

The Doctor's Chart

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THE IMPORTANCE OF SIGNING NON-COMPETITION AGREEMENTS

In this article, we are addressing a common business problem of provider groups: the interplay between the non-competition agreement and confidential business information.

For many years we represented a solo practitioner from a small town in northern Wisconsin. About three years ago, he decided to buy a competing practice in the same town from a practitioner who was retiring. The two practices were merged into one location. Our client's motivation was to expand the practice to an extent that would allow him to add another practitioner to his business. He would then share schedules and calls, with the ultimate goal of someday selling the entire practice to his new colleague.

Our client recruited a young practitioner. After about one month with the retiring practitioner, the young practitioner took over the patient base of the retiring doctor.

Our client had us draft an

employment and non-competition agreement, which was presented to the new practitioner on his first day in the office. Despite our advice, our client did not insist that these two documents be signed prior to the commencement of employment. About two months later, our office followed up to get signed copies of the documents for our files. Our client told us that they were not signed as of yet. We reminded him of our concerns if the non-compete was not signed. He eventually responded and gave us some changes that the new practitioner wanted made; we adjusted the document and returned it to our client. More time passed without our hearing anything. Again, we contacted our client and again the same story . . . the new practitioner had more issues. By this point it was becoming clear that this new practitioner was concerned more with stalling things than he was with signing

tract. We voiced our serious concerns over the situation and suggested if something was not worked out soon, that our client should strongly consider finding a practitioner who would negotiate in good faith and sign the document. Our client felt that recruiting a new provider would be too much work and that the young man would sign eventually. This back-and-forth went on for over two years with our client almost always agreeing to make the modifications requested. (From the author's experience, the contract was a fair agreement for both parties from the beginning).

Finally, things came to a head and the two sides met in our office and discussed all of the young practitioner's latest issues. At the conclusion of the meeting, all agreed what the terms of the agreement would be. Shortly thereafter, at 6:35 p.m. on a Friday night, the young practitioner

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walked into our client's office, dropped his keys on the desk and informed our client that he was quitting, effective immediately, and walked out. Our client never saw it coming.

By the following Monday the young practitioner was open for business in his new practice on the same side of the street just two blocks away. The hemorrhaging of patients from our client to his erstwhile colleague's new business started immediately; almost every patient that he had scheduled at our client's office was seen at the new practitioner's new business. Despite our client's efforts to stem the tide, within two weeks it was clear that over ninety percent of the patients from the practice that our client purchased two years prior were now being treated by the new practitioner in his new practice. Our client lost almost the entire practice that he bought while still deeply in debt from his original purchase.

Our client filed a lawsuit against his ex-employee, alleging breach of trade secrets, breach of duty of loyalty, as well as various other causes of action. Despite the fact that it was proven that the young practitioner took copies of the patient schedules and sent letters to patients the day before he left, the court felt that he did not violate the trade secret laws because our client failed to adequately protect the client list and the patient schedules. The judge relied primarily on the fact that the schedules were located at the front desk and were not adequately marked as confidential, as well as the fact that our client had

a patient sign-up sheet on the front counter for all patients to see. The court's conclusion, therefore, was that the young practitioner legally took the data and used it to convert almost the entire patient base to his new practice.

Additionally, it was proven that while employed by our client, the young practitioner negotiated yellow page ads for his new practice even while he was participating in the formatting of our client's yellow page ad; that he was using our



client's phones to set up his business (our client paid the long distance charges for his future competitor to set up shop); that he put together his client list for his new practice while employed and sent out letters to these clients two days before his departure; and that he offered employment to a clerical employee of our client while both were still employed by our client.

As the litigation progressed, we started to feel that the judge was not seeing things our way and attempted to negotiate a settlement. We did reach an agreement that would have paid for the cost of litigation plus a small amount for damages. Our client decided not to accept the offer and two weeks later the judge dismissed the case. While we felt that this case could have been successful on appeal, the costs were prohibitive. Our client got nothing but a large attorney's bill.

The end result was that our client lost the practice he had purchased a couple years earlier while still largely in debt for the practice and subject to a large overhead.

Throughout the litigation, the judge focused on one theme: "Why did you not have signed employment and non-compete agreements for this employee?" That seemed to be his primary focus and in his decision, he stated that had a non-compete agreement been signed, our client would have likely succeeded.

While non-competes are tough to enforce, they are in many cases vital to help protect medical practices. Of course, the non-compete must be drafted properly to be enforceable and we suggest that your attorney be consulted regarding the agreement. Many times clients use forms from state associations or off the internet. Because of the uniqueness of Wisconsin law relating to non-competes, we find that many of these agreements are not enforceable.

LESSON #1: Get employment and Non-Compete documents drafted properly and make sure the agreements are signed prior to commencing employment.

LESSON #2: Treat patient lists and business records as if your retirement depended on it...make sure you properly mark these records as confidential and make sure you restrict access to "need to know only." Enforce a trade secrets policy.

ARGUING OVER THE SHAPE OF THE TABLE: STRATEGIES FOR SUCCESSFUL MANAGED CARE CONTRACTING

As managed care has gradually become a permanent part of the U.S. medical landscape, all physicians have been forced to live with this monolith. And while most doctors have become accustomed to the idiosyncrasies (many only reluctantly), of the physician-Managed Care Organization (MCO) relationship, certain incidents of that dynamic remain mysterious, and unfortunately quite problematic. This piece will examine one such portion of the relationship: putting together the managed care contract.

Managed care contracts can become relevant in a host of circumstances. One of the most common situations is when an MCO, seeking to improve a particular portion of its service capacity, (i.e., the surgery department) brings an entire new group of providers in to take over that area. Having been involved in the negotiation and formation of a variety of physician group-MCO contracts, the attorneys of this law firm have learned a couple of valuable lessons. It is our advice that while managed care contracts can present a lucrative opportunity, doctors who find themselves salivating would do well to slow down and think about some of the following principles before rushing headlong into a negotiation:

(1) “A house divided upon itself cannot stand....”

While President Lincoln would probably turn over in his grave at the thought of his eloquent words being imported into the context of managed care, his remarks are nonetheless instructive. We cannot over-emphasize enough the importance of the physician group members achieving a consensus among themselves as to the group’s collective goals in any negotiation. This is important for a number of reasons. For one, as with any negotiation, the physician group will assuredly have to give in on a few things before a deal can be consummated. It is crucial, therefore, that the doctors decide what they absolutely will not sacrifice so that they can focus like a laser-beam on ensuring that the key points are achieved. Two, it is essential that the physician group present a united front and negotiate from a position of strength. Attorneys who represent MCOs in these types of negotiations are often quite slick, and sometimes a little arrogant, and will, if they sense indecision or confusion, which will translate to them as meaning weakness, try to bludgeon the physicians into surrender. Doctors who are able to say in good faith that they absolutely cannot take the MCO’s proposal back to their group for consideration without risking a lynching will have much more success in staring down the MCO’s inevitable good cop-bad cop strategy. Finally, there is always the danger that a managed care contract will ultimately prove to have been a mistake. If dissension exists among the group members at the outset, i.e., if the contract is signed with certain physicians not on board, the recriminations that will inevitably erupt in the future will likely jeopardize the long-term well being of the group.

In our experience, one of the best ways to do this is to sit down with the entire group, (not just the key decision-makers) over dinner, or some other relaxed setting, to really talk things through. Affording one medical group client of ours ample time in which questions can be raised in front of all the members, and ensuring that the group’s questions were answered in front of everyone, proved to be our best experience as far as getting all the doctors on the same page.

(2) OBJECTIVITY BREEDS SUCCESS

It is important when first approached by an MCO to step back and evaluate your group objectively. As we noted above, during a negotiation, you will undoubtedly be called upon to make sacrifices. You will acquiesce because it is an innate part of the process. However, if you do not have an unbiased understanding of your strengths and weaknesses from the start, you may find yourself seeking to obtain concessions that are simply unrealistic. Not only does this render you prone to blowing the whole deal, but your intransigence may poison the relationship between the group and the MCO from the outset. Moreover, an unre-

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alistic self-appraisal will unnecessarily prolong the cost and duration of the negotiating process.

In contrast, a sober overview of what it is that you have to offer, as well as your drawbacks, will allow you to negotiate from a position of strength. In our experience, we have found, for instance, that many physicians are loath to accept any sort of post-contract restrictive covenant. It must be remembered, however, that an MCO can hardly enter an arrangement that could allow a group of independent physicians to undercut an entire area of medical practice. While it can be difficult to convince medical groups of the value of analyzing their strengths and weaknesses objectively, I can say in all candor that the best contracts this office has put together have all involved physicians who were willing to do so. Rather than insisting on an untenable concession, and imperiling the chances of even reaching an agreement, a far more productive approach is to focus on the obtainable.

(3) ALLS WELL THAT ENDS WELL

Bearing that old adage in mind is definitely a good idea. As the negotiating process proceeds, you may find yourself feeling like things might be moved along through the occasional unilateral concession. But while making these gestures may speed things up, there are, from our experience, a number of reasons you should do so only carefully.

For one, the MCO needs you at least as much as you need it. The strength that MCOs generally have dictates that when a CEO approaches you, he is doing so for a reason. Rare indeed are service relationships entered into between physician groups and MCOs that are put into place at the former's behest. Thus, keep in mind that in spite of what might appear to be a discrepancy in bargaining power, you are not without recourse. Don't be afraid to use the power you have.

Two, any arrangement that is ultimately finalized will certainly have particular aspects which you would prefer to see adjusted. Your opportunity to improve the arrangement is very short lived; for the most part it is limited to the negotiation itself. Giving things away before you have to, and without obtaining something you want in return, will inevitably harm you because when the situation arises in which you need to concede something to procure something more valuable in return, and you find yourself lacking any cards to play, your success will ultimately turn upon the generosity, or perhaps the lack thereof, of the MCO (or worse, their attorneys!).

Three, you need to remember that any negotiation is a business and that the MCO's administration is primarily concerned not with making friends, but with getting something done to improve its facilities. This means, for instance, that they are not going to give you an enhanced payment rate unless they have to. Likewise, you should not give them a lower payment rate unless you have to, or at least unless you get something in exchange.

Finally, keep in mind that concessions granted too readily will convey a message of weakness, rather than strength, and will, accordingly, significantly impair your negotiating position. If you unilaterally agree, for example, to waive traditional peer review protections, without getting something in exchange, you are sending the message that you will accept less than optimal conditions merely to get the deal done. This will teach the MCO that it can get what it wants simply by insisting on it and adopting a condescending "take it or leave it" approach.

(4) KNOWLEDGE IS POWER

Few people would enter into a long-term business relationship that will dictate whatever professional success they have without knowing exactly what they are getting into. Unfortunately, however, the all-encompassing nature of a managed care contract, as well as the often prolonged duration of the negotiating process, leads to situations in which physicians sometimes overlook crucial aspects of the relationship. Obviously, any complexity inherent in the relationship will depend on a variety of factors; service

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contracts involving entities financed through tax-exempt bonds, for instance, will present a host of challenges that are not otherwise relevant. Nevertheless, there are certain issues the relevance of which transcends the precise nature of the MCO. Clearly, the method of compensation is one issue of paramount importance in any negotiation. There are a variety of approaches to the question of how the physician group is to be compensated. Each will have certain advantages and disadvantages. Thus, it is important for the group to go into a negotiation not only with a clear idea of how they would like to be paid, but also with a knowledge of the other payment methods that are available. Does it make sense, for example, to include a most favored nation clause? Is a discounted fee-for-service method tied to Medicare payment rates the way to go? If so, how should the payment scale be increased? Furthermore, even if a payment method is agreed upon, can we be sure that it comports with the opaque Stark and Anti-kickback law obligations? Possessing a solid baseline of understanding will aid your group not only in getting what you want, but will also demonstrate to the MCO that you know what you are doing. Our most successful negotiations have all involved the same kind of physician-client: doctors who are not afraid to ask us questions and who have a genuine desire to grasp the details of the contract. It is one thing if your attorney assures you, for example, that your contract is compliant with the fraud and abuse laws; it is entirely another, however, if the physicians themselves understand why compliance exists.

5. FIELD YOUR BEST TEAM

One of the first things you will need to decide is who, precisely, you will put forth as your negotiating team. There are a variety of choices here, and what is right for one group might not necessarily be appropriate for another. While the knowledge and experience that outside assistance can bring may prove invaluable, obtaining the same sometimes requires a serious financial commitment. Whatever you ultimately decide, however, there are a few tools which we feel you would be well served to deploy in any negotiation. For one, presenting a small negotiating team is generally more effective than using a larger one. Attempting to speak with too many voices can lead to discord and a negotiation stymied by raucous cacophony. Two, it is wise not to include your group's ultimate decision-maker (i.e., the president) in the negotiating team. The absence of this individual will afford your team the ability to excuse itself from the negotiation, under the pretext of "checking with the boss," if doing so is necessary to avoid being pressured into some less than optimal contract. This can be a valuable maneuver and it is one that we have used on our clients' behalves on numerous occasions. Finally, you should endeavor to ensure that your negotiating team is well apprised of the concerns of all the physicians in your group. Although the significance of this will likely vary with the size and centralization of your organization, failing to settle these issues at the outset will not only imperil the nascent relationship with the MCO, but may foster dissension among the doctors.

Where do we go from here?

The foregoing points are of course only the tip of the iceberg. Most managed care negotiations are fraught with complexity and hard bargaining. Unfortunately, the course of the negotiation is less likely to be as smooth as you might hope. It is not uncommon for these things to be dragged out for over a year. The difficulties and frustrations which you and your colleagues will inevitably encounter will rock your confidence and make you question why it is you even started down the road in the first place. Still, the financial and professional benefits that can accrue from the formation of a long-term services agreement with a successful MCO cannot be overstated. Adopting an intelligent and tough negotiating posture will be invaluable to your efforts to secure the most beneficial agreement possible.

A LITTLE PREVENTION COULD SAVE YOUR PRACTICE

Recently a healthcare client contacted our office with several serious issues. The provider (“Dr. Ross”) is located in Duluth, Minnesota, and owns his own practice. He has been practicing for thirty-five years and recently sold his practice to a younger provider (“Dr. Green”). Dr. Ross entered into an employment agreement with Dr. Green for three years to help ensure a smooth transition and provide Dr. Ross with a healthy income before he fully retires.

Upon taking the practice over, Dr. Green identified problems with client billing and immediately corrected the errors. Most of the issues identified by Dr. Green were simple to correct. However, Dr. Ross did have one fairly serious problem. Several years earlier, Dr. Ross implemented a policy to bill no-shows unless the patient provided twenty-four hour notice. Under this policy, Dr. Ross billed Medicare/Medicaid when Medicare/Medicaid patients failed to show up without providing the requisite notice. This practice was quickly stopped once Dr. Green took over.

Unfortunately for Dr. Ross, the transition did not go smoothly. The two providers frequently argued and their relationship quickly deteriorated. Ultimately, Dr. Green fired Dr. Ross and refused to pay him under the terms of his contract. Dr. Ross then decided to open up a new practice. Once Dr. Green learned of this, he reported Dr. Ross to the state for illegally billing Medicare and Medicaid. The state then contacted the Office of Inspector General. Dr. Ross is now under a full investigation.

Dr. Ross is facing prosecution under the False Claims Act (“FCA”). The FCA, which has civil and criminal applications, has become the statute of choice for fighting healthcare fraud. Cases litigated under the FCA generally begin in one of the following four ways: (1) the filing of a *qui tam* case by a private party (“Realtor”) alleging fraud; (2) an investigation by a federal auditor, investigator, or fiscal intermediary; (3) a national fraud “initiative” targeting a similar group (hospitals, labs, etc.); or (4) a referral from a federal or state criminal prosecutor. The FCA contains a unique enforcement mechanism, which permits private citizens, called *qui tam* Realtors, to file suit on behalf of the government. In a *qui tam* action, the government decides whether to pursue the action; if the government declines, the Realtor may pursue the action alone. The Realtor is allowed to collect a percentage of the money won in any settlement or judgment. These incentives are so enticing that *qui tam* suits have become the major source of FCA cases.

Dr. Ross worsened his situation by failing to implement an effective compliance program. He is facing tremendous civil penalties and possible criminal prosecution for inappropriate Medicare billing.

At the outset, Dr. Ross should have performed more research to determine if the practice of billing no-shows was acceptable. Furthermore, a compliance program for Dr. Ross’ practice would have been a minor expense when compared with the penalties he is now facing. Within a compliance program we generally recommend that

hotlines or anonymous drop boxes be used to allow employees a way to voice their concerns without fear of retaliation. With these devices in place, an employer can argue that the Realtor is simply motivated by personal profit and that the Realtor should have used the outlet before going forward with a *qui tam* action. In addition, Dr. Ross could have performed a small audit on himself to uncover potential fraud and abuse issues. This could be done with random sampling or a full audit; either kind would have revealed many of these problems. Before performing an audit, a physician should remember to utilize an attorney’s services to take advantage of the protections of the attorney-client privilege. By taking some of these steps and consulting an attorney with expertise, Dr. Ross could have avoided the problems he now faces.

Once a problem is discovered, a physician must perform an internal audit pursuant to the compliance program the physician has enacted. This audit should address all records, not merely a sampling. Again, it is wise for the physician to contact an attorney, and the attorney should set up and document the investigation process to maximize the application of the attorney-client and work-product privileges. With a full and objective internal investigation, the physician may be able to convince

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federal and state authorities that a government-led independent investigation is unnecessary. This will ultimately minimize disruption and headaches. An effective corporate compliance program combined with an objective internal audit may influence the prosecutor's decision to file criminal charges and help persuade the government to settle without a lengthy investigation.

The FCA's power is apparent in the penalties that can be imposed under its auspices; the most devastating is the \$5,000-\$11,000 per claim penalty. This penalty is assessed on a per-claim basis regardless of the damages. These penalties are deemed to be mandatory with only two possible exceptions: (1) in the area of voluntary disclosure; and (2) when penalties clearly exceed any rational damages claim. With these two narrow exceptions aside, there is very little room for a physician to avoid civil liability if the claims were fraudulently submitted.

In a case like the aforementioned, Dr. Ross is possibly facing hundreds of thousands of dollars in penalties. Dr. Ross billed Medicare no-shows for a number of years. At this point in the case, we were forced to practice damage control. However, with a little counseling and compliance review much of the doctor's problems could have been averted. Physicians should undertake a little preventative medicine of their own and understand their rights should the government ever come knocking. *While this story is true, names and locations have been adjusted to protect confidentiality.*

PEER REVIEW PITFALL: THE STORY OF HOW ONE DOCTOR STARED DOWN THE PEER REVIEW COMMITTEE

As unthinkable as it may seem right now, anyone reading this could someday have his or her medical staff privileges suspended or revoked. Any such occurrence is a very serious issue, and carries with it profound implications. Given the drastic nature of any adverse peer review action, one hopes that such a thing would only transpire in the direst of circumstances. Unfortunately, however, it has been the experience of this office that adverse peer review actions sometimes derive not from a genuine concern for patient care, but rather as a consequence of petty intraoffice politics. This article is the story of how one physician and her attorneys responded to an ill-founded peer review action.

As we all know, people for one reason or another, sometimes rub other people the wrong way. In this case, the physician in question can be a little difficult to get along with, despite the fact that she is a consummate professional and a talented doctor. She herself admits that her personality can be grating and that the pressures of working in the emergency room sometimes bring out her worst. Our client, who for the sake of anonymity, I shall call, "Dr. Combs," has worked in southern Wisconsin now for several years.

One day Dr. Combs to her shock received what all physicians dread: a letter summarily

suspending her privileges at a hospital at which she was admitted. Dr. Combs felt that this suspension had nothing to do with the reasons traditionally involved in a summary suspension (i.e., some immediate threat to patient care), but rather with intraoffice politics. Dr. Combs was due for recredentialing at the hospital and this seemed, in her opinion, like an opportunity ripe for exploitation by her enemies. It was at this point that she called our office.

Admittedly, when this story was told to two Nell & Associates health care attorneys involved in this matter, we were a little incredulous. After all, Dr. Combs' cry of "they're out to get me" seemed more than convenient. Nevertheless, we attempted to ascertain the exact rationale for the suspension.

We quickly came to learn that the CEO of a hospital to which Dr. Combs' privileges had not been suspended, whom I shall call "Mr. Anderson," upon notice that Dr. Combs was up for recredentialing at the other facility, he sent a letter thereto, explaining why he felt a suspension was warranted. The CEO's letter contained three reasons for his conclusion. Although the first two related to patient care, both episodes had already been evaluated by her hospital's peer review committee and had been determined not to necessitate any disciplinary action by the hospital.

It was, however, the third reason which drove the decision to suspend Dr. Combs' privileges. CEO Anderson had, in his letter to the credentialing committee, alleged that Dr. Combs had, on one occasion, approximately

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eleven months prior to the suspension, showed up for work drunk. We came to learn that on the date in question, one particular nurse came to the conclusion that Dr. Combs was drinking while on call. The thing that struck us as odd about this occurrence, however, was that the nurse's allegations led to absolutely no disciplinary, or even remedial, action against Dr. Combs. Indeed, the only thing that did happen was that CEO Anderson and Dr. Combs sat down to discuss the charges. Although Dr. Combs offered to submit to random testing, the hospital administration demurred. Dr. Combs' schedule and privileges were in no way affected. Now, however, almost a year later, CEO Anderson had suddenly concluded that Dr. Combs should be suspended. CEO Anderson had, moreover, underscored his position in his letter to the hospital's credentialing committee by arguing that Dr. Combs was "eccentric," "brusque," "difficult" and "hard to get a long with."

The hospital at which Dr. Combs' privileges had been summarily suspended established an initial hearing date one week later. The point of this hearing was to determine whether any basis for suspension existed, and whether such an action should be recommended to the medical executive committee. At the initial hearing, Dr. Combs would have to appear alone. Given these facts, as well as our client's understandable impatience, we had to act quickly.

After a conference with Dr. Combs describing the details of the situation, we decided to employ a two-pronged strategy to

fight the suspension. First, we decided to counter Mr. Anderson's attempt to influence the hospital's decision by making him aware of the implications of his actions. The following letter, with certain portions redacted, is the actual document we sent to the CEO:

Dear Mr. Anderson:

As you know, Dr. Combs' medical staff privileges at Brasai Hospital (BH) were recently summarily suspended. It has come to our attention that this action was due in large part to your efforts.

As you will recall, you completed a credentialing questionnaire submitted to you by BH and attached a letter of explanation thereto. After reviewing your letter, I am compelled to bring this matter to your attention. Simply put, I am surprised and taken aback by the gratuitous and unwarranted assault on my client's position and reputation set forth in your correspondence, and am disturbed by the potential implications of your statements and actions for my client's career and future as a physician. Your evaluation of Dr. Combs is as vindictive as it is unfounded, and constitutes an interference with Dr. Combs' relationship with BH and is a basis under state and federal civil conspiracy and antitrust law for legal action by our client against you and the facility you head, Churchill Hospital.

As the chief executive officer of a hospital you must know that the summary suspension of a physician's medical staff privileges is a very serious affair. Not only does such an action deprive the affected doctor of the ability to earn a living, it also places that individual in jeopardy of being reported to the National Practitioner Data Bank and, therefore, puts that doctor's license to practice medicine at risk. Given

the profound consequences of such an action, summary suspensions are generally only implemented when a clear and substantial basis therefor exists. The standard, in other words, is quite high. The BH medical staff bylaws state, for instance, that a summary suspension shall be made, "upon a determination that action must be taken immediately in the best interest of patient care in the hospital."

Alarming, the contents of your evaluation of Dr. Combs relate in no way whatsoever to this standard, and smack of nothing more than an intraoffice vendetta rendered palpable. There is no indication in any of the materials that we have received that Dr. Combs has somehow placed in danger the best interests of her patients. To the contrary, the catalog of incidents referred to in your letter reflect nothing more than a series of subjective observations and unfounded rumors, as well as the rehashing of several long resolved issues, and hardly constitute the type of serious and immediate threat to patient care the justification for which is demanded by the extreme remedy of summary suspension. Your reference to Dr. Combs drinking on the job, for example, are, besides being almost one year old, completely baseless. As the chief executive officer of Churchill Hospital, I would think that if you genuinely believed there was any cause for concern related to alcohol or drug abuse, you certainly would have acted earlier to address what would obviously be a major problem. Given your duty to the hospital and to its patients, it certainly would have been incumbent upon you to do so. Instead, you chose to let this matter go unattended for over eleven months, waiting until a credentialing questionnaire crossed your desk to raise the issue.

Although the peer review process in this matter will take place pursuant to the BH medical staff bylaws, your evaluation of Dr. Combs,

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as it has led to the decision reached to suspend our client, has inextricably intertwined you with the conduct, as well as the ultimate resolution, of that review. The upshot of this is that you have exposed not only yourself but also Churchill Hospital to civil liability. Beyond the defamatory nature of your comments relating to what you perceive to be Dr. Combs' alcohol abuse, the combined effect of the actions taken by you and Churchill Hospital are violative of the civil conspiracy law set forth in Section 134.01 of the Wisconsin Statutes. That law, which prohibits agreements or actions taken by two or more individuals in concert for the purpose of willfully or maliciously injuring another in his reputation, business, or profession, provides for not only injunctive and monetary redress for plaintiffs in the position of Dr. Combs, but also offers the opportunity for our client to obtain punitive damages at your expense. Since your actions have resulted in Dr. Combs losing her medical staff privileges, which of course has precluded her from continuing to treat patients at that facility and has had the attendant effect of impairing her ability to make a living, and indeed have put her entire career as a medical doctor in profound peril, you have transgressed that law and have exposed yourself and Churchill Hospital to liability thereunder. We would, furthermore, be remiss if we did not point out that liability under federal/state antitrust laws may exist as a result of your conspiracy to deprive Dr. Combs of her privileges at BH.

Your attempts to conspire against our client are only underscored by your authoring of the aforementioned credentialing questionnaire. That you yourself, in your capacity as Churchill Hospital CEO, completed that questionnaire, in lieu of it being done by your facility's medical director, strikes this office as a bizarre deviation from standard operating procedure and a usurpation of a duty that

traditionally lies within the province of the hospital medical director. Your lack of a license to practice medicine in Wisconsin belies the logic of you completing the form. In other words, as a layperson, it does not make sense for you to be evaluating Dr. Combs' performance and ability as a physician and one wonders why, if not to harm my client, you would have elected to do so.

The gravity of this situation has made Dr. Combs anxious to resolve this issue as soon as humanly possible. Given your actions, our client is weighing his options under the law vis-à-vis you and Churchill Hospital. As noted above, while we hope BH has received all documentation on this subject, we would ask that: (1) anything that has heretofore been withheld be transmitted immediately thereto; (2) Churchill Hospital's medical director complete an evaluation of Dr. Combs, and that the same be transmitted to BH/MH; and (3) that both of these steps be completed by 5:00 pm.

The point of this letter was not only to put Mr. Anderson on notice that his actions were in transgression of Wisconsin law, but also to let the hospital know what was happening. Doing so constituted the second step in our response. Our reasoning was that if BH understood Mr. Anderson's motivation, they might reconsider and come up with a different, less-harmful solution, if not drop the matter altogether. Our actions in this respect were greatly influenced by the clear necessity of affording BH a graceful way out of this predicament. As everyone knows, word of adverse peer review action spreads like wildfire through a hospital's physician community; BH could hardly afford to send the message to the rest of their doctors that

they would back down because of a letter drafted by an attorney. It is a fact of life that backing someone into a corner, and not giving them a way out, will force them to fight. Thus, we wanted to ensure the hospital could back down without damaging their credibility. Doing so demanded we respond in two ways: (1) attack the CEO's charges directly in a way that would come to the attention of BH, but which would be seen as non-threatening; and (2) go directly to the hospital in a mollifying way and propose a fair solution. Our direct response to BH was, therefore, conciliatory in tone and sanguine as to the concept of resolving the dispute amicably. Accordingly, in a firm yet non-aggressive manner, we simply put the hospitals on notice that their actions were violative of their medical staff bylaws and that they were in jeopardy of losing their peer review immunity under the Health Care Quality Improvement Act. We framed the issue as follows: any report from Mr. Anderson is deficient as a basis for summary suspension and, therefore, any reliance that BH would place thereon and which resulted in some impairment to his privileges, would entitle Dr. Combs to a legal remedy against the hospital. In other words, we wanted to convince the hospital that they had inadvertently put themselves at risk by relying on a report that was both defamatory in nature and given in a means that violated the law. Since BH did not know this when they initially made their decision to suspend Dr. Combs, they could now, after hearing of the non-existent

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decision was based, back down gracefully. This would allow BH to go forward with the credibility of their peer review process intact.

The initial hearing was held shortly after Mr. Anderson and BH received their respective letters. We were pleased when the hospital decided to reinstate Dr. Combs' privileges subject to what amounted to non-NPDB reportable probationary period.

So what can be learned from Dr. Combs' travails? First, physicians should not be apprehensive of challenging a peer review action before it actually commences. Moreover, having the chance to address a peer review before it begins offers the challenging physician a chance to address the issue with any sympathetic committee members who might exist, and thus presents the potential for defusing things before they get out of control. Second, no matter how angry a doctor might be at what he perceives to be an unwarranted peer review, it must be remembered that the institutional pressures that hospitals inevitably face dictate that a facility cannot be perceived by other doctors as having backed down. If other physicians come to the conclusion that they can push around a hospital's peer review process, they will be compelled, if the time comes, to take a hardline vis-à-vis the hospital. Sending this message of weakness is something that a hospital cannot do. Third, do not forget that even when a hospital deploys their peer review process, the facility has certain standards to which adherence is paramount. Any deviation from the hospital's bylaws, for example will likely

expose that institution to liability. Moreover, doctors should never lose sight of just how crucial it is for a facility to maintain immunity for peer review actions under the Health Care Quality Improvement Act of 1986 (HCQIA). Although a discussion of HCQIA is beyond the scope of this article, suffice it to say that there are certain procedural safeguards which hospitals conducting peer review must grant to the affected physicians to maintain the liability shield granted by HCQIA against any subsequent lawsuits raised by those same doctors. Finally, a physician facing a peer review hearing should not be afraid to bring in outside counsel to help navigate through what can easily become a treacherous situation. Although the doctor, in an effort to be cooperative, may be inclined not to bring someone in, failure to do so will place the physician at a severe disad-

TIME TO RECONSIDER YOUR CORPORATE FORM?

Physician groups organized as "C Corporations" in Wisconsin received a shot across their collective bows in the form of a recent decision by the U.S. Tax Court. In the case of Pediatric Surgical Associates, P.C. v. Commissioner, the Tax Court held that deductions claimed by a C Corporation medical practice for salaries paid to its shareholder physicians exceeded the standard for reasonable allowances for the services that were actually rendered by those physicians, and were, therefore, nondeductible corporate dividends. In response, the court imposed a substantial financial penalty on the medical practice.

THE FACTS

Alarming, the way the Pediatric Surgical practice was constituted is pretty similar to how many Wisconsin medical practices are structured. The corporation employed 20 people, six as pediatric surgeons. Four of these six surgeons were under contract as shareholders, and the remaining two were under contract as non-shareholders. While the non-shareholders received only a salary, the shareholders received both a salary and a bonus. The bonuses they received were calculated and paid out periodically as the corporation's cash assets exceeded its anticipated needs. Thus, in spite of the fact that the four shareholders had varying levels of personal production during the years in question, each shareholder received an approximately equal amount of compensation. During the period of time in which all of this was transpiring, the corporation took a tax deduction for all of the compensation it paid to its four shareholder physicians, and never paid a dividend. These deductions were taken pursuant to Internal Revenue Code §162, which provides for a deduction for all ordinary and necessary business expenses, including a "reasonable allowance for salaries or other compensation for services actually rendered." Upon review, the Commissioner of Internal Revenue found deficiencies in the amount of income tax paid

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by the practice in the years of 1994 and 1995, in amounts of approximately \$206,455 and \$287,606 respectively, and assessed penalties of about \$98,000.00.

THE REVIEW

The Tax Court concluded that the deductions taken by the practice exceeded reasonable allowances for the services that were actually rendered, and, therefore, were not deductible under §162. In coming to this conclusion, the Court employed the two-pronged test set forth in the Internal Revenue Code for analyzing the deductibility of payments made as salaries or other compensation, noting that the payments must be: (1) reasonable; and (2) solely for the personal services that were actually rendered. The Court came to the conclusion that the deduction taken by the medical practice was not proper under the Code because a portion of the bonuses paid to the shareholder physicians constituted a disguised dividend, rather than payment for services personally rendered. The Tax Court found that because the bonuses were calculated by dividing equally, among the four shareholders, the amount of cash maintained by the corporation in excess of its expected needs, regardless of which physician actually produced these extra sums, payments in the form of bonuses to the four shareholders included profits that were attributed to work performed by the two non-shareholder physicians. Thus, the Court ruled, any portion of the bonus payments that derived from income generated by the non-shareholders should be considered a non-deductible dividend. Wrapping up its analysis, the Court pointed out that since this

amount could not be deducted by the corporation, corporate tax should have been paid.

WHY DOES THIS MATTER?

The most important consequence of the Pediatric case is its clear implications for medical practices organized as C Corporations. First, any medical practice so organized should bear in mind that if shareholder physicians are compensated with revenue generated through the performance of medical services by non-shareholder physicians, there is a risk that any deduction, or at least a portion of any deduction, that your corporation takes on that basis under §162 will be disallowed as a disguised dividend.

Second, if your medical practice is compensating shareholders on the basis of income attributable to work performed by non-shareholders, you may want to rethink your compensation structure. One option would be to adjust your compensation formula so that profits are not divided equally among the shareholders when it comes time to calculate bonuses, but rather are paid out pursuant to a framework that takes into account the varying levels of shareholder productivity. A second option would be for the shareholder physicians to assume certain duties and obligations (under their employment contracts) for the management and operation of the business. If the entity can demonstrate that the shareholder physician is being paid for legitimate non-fee producing work, (i.e., compensation for administrative work the shareholder has performed) it can be argued that a

genuine basis for this disproportionate compensation exists, and, therefore the §162 deduction is proper. A third option, while a little more dramatic, will ensure that no problems arise. This is to convert the practice from a C Corporation to an S Corporation. Since S Corporations, unlike C Corporations, are not subject to the notorious “double-tax” (they are only taxed once, at the corporate level), any disallowance of a compensation deduction will not materially affect the corporation or its shareholders. There are of course certain organizational obligations mandated by the S Corporation form (the discussion of which is beyond the scope of this article), but the tax advantages that will accrue therefrom may ultimately be more valuable. Finally, C Corporation medical practices that employ non-shareholder physicians may want to consider paying small dividends to their shareholders. This will lessen the likelihood of IRS scrutiny.

WHAT TO DO NOW

If your medical practice is presently organized as a corporation, and if you have sources of revenue beyond the work performed by shareholder physicians you may want to think about contacting your accountant or healthcare attorney. While you may not have any problems under §162, the substantial penalties that can be imposed in tax violation cases dictate that you adopt a proactive approach.

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Jesse Berg is an associate attorney at Nell & Associates, S.C. Jesse earned his B.A. from the University of Minnesota in political science, where he graduated *Phi Beta Kappa*, and his J.D. from Saint Louis University School of Law, where he graduated *cum laude* and with a certificate in health law. The certificate reflects the academic emphasis and clinical training in healthcare law that Jesse received while in law school. Additionally, Jesse received a Masters Degree in Public Health from Saint Louis University School of Public Health.

Jesse's primary area of practice is in healthcare law, including regulatory and compliance issues, he also devotes a substantial portion of his time and energy to the practice of general business law and estate planning.

Jesse is a member of the Brown County and American Bar Associations, the State Bar of Wisconsin Health Law Section, the American Health Lawyers Association, as well as the AHLA's Credentialing and Peer Review Hospitals and Health Systems substantive law committees. He also volunteers with the American Cancer Society. Jesse is also the editor of *The Doctor's Chart*, a quarterly newsletter published by Nell & Associates, S.C. that provides timely analysis of developments in the healthcare industry.

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Jesse is one of three attorneys who work primarily in the healthcare law field. Two of Jesse's colleagues, Rick Nell and Nick Gerhart, also devote a great majority of their time to this area. If you have any questions or need further assistance, please contact Jesse, Rick or Nick.