their clients.

NOTES

1. 85 FR 77561.
2. 42 USC 1395nn.
3. 31 USC 3729.
4. 42 USC 1320a-7b.
5. 42 USC 1320a-7a.
6. Pub L No 104-191.
7. 42 USC 1395dd.
8. Pub L No 104-191, Title XIII.
9. Pub L 99-660, Title IV.
10. MCL 333.17011.
11. MCL 750.428; MCL 333.16221(d)(ii); MCL 445.162.
12. MCL 752.1001 *et seq.*; MCL 400.601 *et seq.*
13. MCL 450.1281.
14. 42 USC 1395nn.
15. 42 CFR 411.351.
16. https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral.
17. 42 USC 1395nn(h)(5)(A).
18. 42 CFR 411.351; 42 USC 1395(x)(r).
19. 42 CFR 411.354.
20. 42 CFR 411.351.
21. 42 USC 1395nn(g)(3)-(4).
22. 42 USC 1395y(o).
23. 42 CFR 411.355(b).
24. 42 CFR 411.355(b).
25. 42 CFR 411.355(b)(2)(i)(A).
26. 42 CFR 411.355(b)(2)(ii)-(iii); 42 CFR 411.351.
27. 42 CFR 411.357(c).
28. 42 CFR 411.357(d).
29. 42 CFR 411.357(a)-(b).
30. 42 CFR 411.357(l).
31. 42 CFR 411.356(a).
32. 42 CFR 411.356(c).
33. 42 CFR 411.357(f).
34. 42 CFR 411.357(m); 42 CFR 411.357(k).
35. 85 FR 77561.
36. 42 CFR 411.352.
37. 85 FR 77564.
38. 85 FR 77492.
39. 85 FR 77561.
40. 42 CFR 411.352(i)(1)(ii).
41. 85 FR 77561.
42. 85 FR 77565.
43. 42 CFR 411.352.
44. 85 FR 77563; 42 CFR 411.351.
45. 85 FR 77565.
46. 85 FR 77563.
47. 42 CFR 411.352(i)(4).
48. MCL 450.1489; MCL 450.4515.

Theresamarie Mantese of Mantese Honigman, PC, concentrates her practice on health care and business litigation. Her clients include licensed health care professionals, physicians, and health care and business entities.

Douglas L. Toering of Mantese Honigman, PC, is a past chair of the SBM's Business Law Section, for which he chairs the Commercial Litigation Committee and Business Courts Committee. His practice includes commercial litigation including shareholder litigation and insurance litigation, business transactional matters, healthcare law, and business mediation.

M. Jennifer Chaves, an associate at Mantese Honigman, PC, focuses her practice on business and health care law. Prior to pursuing a career in law, Ms. Chaves worked eleven years as a statistician, data modeler, production engineer, and laboratory technologist in the chemical manufacturing industry.