Perils of physician-owned PT practices

By Mark Cantrell

There was a time, not so long ago, when most PTs worked as hospital employees. After World War II, the PT profession came into its own with increasingly formalized standards of care, and today the DPT degree and the spread of direct access has raised the profession to a more respected status. But those gains are being overshadowed by another trend — the employment of therapists by physicians — and some fear those gains will be erased.

The APTA has gone on record against this practice, stating that it "opposes the ownership of physical therapy services by physicians, and supports federal and state laws and regulations that prohibit physician ownership of physical therapy services." However, just two states — Delaware and South Carolina — actually prohibit doctors from owning PT practices.

Identifying the pieces

"Employment of PTs by physicians has grown dramatically over the last 10 years," notes Francis Welk, PT, DPT, MEd, a PT consultant in Bloomsburg, Pa. "I would suggest that a lot of it is a result of the healthcare dollar getting tighter. Physicians have learned that they can exchange a stream of patients for some revenue if they employ physical therapists. It's about marketplace control and revenue streams."

Doug Sparks, a Wall Street investment banker based in Houston, noticed the trend and realized it presented an opportunity to broker those partnerships. His firm, MD+PT=Partners LLC, has garnered more than three million dollars in the past year by setting up contract arrangements between doctors and PTs. "The biggest problem therapists have is physicians bringing PT in-house," Sparks says. "My objective is to take PT practices that are already working with a physician and have the physical therapist provide services for him under the doctor's provider number. The physician bills and collects for the services, and when he gets paid, he pays you for that work."

The advantage for the therapist is a guaranteed revenue stream that ensures a measure of practice stability. The disadvantage is that physicians retain between 8 and 10 percent of monies collected — but that loss is offset by higher patient volume, Sparks says. "Many therapists think you're the devil for even suggesting they work with a physician, but what else are you going to do? Since doctors are looking for solutions, I tell PTs they might as well be that solution."

In 1989, Congress passed the first physician self-referral (Stark) law, designed to prevent doctors from referring patients to a facility in which they have a financial interest. It was subsequently expanded to include physical therapy services in 1993. "But there were some exceptions written in, so the bottom line is that the Stark Law essentially does allow physician ownership of PT," Welk says.

Right fit?

But just because a practice isn't specifically prohibited by law doesn't mean it's good for the profession; Welk asks: "What happens to the consumer's choice under that model? If a single therapist is getting all the referrals for a physician, how is that benefiting the patient? We want to move toward APTA's concept of Vision 2020 and a higher degree of professionalism, and going back into an employment setting under a physician seems to be the antithesis of that."

"For the past 60 or 70 years, our profession has gradually become more autonomous," Welk continues. "We've taken control of our own licensure process and moved away from outside regulation and control, to control by the profession.

A Brief History of Stark Laws

1972 Congress passes an anti-kickback rule prohibiting MDs and other providers from accepting compensation for generating business from Medicare or Medicaid. Exceptions apply.

1989 Stark I enacted. MDs may not refer patients to a clinical laboratory in which they have a financial interest. Exceptions apply.

1993 Stark II. The referral ban is extended to 10 more services, including PT. Exceptions apply.

2007 Stark III. Existing prohibitions are refined and clarified.

As more of us achieve DPT, we aspire to an even higher level of independence and autonomy, including control of the economic and business aspects."

That's not to say that there should be a contentious relationship between doctors and therapists, Welk explains. "The [PT] profession certainly wants to work with physicians and the established medical models. Even as we move toward what we see as more autonomy and independence in our practices, that's a bond we want to retain — that bond of collaboration and interdependent practices."

Control issues

Still, any partnership between an MD and a PT must address issues of control, and that depends on what each party brings to the table, says David Glusman, CPA, DABFA, CFS, CrFA, a consultant with Margolis & Company PC in Bala Cynwyd, Pa. "If bringing capital to the venture is prime, then whoever has more ability to raise capital will gain a majority interest. If control of the original patient base is key, the physician will likely have the ability to control the venture. If the operation and recruitment of the PT side is prime, the physical therapist will more likely be in control."

Glusman adds, "The essence is the golden rule: He with the most gold makes the rules — the gold being whatever is most valuable to the venture."

The best model for therapist-physician collaboration, Welk says, is a simple leasing agreement. "If a doctor has, say, 1,500 square feet available, you can approach him and say, 'I'll lease that from you at fair market value and will see your patients and anyone else's who come through the door.' It becomes a purely landlord-tenant arrangement." ●

Mark Cantrell is a medical writer for the Gannett Healthcare Group. To comment on this story, send e-mail to pteditor@gannetthg.com.

Resource

Centers for Medicare and Medicaid, Physician Self Referral: www.cms.hhs.gov/PhysicianSelfReferral/04a_regphase3.asp