

other period as Congress may specify), the hospital is not a specialty hospital;

(iii) The ownership or investment interest is in the entire hospital and not merely in a distinct part or department of the hospital; and

(iv) The hospital meets the requirements described in §411.362 not later than September 23, 2011.

[72 FR 51091, Sept. 5, 2007, as amended at 75 FR 72260, Nov. 24, 2010]

**§411.357 Exceptions to the referral prohibition related to compensation arrangements.**

For purposes of §411.353, the following compensation arrangements do not constitute a financial relationship:

(a) *Rental of office space.* Payments for the use of office space made by a lessee to a lessor if there is a rental or lease agreement that meets the following requirements:

(1) The agreement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The term of the agreement is at least 1 year. To meet this requirement, if the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(3) The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee (and is not shared with or used by the lessor or any person or entity related to the lessor), except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.

(4) The rental charges over the term of the agreement are set in advance and are consistent with fair market value.

(5) The rental charges over the term of the agreement are not determined—

(i) In a manner that takes into account the volume or value of any refer-

als or other business generated between the parties; or

(ii) Using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated in the office space; or

(B) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.

(6) The agreement would be commercially reasonable even if no referrals were made between the lessee and the lessor.

(7) A holdover month-to-month rental for up to 6 months immediately following the expiration of an agreement of at least 1 year that met the conditions of paragraphs (a)(1) through (a)(6) of this section satisfies the requirements of paragraph (a) of this section, provided that the holdover rental is on the same terms and conditions as the immediately preceding agreement.

(b) *Rental of equipment.* Payments made by a lessee to a lessor for the use of equipment under the following conditions:

(1) A rental or lease agreement is set out in writing, is signed by the parties, and specifies the equipment it covers.

(2) The equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee and is not shared with or used by the lessor or any person or entity related to the lessor.

(3) The agreement provides for a term of rental or lease of at least 1 year. To meet this requirement, if the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(4) The rental charges over the term of the agreement are set in advance, are consistent with fair market value, and are not determined—

(i) In a manner that takes into account the volume or value of any referrals or other business generated between the parties; or

(ii) Using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed on or business generated through the use of the equipment; or

(B) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.

(5) The agreement would be commercially reasonable even if no referrals were made between the parties.

(6) A holdover month-to-month rental for up to 6 months immediately following the expiration of an agreement of at least 1 year that met the conditions of paragraphs (b)(1) through (b)(5) of this section satisfies the requirements of paragraph (b) of this section, provided that the holdover rental is on the same terms and conditions as the immediately preceding agreement.

(c) *Bona fide employment relationships.* Any amount paid by an employer to a physician (or immediate family member) who has a *bona fide* employment relationship with the employer for the provision of services if the following conditions are met:

(1) The employment is for identifiable services.

(2) The amount of the remuneration under the employment is—

(i) Consistent with the fair market value of the services; and

(ii) Except as provided in paragraph (c)(4) of this section, is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.

(3) The remuneration is provided under an agreement that would be commercially reasonable even if no referrals were made to the employer.

(4) Paragraph (c)(2)(ii) of this section does not prohibit payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or immediate family member of the physician).

(d) *Personal service arrangements.* (1) *General*—Remuneration from an entity under an arrangement or multiple arrangements to a physician or his or her immediate family member, or to a group practice, including remuneration for specific physician services fur-

nished to a nonprofit blood center, if the following conditions are met:

(i) Each arrangement is set out in writing, is signed by the parties, and specifies the services covered by the arrangement.

(ii) The arrangement(s) covers all of the services to be furnished by the physician (or an immediate family member of the physician) to the entity. This requirement is met if all separate arrangements between the entity and the physician and the entity and any family members incorporate each other by reference or if they cross-reference a master list of contracts that is maintained and updated centrally and is available for review by the Secretary upon request. The master list must be maintained in a manner that preserves the historical record of contracts. A physician or family member can “furnish” services through employees whom they have hired for the purpose of performing the services; through a wholly-owned entity; or through *locum tenens* physicians (as defined at §411.351, except that the regular physician need not be a member of a group practice).

(iii) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement(s).

(iv) The term of each arrangement is for at least 1 year. To meet this requirement, if an arrangement is terminated during the term with or without cause, the parties may not enter into the same or substantially the same arrangement during the first year of the original term of the arrangement.

(v) The compensation to be paid over the term of each arrangement is set in advance, does not exceed fair market value, and, except in the case of a physician incentive plan (as defined at §411.351 of this subpart), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(vi) The services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law.

(vii) A holdover personal service arrangement for up to 6 months following the expiration of an agreement of at least 1 year that met the conditions of paragraph (d) of this section satisfies the requirements of paragraph (d) of this section, provided that the holdover personal service arrangement is on the same terms and conditions as the immediately preceding agreement.

(2) *Physician incentive plan exception.* In the case of a physician incentive plan (as defined at §411.351) between a physician and an entity (or downstream contractor), the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(i) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services furnished with respect to a specific individual enrolled with the entity.

(ii) Upon request of the Secretary, the entity provides the Secretary with access to information regarding the plan (including any downstream contractor plans), in order to permit the Secretary to determine whether the plan is in compliance with paragraph (d)(2) of this section.

(iii) In the case of a plan that places a physician or a physician group at substantial financial risk as defined at §422.208, the entity or any downstream contractor (or both) complies with the requirements concerning physician incentive plans set forth in §422.208 and §422.210 of this chapter.

(e) *Physician recruitment.* (1) Remuneration provided by a hospital to recruit a physician that is paid directly to the physician and that is intended to induce the physician to relocate his or her medical practice to the geographic area served by the hospital in order to become a member of the hospital's medical staff, if all of the following conditions are met:

(i) The arrangement is set out in writing and signed by both parties;

(ii) The arrangement is not conditioned on the physician's referral of patients to the hospital;

(iii) The hospital does not determine (directly or indirectly) the amount of the remuneration to the physician based on the volume or value of any actual or anticipated referrals by the physician or other business generated between the parties; and

(iv) The physician is allowed to establish staff privileges at any other hospital(s) and to refer business to any other entities (except as referrals may be restricted under an employment or services contract that complies with §411.354(d)(4)).

(2)(i) The "geographic area served by the hospital" is the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients. The geographic area served by the hospital may include one or more zip codes from which the hospital draws no inpatients, provided that such zip codes are entirely surrounded by zip codes in the geographic area described above from which the hospital draws at least 75 percent of its inpatients.

(ii) With respect to a hospital that draws fewer than 75 percent of its inpatients from all of the contiguous zip codes from which it draws inpatients, the "geographic area served by the hospital" will be deemed to be the area composed of all of the contiguous zip codes from which the hospital draws its inpatients.

(iii) *Special optional rule for rural hospitals.* In the case of a hospital located in a rural area (as defined at §411.351), the "geographic area served by the hospital" may also be the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 90 percent of its inpatients. If the hospital draws fewer than 90 percent of its inpatients from all of the contiguous zip codes from which it draws inpatients, the "geographic area served by the hospital" may include noncontiguous zip codes, beginning with the noncontiguous zip code in which the highest percentage of the hospital's inpatients resides, and continuing to add noncontiguous zip codes in decreasing order of percentage of inpatients.

(iv) A physician will be considered to have relocated his or her medical practice if the medical practice was located outside the geographic area served by the hospital and—

(A) The physician moves his or her medical practice at least 25 miles and into the geographic area served by the hospital; or

(B) The physician moves his medical practice into the geographic area served by the hospital, and the physician's new medical practice derives at least 75 percent of its revenues from professional services furnished to patients (including hospital inpatients) not seen or treated by the physician at his or her prior medical practice site during the preceding 3 years, measured on an annual basis (fiscal or calendar year). For the initial "start up" year of the recruited physician's practice, the 75 percent test in the preceding sentence will be satisfied if there is a reasonable expectation that the recruited physician's medical practice for the year will derive at least 75 percent of its revenues from professional services furnished to patients not seen or treated by the physician at his or her prior medical practice site during the preceding 3 years.

(3) The recruited physician will not be subject to the relocation requirement of this paragraph, provided that he or she establishes his or her medical practice in the geographic area served by the recruiting hospital, if—

(i) He or she is a resident or physician who has been in practice 1 year or less;

(ii) He or she was employed on a full-time basis for at least 2 years immediately prior to the recruitment arrangement by one of the following (and did not maintain a private practice in addition to such full-time employment):

(A) A Federal or State bureau of prisons (or similar entity operating one or more correctional facilities) to serve a prison population;

(B) The Department of Defense or Department of Veterans Affairs to serve active or veteran military personnel and their families; or

(C) A facility of the Indian Health Service to serve patients who receive

medical care exclusively through the Indian Health Service; or

(iii) The Secretary has deemed in an advisory opinion issued under section 1877(g) of the Act that the physician does not have an established medical practice that serves or could serve a significant number of patients who are or could become patients of the recruiting hospital.

(4) In the case of remuneration provided by a hospital to a physician either indirectly through payments made to another physician practice, or directly to a physician who joins a physician practice, the following additional conditions must be met:

(i) The written agreement in paragraph (e)(1) is also signed by the physician practice.

(ii) Except for actual costs incurred by the physician practice in recruiting the new physician, the remuneration is passed directly through to or remains with the recruited physician.

(iii) In the case of an income guarantee of any type made by the hospital to a recruited physician who joins a physician practice, the costs allocated by the physician practice to the recruited physician do not exceed the actual additional incremental costs attributable to the recruited physician. With respect to a physician recruited to join a physician practice located in a rural area or HPSA, if the physician is recruited to replace a physician who, within the previous 12-month period, retired, relocated outside of the geographic area served by the hospital, or died, the costs allocated by the physician practice to the recruited physician do not exceed either—

(A) The actual additional incremental costs attributable to the recruited physician; or

(B) The lower of a *per capita* allocation or 20 percent of the practice's aggregate costs.

(iv) Records of the actual costs and the passed-through amounts are maintained for a period of at least 5 years and made available to the Secretary upon request.

(v) The remuneration from the hospital under the arrangement is not determined in a manner that takes into

account (directly or indirectly) the volume or value of any actual or anticipated referrals by the recruited physician or the physician practice (or any physician affiliated with the physician practice) receiving the direct payments from the hospital.

(vi) The physician practice may not impose on the recruited physician practice restrictions that unreasonably restrict the recruited physician's ability to practice medicine in the geographic area served by the hospital.

(vii) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(5) Recruitment of a physician by a hospital located in a rural area (as defined at §411.351) to an area outside the geographic area served by the hospital is permitted under this exception if the Secretary determines in an advisory opinion issued under section 1877(g) of the Act that the area has a demonstrated need for the recruited physician and all other requirements of this paragraph (e) are met.

(6) This paragraph (e) applies to remuneration provided by a federally qualified health center or a rural health clinic in the same manner as it applies to remuneration provided by a hospital, provided that the arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(f) *Isolated transactions.* Isolated financial transactions, such as a one-time sale of property or a practice, if all of the following conditions are met:

(1) The amount of remuneration under the isolated transaction is—

(i) Consistent with the fair market value of the transaction; and

(ii) Not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician or other business generated between the parties.

(2) The remuneration is provided under an agreement that would be commercially reasonable even if the physician made no referrals to the entity.

(3) There are no additional transactions between the parties for 6 months after the isolated transaction, except for transactions that are specifically excepted under the other provisions in §411.355 through §411.357 and except for commercially reasonable post-closing adjustments that do not take into account (directly or indirectly) the volume or value of referrals or other business generated by the referring physician.

(g) *Certain arrangements with hospitals.* Remuneration provided by a hospital to a physician if the remuneration does not relate, directly or indirectly, to the furnishing of DHS. To qualify as "unrelated," remuneration must be wholly unrelated to the furnishing of DHS and must not in any way take into account the volume or value of a physician's referrals. Remuneration relates to the furnishing of DHS if it—

(1) Is an item, service, or cost that could be allocated in whole or in part to Medicare or Medicaid under cost reporting principles;

(2) Is furnished, directly or indirectly, explicitly or implicitly, in a selective, targeted, preferential, or conditioned manner to medical staff or other persons in a position to make or influence referrals; or

(3) Otherwise takes into account the volume or value of referrals or other business generated by the referring physician.

(h) *Group practice arrangements with a hospital.* An arrangement between a hospital and a group practice under which DHS are furnished by the group but are billed by the hospital if the following conditions are met:

(1) With respect to services furnished to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1861(b)(3) of the Act.

(2) The arrangement began before, and has continued in effect without interruption since, December 19, 1989.

(3) With respect to the DHS covered under the arrangement, at least 75 percent of these services furnished to patients of the hospital are furnished by the group under the arrangement.

(4) The arrangement is in accordance with a written agreement that specifies

the services to be furnished by the parties and the compensation for services furnished under the agreement.

(5) The compensation paid over the term of the agreement is consistent with fair market value, and the compensation per unit of service is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(6) The compensation is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made to the entity.

(i) *Payments by a physician.* Payments made by a physician (or his or her immediate family member)—

(1) To a laboratory in exchange for the provision of clinical laboratory services; or

(2) To an entity as compensation for any other items or services that are furnished at a price that is consistent with fair market value, and that are not specifically excepted by another provision in §§411.355 through 411.357 (including, but not limited to, §411.357(1)). “Services” in this context means services of any kind (not merely those defined as “services” for purposes of the Medicare program in §400.202 of this chapter).

(j) *Charitable donations by a physician.* *Bona fide* charitable donations made by a physician (or immediate family member) to an entity if all of the following conditions are satisfied:

(1) The charitable donation is made to an organization exempt from taxation under the Internal Revenue Code (or to a supporting organization);

(2) The donation is neither solicited, nor offered, in any manner that takes into account the volume or value of referrals or other business generated between the physician and the entity; and

(3) The donation arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(k) *Nonmonetary compensation.* (1) Compensation from an entity in the form of items or services (not including cash or cash equivalents) that does not exceed an aggregate of \$300 per cal-

endar year, as adjusted for inflation in accordance with paragraph (k)(2) of this section, if all of the following conditions are satisfied:

(i) The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician.

(ii) The compensation may not be solicited by the physician or the physician’s practice (including employees and staff members).

(iii) The compensation arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act) or any Federal or State law or regulation governing billing or claims submission.

(2) The annual aggregate nonmonetary compensation limit in this paragraph (k) is adjusted each calendar year to the nearest whole dollar by the increase in the Consumer Price Index—Urban All Items (CPI-U) for the 12-month period ending the preceding September 30. CMS displays after September 30 each year both the increase in the CPI-U for the 12-month period and the new nonmonetary compensation limit on the physician self-referral Web site: [http://www.cms.hhs.gov/PhysicianSelfReferral/10\\_CPI-U\\_Updates.asp](http://www.cms.hhs.gov/PhysicianSelfReferral/10_CPI-U_Updates.asp).

(3) Where an entity has inadvertently provided nonmonetary compensation to a physician in excess of the limit (as set forth in paragraph (k)(1) of this section), such compensation is deemed to be within the limit if—

(i) The value of the excess nonmonetary compensation is no more than 50 percent of the limit; and

(ii) The physician returns to the entity the excess nonmonetary compensation (or an amount equal to the value of the excess nonmonetary compensation) by the end of the calendar year in which the excess nonmonetary compensation was received or within 180 consecutive calendar days following the date the excess nonmonetary compensation was received by the physician, whichever is earlier.

(iii) Paragraph (k)(3) may be used by an entity only once every 3 years with respect to the same referring physician.

(4) In addition to nonmonetary compensation up to the limit described in

paragraph (k)(1) of this section, an entity that has a formal medical staff may provide one local medical staff appreciation event per year for the entire medical staff. Any gifts or gratuities provided in connection with the medical staff appreciation event are subject to the limit in paragraph (k)(1).

(1) *Fair market value compensation.* Compensation resulting from an arrangement between an entity and a physician (or an immediate family member) or any group of physicians (regardless of whether the group meets the definition of a group practice set forth in §411.352) for the provision of items or services (other than the rental of office space) by the physician (or an immediate family member) or group of physicians to the entity, or by the entity to the physician (or an immediate family member) or a group of physicians, if the arrangement is set forth in an agreement that meets the following conditions:

(1) The arrangement is in writing, signed by the parties, and covers only identifiable items or services, all of which are specified in the agreement.

(2) The writing specifies the time-frame for the arrangement, which can be for any period of time and contain a termination clause, provided that the parties enter into only one arrangement for the same items or services during the course of a year. An arrangement made for less than 1 year may be renewed any number of times if the terms of the arrangement and the compensation for the same items or services do not change.

(3) The writing specifies the compensation that will be provided under the arrangement. The compensation must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physician. Compensation for the rental of equipment may not be determined using a formula based on—

(i) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated through the use of the equipment; or

(ii) Per-unit of service rental charges, to the extent that such

charges reflect services provided to patients referred by the lessor to the lessee.

(4) The arrangement is commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties.

(5) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(6) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates a Federal or State law.

(m) *Medical staff incidental benefits.* Compensation in the form of items or services (not including cash or cash equivalents) from a hospital to a member of its medical staff when the item or service is used on the hospital's campus, if all of the following conditions are met:

(1) The compensation is offered to all members of the medical staff practicing in the same specialty (but not necessarily accepted by every member to whom it is offered) without regard to the volume or value of referrals or other business generated between the parties.

(2) Except with respect to identification of medical staff on a hospital web site or in hospital advertising, the compensation is provided only during periods when the medical staff members are making rounds or are engaged in other services or activities that benefit the hospital or its patients.

(3) The compensation is provided by the hospital and used by the medical staff members only on the hospital's campus. Compensation, including, but not limited to, internet access, pagers, or two-way radios, used away from the campus only to access hospital medical records or information or to access patients or personnel who are on the hospital campus, as well as the identification of the medical staff on a hospital web site or in hospital advertising, meets the "on campus" requirement of this paragraph (m) of this section.

(4) The compensation is reasonably related to the provision of, or designed to facilitate directly or indirectly the

delivery of, medical services at the hospital.

(5) The compensation is of low value (that is, less than \$25) with respect to each occurrence of the benefit (for example, each meal given to a physician while he or she is serving patients who are hospitalized must be of low value). The \$25 limit in this paragraph (m)(5) is adjusted each calendar year to the nearest whole dollar by the increase in the Consumer Price Index—Urban All Items (CPI-I) for the 12 month period ending the preceding September 30. CMS displays after September 30 each year both the increase in the CPI-I for the 12 month period and the new limits on the physician self-referral web site: [http://www.cms.hhs.gov/PhysicianSelfReferral/10\\_CPI-U\\_Updates.asp](http://www.cms.hhs.gov/PhysicianSelfReferral/10_CPI-U_Updates.asp).

(6) The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties.

(7) The compensation arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(8) Other facilities and health care clinics (including, but not limited to, federally qualified health centers) that have *bona fide* medical staffs may provide compensation under this paragraph (m) on the same terms and conditions applied to hospitals under this paragraph (m).

(n) *Risk-sharing arrangements.* Compensation pursuant to a risk-sharing arrangement (including, but not limited to, withholds, bonuses, and risk pools) between a MCO or an IPA and a physician (either directly or indirectly through a subcontractor) for services provided to enrollees of a health plan, provided that the arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission. For purposes of this paragraph (n), “health plan” and “enrollees” have the meanings set forth in §1001.952(1) of this title.

(o) *Compliance training.* Compliance training provided by an entity to a physician (or to the physician’s imme-

diately family member or office staff) who practices in the entity’s local community or service area, provided that the training is held in the local community or service area. For purposes of this paragraph (o), “compliance training” means training regarding the basic elements of a compliance program (for example, establishing policies and procedures, training of staff, internal monitoring, or reporting); specific training regarding the requirements of Federal and State health care programs (for example, billing, coding, reasonable and necessary services, documentation, or unlawful referral arrangements); or training regarding other Federal, State, or local laws, regulations, or rules governing the conduct of the party for whom the training is provided. For purposes of this paragraph, “compliance training” includes programs that offer continuing medical education credit, provided that compliance training is the primary purpose of the program.

(p) *Indirect compensation arrangements.* Indirect compensation arrangements, as defined at §411.354(c)(2), if all of the following conditions are satisfied:

(1)(i) The compensation received by the referring physician (or immediate family member) described in §411.354(c)(2)(ii) is fair market value for services and items actually provided and not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician for the entity furnishing DHS.

(ii) Compensation for the rental of office space or equipment may not be determined using a formula based on—

(A) A percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed on or business generated in the office space or to the services performed or business generated through the use of the equipment; or

(B) Per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee.

(2) The compensation arrangement described in §411.354(c)(2)(ii) is set out in writing, signed by the parties, and



specifies the services covered by the arrangement, except in the case of a *bona fide* employment relationship between an employer and an employee, in which case the arrangement need not be set out in a written contract, but must be for identifiable services and be commercially reasonable even if no referrals are made to the employer.

(3) The compensation arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(q) *Referral services.* Remuneration that meets all of the conditions set forth in §1001.952(f) of this title.

(r) *Obstetrical malpractice insurance subsidies.* Remuneration that meets all of the conditions of paragraph (r)(1) or (2) of this section.

(1) Remuneration that meets all of the conditions set forth in §1001.952(o) of this title.

(2) A payment from a hospital, federally qualified health center, or rural health clinic that is used to pay for some or all of the costs of malpractice insurance premiums for a physician who engages in obstetrical practice as a routine part of his or her medical practice, if all of the following conditions are met:

(i)(A) The physician's medical practice is located in a rural area, a primary care HPSA, or an area with demonstrated need for the physician's obstetrical services as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(B) At least 75 percent of the physician's obstetrical patients reside in a medically underserved area or are members of a medically underserved population.

(ii) The arrangement is set out in writing, is signed by the physician and the hospital, federally qualified health center, or rural health clinic providing the payment, and specifies the payment to be made by the hospital, federally qualified health center, or rural health clinic and the terms under which the payment is to be provided.

(iii) The arrangement is not conditioned on the physician's referral of patients to the hospital, federally quali-

fied health center, or rural health clinic providing the payment.

(iv) The hospital, federally qualified health center, or rural health clinic does not determine (directly or indirectly) the amount of the payment based on the volume or value of any actual or anticipated referrals by the physician or any other business generated between the parties.

(v) The physician is allowed to establish staff privileges at any hospital(s), federally qualified health center(s), or rural health clinic(s) and to refer business to any other entities (except as referrals may be restricted under an employment arrangement or services contract that complies with §411.354(d)(4)).

(vi) The payment is made to a person or organization (other than the physician) that is providing malpractice insurance (including a self-funded organization).

(vii) The physician treats obstetrical patients who receive medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

(viii) The insurance is a *bona fide* malpractice insurance policy or program, and the premium, if any, is calculated based on a *bona fide* assessment of the liability risk covered under the insurance.

(ix)(A) For each coverage period (not to exceed 1 year), at least 75 percent of the physician's obstetrical patients treated under the coverage of the obstetrical malpractice insurance during the prior period (not to exceed 1 year)—

(1) Resided in a rural area, HPSA, medically underserved area, or an area with a demonstrated need for the physician's obstetrical services as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(2) Were part of a medically underserved population.

(B) For the initial coverage period (not to exceed 1 year), the requirements of paragraph (r)(2)(ix)(A) of this section will be satisfied if the physician certifies that he or she has a reasonable expectation that at least 75 percent of the physician's obstetrical patients treated under the coverage of the malpractice insurance will—

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(1) Reside in a rural area, HPSA, medically underserved area, or an area with a demonstrated need for the physician's obstetrical services as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(2) Be part of a medically underserved population.

(x) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(3) For purposes of paragraph (r)(2) of this section, *costs of malpractice insurance premiums* means:

(i) For physicians who engage in obstetrical practice on a full-time basis, any costs attributable to malpractice insurance; or

(ii) For physicians who engage in obstetrical practice on a part-time or sporadic basis, the costs attributable exclusively to the obstetrical portion of the physician's malpractice insurance, and related exclusively to obstetrical services provided—

(A) In a rural area, primary care HPSA, or an area with demonstrated need for the physician's obstetrical services, as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(B) In any area, provided that at least 75 percent of the physician's obstetrical patients treated in the coverage period (not to exceed 1 year) resided in a medically underserved area or were part of a medically underserved population.

(s) *Professional courtesy*. Professional courtesy (as defined at §411.351) offered by an entity with a formal medical staff to a physician or a physician's immediate family member or office staff if all of the following conditions are met:

(1) The professional courtesy is offered to all physicians on the entity's *bona fide* medical staff or in such entity's local community or service area without regard to the volume or value of referrals or other business generated between the parties;

(2) The health care items and services provided are of a type routinely provided by the entity;

(3) The entity has a professional courtesy policy that is set out in writing and approved in advance by the entity's governing body;

(4) The professional courtesy is not offered to a physician (or immediate family member) who is a Federal health care program beneficiary, unless there has been a good faith showing of financial need; and

(5) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(t) *Retention payments in underserved areas*—(1) *Bona fide written offer*. Remuneration provided by a hospital directly to a physician on the hospital's medical staff to retain the physician's medical practice in the geographic area served by the hospital (as defined in paragraph (e)(2) of this section), if all of the following conditions are met:

(i) The physician has a *bona fide* firm, written recruitment offer or offer of employment from a hospital, academic medical center (as defined at §411.355(e)), or physician organization (as defined at §411.351) that is not related to the hospital making the payment, and the offer specifies the remuneration being offered and requires the physician to move the location of his or her medical practice at least 25 miles and outside of the geographic area served by the hospital making the retention payment.

(ii) The requirements of §411.357(e)(1)(i) through §411.357(e)(1)(iv) are satisfied.

(iii) Any retention payment is subject to the same obligations and restrictions, if any, on repayment or forgiveness of indebtedness as the written recruitment offer or offer of employment.

(iv) The retention payment does not exceed the lower of—

(A) The amount obtained by subtracting the physician's current income from physician and related services from the income the physician would receive from comparable physician and related services in the written recruitment or employment offer, provided that the respective incomes are determined using a reasonable and consistent methodology, and that they are

calculated uniformly over no more than a 24-month period; or

(B) The reasonable costs the hospital would otherwise have to expend to recruit a new physician to the geographic area served by the hospital to join the medical staff of the hospital to replace the retained physician.

(v) The requirements of paragraph (t)(3) are satisfied.

(2) *Written certification from physician.* Remuneration provided by a hospital directly to a physician on the hospital's medical staff to retain the physician's medical practice in the geographic area served by the hospital (as defined in paragraph (e)(2) of this section), if all of the following conditions are met:

(i) The physician furnishes to the hospital before the retention payment is made a written certification that the physician has a *bona fide* opportunity for future employment by a hospital, academic medical center (as defined at §411.355(e)), or physician organization (as defined at §411.351) that requires the physician to move the location of his or her medical practice at least 25 miles and outside the geographic area served by the hospital. The certification contains at least the following—

(A) Details regarding the steps taken by the physician to effectuate the employment opportunity;

(B) Details of the physician's employment opportunity, including the identity and location of the physician's future employer or employment location or both, and the anticipated income and benefits (or a range for income and benefits);

(C) A statement that the future employer is not related to the hospital making the payment;

(D) The date on which the physician anticipates relocating his or her medical practice outside of the geographic area served by the hospital; and

(E) Information sufficient for the hospital to verify the information included in the written certification.

(ii) The hospital takes reasonable steps to verify that the physician has a *bona fide* opportunity for future employment that requires the physician to relocate outside the geographic area served by the hospital.

(iii) The requirements of §411.357(e)(1)(i) through §411.357(e)(1)(iv) are satisfied.

(iv) The retention payment does not exceed the lower of—

(A) An amount equal to 25 percent of the physician's current income (measured over no more than a 24-month period), using a reasonable and consistent methodology that is calculated uniformly; or

(B) The reasonable costs the hospital would otherwise have to expend to recruit a new physician to the geographic area served by the hospital to join the medical staff of the hospital to replace the retained physician.

(v) The requirements of paragraph (t)(3) are satisfied.

(3) Remuneration provided under paragraph (t)(1) or (t)(2) must meet the following additional requirements:

(i)(A) The physician's current medical practice is located in a rural area or HPSA (regardless of the physician's specialty) or is located in an area with demonstrated need for the physician as determined by the Secretary in an advisory opinion issued in accordance with section 1877(g)(6) of the Act; or

(B) At least 75 percent of the physician's patients reside in a medically underserved area or are members of a medically underserved population.

(ii) The hospital does not enter into a retention arrangement with a particular referring physician more frequently than once every 5 years.

(iii) The amount and terms of the retention payment are not altered during the term of the arrangement in any manner that takes into account the volume or value of referrals or other business generated by the physician.

(iv) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(4) The Secretary may waive the relocation requirement of paragraphs (t)(1) and (t)(2) of this section for payments made to physicians practicing in a HPSA or an area with demonstrated need for the physician through an advisory opinion issued in accordance with

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section 1877(g)(6) of the Act, if the retention payment arrangement otherwise complies with all of the conditions of this paragraph.

(5) This paragraph (t) applies to remuneration provided by a federally qualified health center or a rural health clinic in the same manner as it applies to remuneration provided by a hospital.

(u) *Community-wide health information systems.* Items or services of information technology provided by an entity to a physician that allow access to, and sharing of, electronic health care records and any complementary drug information systems, general health information, medical alerts, and related information for patients served by community providers and practitioners, in order to enhance the community's overall health, provided that—

(1) The items or services are available as necessary to enable the physician to participate in a community-wide health information system, are principally used by the physician as part of the community-wide health information system, and are not provided to the physician in any manner that takes into account the volume or value of referrals or other business generated by the physician;

(2) The community-wide health information systems are available to all providers, practitioners, and residents of the community who desire to participate; and

(3) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(v) *Electronic prescribing items and services.* Nonmonetary remuneration (consisting of items and services in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information, if all of the following conditions are met:

(1) The items and services are provided by a—

(i) Hospital to a physician who is a member of its medical staff;

(ii) Group practice (as defined at §411.352) to a physician who is a mem-

ber of the group (as defined at §411.351); or

(iii) PDP sponsor or MA organization to a prescribing physician.

(2) The items and services are provided as part of, or are used to access, an electronic prescription drug program that meets the applicable standards under Medicare Part D at the time the items and services are provided.

(3) The donor (or any person on the donor's behalf) does not take any action to limit or restrict the use or compatibility of the items or services with other electronic prescribing or electronic health records systems.

(4) For items or services that are of the type that can be used for any patient without regard to payer status, the donor does not restrict, or take any action to limit, the physician's right or ability to use the items or services for any patient.

(5) Neither the physician nor the physician's practice (including employees and staff members) makes the receipt of items or services, or the amount or nature of the items or services, a condition of doing business with the donor.

(6) Neither the eligibility of a physician for the items or services, nor the amount or nature of the items or services, is determined in a manner that takes into account the volume or value of referrals or other business generated between the parties.

(7) The arrangement is set forth in a written agreement that—

(i) Is signed by the parties;

(ii) Specifies the items and services being provided and the donor's cost of the items and services; and

(iii) Covers all of the electronic prescribing items and services to be provided by the donor. This requirement is met if all separate agreements between the donor and the physician (and the donor and any family members of the physician) incorporate each other by reference or if they cross-reference a master list of agreements that is maintained and updated centrally and is available for review by the Secretary upon request. The master list must be maintained in a manner that preserves the historical record of agreements.

(8) The donor does not have actual knowledge of, and does not act in reckless disregard or deliberate ignorance

of, the fact that the physician possesses or has obtained items or services equivalent to those provided by the donor.

(w) *Electronic health records items and services.* Nonmonetary remuneration (consisting of items and services in the form of software or information technology and training services) necessary and used predominantly to create, maintain, transmit, or receive electronic health records, if all of the following conditions are met:

(1) The items and services are provided by an entity (as defined at §411.351) to a physician.

(2) The software is interoperable (as defined at §411.351) at the time it is provided to the physician. For purposes of this paragraph, software is deemed to be interoperable if a certifying body recognized by the Secretary has certified the software no more than 12 months prior to the date it is provided to the physician.

(3) The donor (or any person on the donor's behalf) does not take any action to limit or restrict the use, compatibility, or interoperability of the items or services with other electronic prescribing or electronic health records systems.

(4) Before receipt of the items and services, the physician pays 15 percent of the donor's cost for the items and services. The donor (or any party related to the donor) does not finance the physician's payment or loan funds to be used by the physician to pay for the items and services.

(5) Neither the physician nor the physician's practice (including employees and staff members) makes the receipt of items or services, or the amount or nature of the items or services, a condition of doing business with the donor.

(6) Neither the eligibility of a physician for the items or services, nor the amount or nature of the items or services, is determined in a manner that directly takes into account the volume or value of referrals or other business generated between the parties. For purposes of this paragraph, the determination is deemed not to directly take into account the volume or value of referrals or other business generated between the parties if any one of the following conditions is met:

(i) The determination is based on the total number of prescriptions written by the physician (but not the volume or value of prescriptions dispensed or paid by the donor or billed to the program);

(ii) The determination is based on the size of the physician's medical practice (for example, total patients, total patient encounters, or total relative value units);

(iii) The determination is based on the total number of hours that the physician practices medicine;

(iv) The determination is based on the physician's overall use of automated technology in his or her medical practice (without specific reference to the use of technology in connection with referrals made to the donor);

(v) The determination is based on whether the physician is a member of the donor's medical staff, if the donor has a formal medical staff;

(vi) The determination is based on the level of uncompensated care provided by the physician; or

(vii) The determination is made in any reasonable and verifiable manner that does not directly take into account the volume or value of referrals or other business generated between the parties.

(7) The arrangement is set forth in a written agreement that—

(i) Is signed by the parties;

(ii) Specifies the items and services being provided, the donor's cost of the items and services, and the amount of the physician's contribution; and

(iii) Covers all of the electronic health records items and services to be provided by the donor. This requirement is met if all separate agreements between the donor and the physician (and the donor and any family members of the physician) incorporate each other by reference or if they cross-reference a master list of agreements that is maintained and updated centrally and is available for review by the Secretary upon request. The master list must be maintained in a manner that preserves the historical record of agreements.

(8) The donor does not have actual knowledge of, and does not act in reckless disregard or deliberate ignorance

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of, the fact that the physician possesses or has obtained items or services equivalent to those provided by the donor.

(9) For items or services that are of the type that can be used for any patient without regard to payer status, the donor does not restrict, or take any action to limit, the physician's right or ability to use the items or services for any patient.

(10) The items and services do not include staffing of physician offices and are not used primarily to conduct personal business or business unrelated to the physician's medical practice.

(11) The electronic health records software contains electronic prescribing capability, either through an electronic prescribing component or the ability to interface with the physician's existing electronic prescribing system that meets the applicable standards under Medicare Part D at the time the items and services are provided.

(12) The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any Federal or State law or regulation governing billing or claims submission.

(13) The transfer of the items or services occurs and all conditions in this paragraph (w) are satisfied on or before December 31, 2013.

[72 FR 51091, Sept. 5, 2007; 72 FR 68076, Dec. 4, 2007, as amended at 73 FR 48752, Aug. 19, 2008; 73 FR 57543, Oct. 3, 2008]

### §411.361 Reporting requirements.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, all entities furnishing services for which payment may be made under Medicare must submit information to CMS or to the Office of Inspector General (OIG) concerning their reportable financial relationships (as defined in paragraph (d) of this section), in the form, manner, and at the times that CMS or OIG specifies.

(b) *Exception.* The requirements of paragraph (a) of this section do not apply to entities that furnish 20 or fewer Part A and Part B services during a calendar year, or to any Medicare covered services furnished outside the United States.

(c) *Required information.* The information requested by CMS or OIG can include the following:

(1) The name and unique physician identification number (UPIN) or the national provider identifier (NPI) of each physician who has a reportable financial relationship with the entity.

(2) The name and UPIN or NPI of each physician who has an immediate family member (as defined at §411.351) who has a reportable financial relationship with the entity.

(3) The covered services furnished by the entity.

(4) With respect to each physician identified under paragraphs (c)(1) and (c)(2) of this section, the nature of the financial relationship (including the extent or value of the ownership or investment interest or the compensation arrangement) as evidenced in records that the entity knows or should know about in the course of prudently conducting business, including, but not limited to, records that the entity is already required to retain to comply with the rules of the Internal Revenue Service and the Securities and Exchange Commission and other rules of the Medicare and Medicaid programs.

(d) *Reportable financial relationships.* For purposes of this section, a reportable financial relationship is any ownership or investment interest, as defined at §411.354(b) or any compensation arrangement, as defined at §411.354(c), except for ownership or investment interests that satisfy the exceptions set forth in §411.356(a) or §411.356(b) regarding publicly-traded securities and mutual funds.

(e) *Form and timing of reports.* Entities that are subject to the requirements of this section must submit the required information, upon request, within the time period specified by the request. Entities are given at least 30 days from the date of the request to provide the information. Entities must retain the information, and documentation sufficient to verify the information, for the length of time specified by the applicable regulatory requirements for the information, and, upon request, must make that information and documentation available to CMS or OIG.

(f) *Consequences of failure to report.* Any person who is required, but fails,