

Physician Organizations

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—from a declaration of the American Bar Association

“It Takes Two to Tango”¹— Increased Government Enforcement Against Individual Physicians

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The Trusted Gatekeepers

Physicians play a central role in the ordering and delivery of healthcare services. As “gatekeepers to the healthcare system,”² the government has historically placed an “enormous amount of trust in the physician’s judgment.”³ Based on this trust, individual physicians historically were not subject to the same level of governmental scrutiny as were hospitals and other healthcare facilities. In addition to appearing less sympathetic to a potential jury, hospitals and healthcare facilities were also more appealing enforcement targets because of their more significant financial resources. As a consequence, some in the physician community often viewed compliance with federal healthcare laws and regulations as more of a concern for the healthcare facility, and not the physician.

Although in past years hospitals and healthcare facilities have been the government’s primary target, several recent settlements involving individual physicians demonstrate that the government could be expanding its enforcement net to include the other side of those financial relationships—physicians accused of soliciting and/or accepting illegal remuneration in exchange for referrals. As a result, physicians and their counsel should take note of the risks of government enforcement actions in response to any involvement in transactions with healthcare facilities and providers that may violate



federal healthcare laws. As recently noted by U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) Chief Counsel Lewis Morris, “When we’re doing our analysis of the [healthcare] fraud problem, we have come to recognize we’re only going to get our arms around this if we address both parties to the scheme.”⁴

Recent Enforcement Actions Involving Individual Physicians

In December 2007, HealthSouth Corporation agreed to pay \$14.2 million to settle allegations by the U.S. Department of Justice (DOJ) that HealthSouth had paid illegal kickbacks to physicians who referred patients for care in some of its hospitals, outpatient rehabilitation clinics, and ambulatory surgery centers.⁵

The government then turned its attention to the individual physicians involved in these arrangements. On December 1, 2009, DOJ announced that Kerlan-Jobe Orthopedic Clinic (Kerlan-Jobe), a sports medicine clinic located in Los Angeles, CA, agreed to pay the United States \$3 million to settle allegations that it received illegal kickbacks from HealthSouth Corporation.⁶

The settlement originally stemmed from HealthSouth’s self-disclosure in 2004 and 2005 of certain financial relationships with physicians, including Kerlan-Jobe, to the U.S. Attorney for the Northern District of Alabama and the OIG. The investigation leading to the Kerlan-Jobe settlement was a collaborative effort of the DOJ Civil Division, the U.S. Attorney’s Office for the Central District of California, and the OIG. Kerlan-Jobe settled with the DOJ to resolve allegations that HealthSouth paid kickbacks to Kerlan-Jobe in the form of stock option grants, donations to the Kerlan-Jobe Foundation, loan forgiveness on an equipment lease, and what was described by DOJ as “disproportionately high ownership interest in a jointly owned ambulatory surgery center.”

In another recent example of government enforcement against individual physicians, the U.S. Attorney’s Office for New Jersey announced on September 16, 2009, that the government reached settlements totaling approximately \$960,000 with three cardiologists who had allegedly received kickbacks through sham employment contracts with the University of Medicine and Dentistry of New Jersey (UMDNJ).⁷ The government alleged that beginning in 1995, UMDNJ began to enter into part-time employment agreements with local cardiologists to perform bona fide services. The government further alleged that it was understood that the services to be provided by the cardiologists

were never to be performed, and thus served as illegal kickbacks intended to boost referrals to UMDNJ. In announcing the settlement agreement, Acting U.S. Attorney Ralph Marra stated that the government “will continue to pursue those physicians who abuse and defraud federal healthcare programs by making referrals based on financial considerations rather than the best interests of patients.”⁸

The settlement agreements with the cardiologists are part of a larger investigation against UMDNJ, pursuant to which UMDNJ agreed to pay the government approximately \$8.3 million to settle allegations that it paid illegal kickbacks to cardiologists and submitted false claims to the government.⁹ The government has also reached settlements with six other cardiologists, including two cardiologists who have pleaded guilty to criminal embezzlement charges, in connection with the employment contract scheme. The government further stated that it will continue its investigation of other physicians that may be involved in the contract scheme.¹⁰

On March 9, 2010, the DOJ announced that Rush University Medical Center (Rush) in Chicago, IL, entered into a settlement agreement with the government, and agreed to pay \$1.5 million to resolve allegations that Rush submitted false claims.¹¹ The allegations against Rush included entering into certain leasing arrangements for office space with two individual physicians and three physician practice groups, including Midwest Orthopedics at Rush LLC (Midwest), that violated the Stark Law.¹² Midwest was named as a defendant pursuant to the whistleblower complaint filed by Dr. Robert Goldberg and June Beecham.¹³ Although the government declined to intervene as to claims against Midwest, they reserved the right to intervene at a later date for good cause.¹⁴ As a consequence, the government may choose to intervene in the future to focus on the individual physicians involved in these financial relationships.

It is not only individual physicians who are being targeted. As a further sign that the government may be expanding its enforcement efforts beyond healthcare facilities, Michael Bakst, PhD, former chief executive officer of Community Memorial Hospital of Ventura, CA, recently entered into a \$64,000 settlement with the government to resolve allegations that he violated the federal physician self-referral law.¹⁵ The government alleged Bakst personally negotiated financial arrangements with physicians and directed improper payments to them in violation of the Stark law.¹⁶ In the OIG’s October 5, 2009, press release, Morris stated, “The Office of Inspector General strongly believes that, in addition to holding corporations accountable for healthcare fraud, individuals who caused the fraud should also be held accountable.”¹⁷





Government's Increased Emphasis on Targeting Healthcare Fraud

Throughout the recent healthcare reform debate, it has frequently been emphasized that the U.S. government loses more than \$60 billion each year to healthcare fraud.¹⁸ However, in recent congressional testimony, Morris stated that for every dollar spent on OIG oversight from fiscal years (FYs) 2006-2008, there was a return of \$17 to the federal healthcare programs.¹⁹ As a consequence, it is not surprising that combating healthcare fraud is one of the few areas that has captured strong bipartisan consensus. Due to the fiscal demands resulting from expanded health coverage, healthcare fraud enforcement is viewed as an attractive potential revenue stream. As a result, the Obama Administration has increased its emphasis on healthcare fraud, including a surge in funding for healthcare fraud enforcement and ratcheting up anti-fraud rhetoric.²⁰

In a public demonstration of their commitment to the enforcement of healthcare fraud, HHS and DOJ held a National Summit on Healthcare Fraud on January 28, 2010. In his remarks at the conference, U.S. Attorney General Eric Holder stated that "in the area of healthcare fraud, we must continue to think outside the box and pursue innovative investigative and prosecutorial strategies."²¹ In addition, Holder noted that the White House's FY ending 2010 budget called for an increase from nearly \$200 million to \$300 million in the budget for fighting healthcare fraud.²² Notably, the FY ending 2011 budget includes an additional request of \$250 million in addition to the FY 2010 budget increase, so that the government "is better able to minimize inappropriate payments, close loopholes, and provide greater value for program expenditures to beneficiaries and taxpayers."²³ Holder also made note of additional regulatory and legislative reforms that potentially could be on the way in prosecuting healthcare fraud.²⁴

In the legislative arena, President Barack Obama recently signed Pub. L. No. 111-148, the Patient Protection and Affordable Care Act (PPACA), on March 23, 2009, which includes additional tools to combat healthcare fraud and abuse. Specifically, PPACA revises

the intent requirement in the Anti-Kickback Statute so that no proof of actual knowledge of the Anti-Kickback Statute or specific intent to violate the statute is required.²⁵ In addition, PPACA allows for claims for services in violation of the Anti-Kickback Statute to constitute a false or fraudulent claim under the False Claims Act,²⁶ and increases the Sentencing Guidance level for healthcare fraud offenses.²⁷ The inclusion of this language in PPACA reflects the importance being placed by the government on increased healthcare fraud enforcement and could further result in increased liability to physicians.²⁸

Increased Government Enforcement on the Horizon

Overall, the message from the government appears to signal a more expansive and aggressive stance on healthcare fraud enforcement in which individual physicians could increasingly find themselves to be the subject. Although physicians have been subject to enforcement before,²⁹ the increased attention and funding by the government toward enforcing healthcare fraud, combined with the Kerlan-Jobe, UMDNJ, and Bakst settlements, may illustrate the beginning of an accelerated trend of enforcement actions against individual physicians. While hospitals and other healthcare facilities will likely continue to be targeted by the government, individual physicians may need to start taking a more active role in compliance. Although it is difficult to predict the frequency of enforcement actions involving physicians in the near future, the government appears to be sending a message to the healthcare industry that "under the anti-kickback statute and Stark self-referral law, it takes two to tango."³⁰

- 1 Gregg Blesch, *Making Them Pay - High-Cost of Healthcare Reform is Fueling More Fraud Enforcement, Putting Hospitals, Physicians, Other Providers on Notice*, MOD. HEALTHCARE (Oct. 12, 2009) (quoting Lewis Morris, Chief Counsel to the Inspector General, U.S. Dept. of Health and Human Services), available with subscription at www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20091012/REG/910099990.
- 2 *Id.*
- 3 *Id.*
- 4 *Id.*
- 5 Press Release, U.S. Dept. of Justice, HealthSouth and Physicians Pay \$14.9 Million to Settle Health Care Fraud Claims (Dec. 14, 2007), available at www.justice.gov/opa/pr/2007/December/07_civ_1007.html.
- 6 Press Release, U.S. Dept. of Justice, Los Angeles' Kerlan Jobe Orthopaedic Clinic Pays \$3 Million to Settle Kickback Allegations (Dec. 1, 2009), available at www.justice.gov/opa/pr/2009/December/09-civ-1294.html; see also Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Kerlan-Jobe Orthopaedic Clinic (entered into by Kerlan-Jobe as a condition of continued participation in federal healthcare programs), available at http://oig.hhs.gov/fraud/cia/agreements/Kerlan_Jobe_orthopaedic_clinic_11252009.pdf.
- 7 Press Release, U.S. Dept. of Justice U.S. Attorney, District of New Jersey, Three More Cardiologists Settle With Government Over Kickback Related to UMDNJ Cardiology Program (Sep. 17, 2009), available at www.justice.gov/usao/nj/press/press/files/pdf/umdn0917%20rel.pdf.
- 8 *Id.*
- 9 Press Release, U.S. Dept. of Justice U.S. Attorney, District of New Jersey, UMDNJ to Pay More Than \$8 Million to Settle Kickback Case Related to Cardiology Program (Sept. 30, 2009), available at www.justice.gov/usao/nj/press/press/files/pdf/umdnj0930%20rel.pdf; see also Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and the University of Medicine and Dentistry of

- New Jersey (entered into by UMDNJ as a condition of continued participation in federal healthcare programs), available at www.justice.gov/usao/nj/press/press/files/pdf/UMDNJ%20Corporate%20Integrity%20Agreement.pdf.
- 10 *Supra* note 7.
- 11 Press Release, U.S. Dep't of Justice, Chicago Hospital to Pay More Than \$1.5 Million to Resolve Medicare False Claims Act Allegations, (Mar. 9, 2010), available at www.justice.gov/opa/pr/2010/March/10-civ-240.html; see also *United States ex rel. Goldberg v. Rush University Medical Center*, No. 1:04-cv-04584 (N.D. Ill.).
- 12 *Id.*
- 13 See Complaint for Damages and Other Relief Under the Federal False Claims Act, *United States ex rel. Goldberg v. Rush University Medical Center and Midwest Orthopedic, LLC*, No. 1:04-cv-04584, (N.D. Ill. filed July 12, 2004); Amended Complaint filed November 1, 2005, named Rush SurgiCenter Ltd. Partnership and Dr. Brian J. Cole as additional defendants. Rush SurgiCenter Ltd. Partnership is a multi-specialty surgery center owned in part by Rush and Midwest physicians. Dr. Cole is a member of Midwest.
- 14 Notice of Intervention in Part and Declination in Part and Joint Stipulation of Partial Dismissal, *United States ex rel. Goldberg v. Rush University Medical Center, Midwest Orthopedics at Rush, LLC, Rush SurgiCenter, Ltd. P'ship, and Brian Cole, M.D.*, No. 1:04-cv-04584, (N.D. Ill. filed March 5, 2010).
- 15 Press Release, U.S. Dep't of Health and Human Services, Office of Inspector General, OIG Enters Into Civil Monetary Penalties Settlement With Former Hospital Executive Director, (Oct. 5, 2009), available at <http://oig.hhs.gov/publications/docs/press/2009/BasktCMPNewsRelease508.pdf>. In 2007 the government entered into a \$1.5 million civil settlement with Community Memorial Hospital resolving the hospital's liability.
- 16 *Id.*
- 17 *Id.* Another noteworthy case involving enforcement against a hospital executives is *United States v. Rogan*, No. 02-C3310, 2006 WL 2860972 (N.D. Ill. Sep. 29, 2006). The United States District Court, Northern District of Illinois, issued a verdict of approximately \$64 million in a False Claims Act lawsuit against Peter Rogan, the former owner and chief executive officer of Edgewater Medical Center (Edgewater), a Chicago teaching hospital. The verdict was based on a finding that Rogan caused Edgewater to submit false claims to Medicare and Medicaid for services to patients referred by physicians with whom Edgewater had prohibited financial relationships that violated the Stark and Anti-Kickback laws.
- 18 Statement of Lewis Morris, Chief Counsel to the Inspector General, U.S. Dep't of Health and Human Services, before the Senate Subcommittee on Federal Financial Management, Government Information, Federal Services and International Security, (April 22, 2009). See also *Senator Tom Coburn Discusses Cost Containment at the White House Health Summit*, WASH POST, (Feb. 25, 2010), available at www.washingtonpost.com/wpdyn/content/article/2010/02/25/AR2010022502664.html; Michael Crowley, *Bad Medicine and Out-of-Control Health-Care Fraud*, READER'S DIGEST (Oct. 2009), available at www.rd.com/your-america-inspiring-people-and-stories/bad-medicine-and-outofcontrol-healthcare-fraud/article163549.html.
- 19 Statement of Lewis Morris, *supra* note 18.
- 20 See Helene Cooper and Robert Pear, *Obama Gets Tough on Health Care Fraud*, N.Y. TIMES, (Mar. 10, 2010), available at www.nytimes.com/2010/03/11/health/policy/11health.html.
- 21 U.S. Attorney General Eric H. Holder Jr., Remarks at the National Health Care Fraud Summit, (Jan. 28, 2010), available at www.stopmedicarefraud.gov/innews/holderremarks.html.
- 22 *Id.*
- 23 Exec. Office of The President, Office of Mgmt. & Budget, Budget of the United States Government, Fiscal Year 2011 (2010), available at www.whitehouse.gov/omb/budget/fy2011/assets/health.pdf.
- 24 Cooper and Pear, *supra* note 20.
- 25 Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, § (E) 6401(h) (2010).
- 26 *Id.* at § (E) 6401(g).
- 27 *Id.* at § (F) 10606.
- 28 Other noteworthy PPACA provisions that expand existing healthcare fraud and abuse laws include an amendment to the in-office ancillary services exception under Stark by requiring a referring physician to inform patients in writing, at the time of a referral, that the patients may obtain specified imaging from a person other than the referring physician. PPACA, Pub. L. No. 111-148, § 6003 (2010). In addition, PPACA includes strict limits and restrictions to the Stark Law exception that allows physicians to have ownership interest in hospitals. *Id.* at § 6001. Further, PPACA expands the subpoena power of the Department of Health and Human Services to cases in which a party is alleged to have defrauded federal healthcare programs. *Id.* at § 6402.
- 29 *United States v. LaHue*, 170 F3d 1026 (10th Cir. 1999).
- 30 Blesch, *supra* note 1.

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Medicare's Recent Elimination of Consultation Codes—Intended and Unintended Consequences

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The Centers for Medicare & Medicaid Services (CMS) recently eliminated the use of inpatient and office/outpatient consultation codes in the 2010 Medicare Physician Fee Schedule final rule (New Consultation Rule or the Rule).¹ As a result, effective January 1, 2010, the Medicare fee-for-service program² no longer recognizes the American Medical Association Current Procedural Terminology (CPT) codes for inpatient and outpatient/office consultations. Consultation codes are now only accepted for telehealth services. The New Consultation Rule has had and will continue to have major effects upon physician billing practices. This article reviews the basic elements of the Rule and some of its practical consequences.

Background

Prior to the New Consultation Rule's enactment, Medicare reimbursed consultations at a higher level than standard evaluation and management (E/M) services. A consultation differs from a similar E/M service in that it is initiated by a specific request for assistance with a particular course of treatment or diagnosis (with the understanding that the patient will be returned to the requesting provider's care following the consultation), while an E/M service does not involve such a specific request of one provider from another provider and can be part of a patient's general/continuous course of care. Prior to the Rule, CMS permitted the use of consultation codes if certain conditions were met. In particular, the request and need for the consultation had to be documented and the physician providing the consultation to the requesting physician was required to provide a written report to the requesting physician. CMS also made the distinction between a consultation and a patient "transfer of care," the latter of which required the use of new or established patient E/M codes as opposed to consultation codes.³

In March, 2006, the U.S. Department of Health and Human Services Office of Inspector General issued a report finding that Medicare paid approximately \$1.1 billion more in 2001 than it should have for services billed as consultations due to non-conformance with Medicare requirements, including the lack of appropriate documentation.⁴ Despite CMS' efforts to educate physicians, particularly with respect to the difference between consultations and other E/M services, CMS indicated that ambiguities and disagreements remained regarding the appropriate use of consultation codes.⁵ CMS also stated that over the years, the documentation requirements for consultations have been reduced to such a level that there is no longer a significant difference



between the requirements for consultations and E/M services to justify the payment disparity.⁶ These factors led to CMS' enactment of the Rule.

The New Consultation Rule—Basic Requirements

The basic requirements of the Rule are as follows:

- Services that would have previously been billed with CPT codes 99241-99245 (inpatient) and 99251-99255 (outpatient/office) are now to be billed using E/M codes that represent the appropriate location and complexity of the service provided.
- In the inpatient hospital and nursing facility settings, physicians or qualified non-physician practitioners (NPPs) (where permitted) who perform an initial evaluation should bill the initial hospital care codes (99221-99223) or nursing facility care codes (99304-99306). The principal physician of record—who is defined as the physician who oversees the patient's care—should append modifier “-AI” to the appropriate E/M code to distinguish the principal physician from others who provide specialty services to the patient. All others who perform an initial evaluation on the patient should bill only the E/M code appropriate for the service's complexity. Follow-up visits in the facility setting should be billed as subsequent hospital/nursing facility visits, as is the current policy.
- In the office or other outpatient setting, CPT codes 99201-99215 should be used depending on the visit's complexity and whether the patient is new or established.
- In all cases, physicians/practitioners must report the most appropriate available codes for services that were previously billed using CPT consultation codes; existing E/M documentation guidelines must be followed.

CMS issued a Medlearn Matters article (MM6740) outlining the requirements of the New Consultation Rule⁷ and a separate Medlearn Matters article (SE1010) responding to specific questions regarding the Rule.⁸

Practical Consequences

The effects of the New Consultation Rule are far reaching and raise multiple questions. CMS addressed several of these questions in its Medlearn Matters article SE1010 and other guidance. Some of CMS' responses, as well as administrative difficulties resulting from the Rule that CMS did not address, are discussed below.

Financial Impact

CMS indicated that the New Consultation Rule is budget neutral due to increases made to the work relative value units for E/M service codes that replace the consultation codes. Therefore, while physicians will no longer receive higher reimbursement amounts associated with consultation codes, they will benefit from an across-the-board increase in payments for E/M services, CMS said. However, CMS acknowledged that the Rule will have a "somewhat differential impact on various groups of providers and/or practitioners."⁹ For instance, specialists such as neurologists and endocrinologists are likely to experience a greater negative financial impact as a result of the Rule, while primary care providers may see a boost in their reimbursement. Physician practices should closely track their billing and reimbursement to assess the complete scope of the Rule's financial effects and whether further policy changes in this area are warranted.

"Principal Physician of Record" Modifier and Use of Initial and Subsequent Hospital Care Codes

CMS said that claims appending modifier -AI to codes other than initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected. In addition, although CMS expects the CPT code used to accurately reflect the service provided, CMS instructed Medicare contractors to not find fault with the use of a subsequent hospital care code merely because it was actually the provider's first E/M service to an inpatient during a hospital stay. CMS also stated that it has alerted Medicare contractors to expect more initial hospital care E/M codes and a different proportion of such codes; CMS expects Medicare contractors to take this into consideration when deciding whether to pursue medical or other claims review.¹⁰

No "Crosswalk" Provided—Minimum Components of E/M and Consultation Services Do Not Match

CMS declined to provide a coding crosswalk that would identify each of the eliminated consultation codes and the corresponding replacement E/M codes considered to be equivalent to each of the eliminated codes. CMS expects physicians/practitioners to use an available E/M code that is most appropriate for the service, stating that the Rule "may actually simplify coding because physicians . . . will not have to determine whether the requirements to bill a consult are met."¹¹ While CMS acknowledged that the code descriptors of E/M codes and consultation codes do not exactly match (for instance, the lowest level inpatient consultation CPT code 99251 requires a "problem focused history," while initial hospital care CPT code 99221 requires a "detailed or comprehensive history"), CMS explained that a particular E/M code may be reported for a service if the requirements for billing that



particular code are met in consideration of the service actually provided.¹² Therefore, CMS is essentially directing providers to disregard previous practice for the billing of consultation codes and adjust to the existing requirements for E/M services.

Elimination of Consultation Documentation Requirements and Potential Effect on Coordinated Care

In the preamble to the New Consultation Rule, CMS addressed comments that the elimination of the consultation codes—and, as a result, the elimination of the documentation requirements for a consultation service, such as the written report to a requesting physician—would financially discourage communication and coordination between healthcare providers. In response, CMS stated that it was aware of no evidence that the Rule would have such a result, but that it would be attentive to any concerns that develop with respect to coordination of care.¹³ In an apparent further response to this concern, CMS commented in its Medlearn Matters article MM6740 that "conventional medical practice" is to document referrals between physicians for the evaluation of patients and that, in order to promote proper coordination of care, physicians should continue to document requests for evaluations and communicate the results of such evaluations to requesting physicians.¹⁴ Therefore, while there does not appear to be an explicit CMS requirement that such documentation occur, CMS appears to encourage it.

NPPs/Shared Visits

Prior to the New Consultation Rule, Medicare would not pay for consultations if they were "split/shared" with a NPP.¹⁵ In response to a question as to how E/M services that were previously reported with consultation codes and are provided in a split/shared manner should now be billed, CMS stated that the split/shared rules that currently apply to E/M services will continue to apply, including situations where the services were previously reported with consultation codes.¹⁶ With this response, it appears that CMS will now permit consultation services (which now must be billed with an E/M code) to be split/shared, provided that the "incident to" requirements are met in the office setting or that the split/shared requirements are met in the hospital setting (as

applicable).¹⁷ This could provide a significant benefit to physicians who routinely work with NPPs.

New/Established Patient Rules Will Now Apply to Consultation Services

Now that consultation codes will be replaced with E/M codes, CMS has confirmed that the current rules that apply to E/M codes with respect to new and established patient office visits will now apply to consultation services. This means that a consulting physician will receive reimbursement for a consultation service billed as a “new patient” E/M service only if the patient has not received professional services from the consulting physician or a physician in the same group practice and specialty as the consulting physician for the previous three years.¹⁸ This may have significant impacts for multi-specialty group practices that commonly receive cross-specialty consultation referrals. It will present particular difficulties for consultation referrals between group practice specialists in different sub-specialties who would like to use new patient E/M codes; this is due to Medicare contractors’ general inability to recognize sub-specialties.

In order to identify the specialty of the physicians submitting claims, Medicare contractors generally rely on the broad specialty designations made by physicians/practitioners when they enroll in Medicare; these specialty categories do not provide for a sub-specialty designation (i.e., neuro-ophthalmology). In addition, Medicare contractors generally determine whether physicians are in the same group practice by looking to the tax identification number of the group. Therefore, sub-part National Provider Identifiers (NPIs) established under the same tax identification number would not assist in distinguishing specialties within a group practice for purposes of the “new patient” rule. As a result, Medicare contractors will likely not have a mechanism to validate a claim for a new patient E/M consultation service requested by, for instance, an ophthalmologist and provided by a neuro-ophthalmologist in the same group practice under the same group tax identification number (i.e., the patient was treated by a physician in the same group practice and same broad specialty category as the consulting physician in the previous three years and, therefore, does not qualify as a “new patient”). Certain Medicare contractors have indicated that new patient E/M services billed in such a case will initially be denied, but that on appeal, the claim can be paid if the provider demonstrates that the consulting physician is in fact in a distinct specialty. Even if such a claim is permitted to be reimbursed on appeal, this presents obvious difficulties for consulting physicians who bill new patient E/M codes. These difficulties will continue until or unless Medicare contractors establish explicit policies permitting new patient E/M codes for group practice sub-specialty E/M referrals and implement a mechanism to recognize distinct physician sub-specialties upon initial claim submission.

Medicare Secondary Payer and Private Payor Consultation Policies

Under the Rule, Medicare will no longer recognize CPT consultation codes, even in the case of Medicare secondary payments.

Therefore, for purposes of Medicare secondary payment, if a primary payor continues to recognize CPT consultation codes that are eliminated under Medicare and the physician chooses to bill the primary payor with such consultation codes, the physician may not then report the consultation codes to Medicare; the physician must “switch” from the consultation codes reported to the primary payor and report to Medicare an E/M code appropriate for the service.¹⁹ Therefore, physicians have to significantly alter their billing practices to accommodate the differing policies among Medicare and private payors with respect to billing for consultation services.

Conclusion

Complications can be expected as physicians and Medicare contractors transition to the requirements of the New Consultation Rule. If the Rule results in significant negative consequences, further policy changes may be warranted. In the meantime, physician practices—particularly specialty practices that rely heavily on consultation services—must provide appropriate training to their staff regarding the Rule’s requirements, closely monitor any policy developments in this area, and keep careful track of their billing activity and reimbursement to assess the full scope of the Rule’s impact.

- 1 Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, 74 Fed. Reg. 61,737 (Nov. 25, 2009) (to be codified at 42 C.F.R. pts. 410, 411, 414 et al.).
- 2 The New Consultation Rule only applies to services paid under the Medicare Fee-For-Service program. It does not revise existing policies or rules governing Medicare Advantage or non-Medicare insurers. Medicare Advantage plans should be contacted with respect to their policy regarding consultations.
- 3 U.S. Dept of Health and Human Services, Centers for Medicare & Medicaid Services, Transmittal 788, Medicare Claims Processing Manual (Pub 100-04) (Dec. 20, 2005), available at www.cms.hhs.gov/transmittals/downloads/r788cp.pdf.
- 4 U.S. Dept of Health and Human Services, Office of Inspector General, Consultations in Medicare: Coding and Reimbursement, OEI-09-02-00030 (Mar. 2006), available at <http://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf>.
- 5 74 Fed. Reg. at 61,769.
- 6 74 Fed. Reg. at 61,771.
- 7 U.S. Dept of Health and Human Services, Centers for Medicare & Medicaid Services, MLN Matters Article MM6740, *Revisions to Consultation Services Payment Policy*, available at www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf.
- 8 U.S. Dept of Health and Human Services, Centers for Medicare & Medicaid Services, MLN Matters Article SE1010, *Questions and Answers on Reporting Physician Consultation Services*, available at www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf.
- 9 74 Fed. Reg. at 61,772.
- 10 MLN Matters SE1010, *supra* note 8.
- 11 74 Fed. Reg. at 61,770-71.
- 12 MLN Matters SE1010, *supra* note 8.
- 13 74 Fed. Reg. at 61,774.
- 14 MLN Matters SE1010, *supra* note 8.
- 15 Transmittal 1875, Medicare Claims Processing Manual (Pub 100-04) (Dec. 20, 2005), available at www.cms.hhs.gov/Transmittals/downloads/R1875CP.pdf.
- 16 MLN Matters SE1010, *supra* note 8.
- 17 Claims Processing Manual, *supra* note 3, at Ch. 12, Section 30.6.1(B).
- 18 MLN Matters SE1010, *supra* note 8.
- 19 *Id.*

Seven Key Issues When Representing a Physician Entering Into His or Her First Employment Agreement

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Introduction

When representing a physician first starting out in private practice, the physician's attorney should clearly explain the process of the employer-employee relationship and the life cycle of the physician-practice association. In this role, the attorney wears several hats. As educator, the attorney should ensure that the physician understands what he or she is signing. The attorney should also focus on the legal issues involved. The end result should be that the physician is empowered to make the business decision as to whether the proposed arrangement, with appropriate revisions, is clear cut and viable. When advising a physician-client, the attorney should look at the proposed relationship from the physician's perspective, speak to him or her in terms that the physician can easily understand, and use clear examples.

An attorney must address many issues when reviewing a physician employment agreement. The following are seven key issues (not in order of priority):

Compensation and Fringe Benefits

Compensation varies widely depending on area of specialty and geographic region. An employment agreement should specify both the amount and timing of compensation in a clear and succinct manner. The physician should confirm the payroll policies of the employer (i.e., bi-weekly payment of compensation), ensure that such policies are satisfactory to the employee, and, if important, that such policies are spelled out in the agreement. If the term of the agreement is for more than one year, annual compensation increases should be included and set forth in detail in the agreement, and the amounts of such increases should be specified. Leaving such increases to the discretion of the practice's board of directors may result in no raise for the physician.

Many agreements contain a provision whereby at least a portion of the compensation is based on productivity measures. If the compensation section includes such a provision, the methodology for calculating productivity-based compensation should be clearly spelled out in the agreement. Is the formula based on billings, collections, charges, relative value units (RVUs), profitability, or some combination of these items? Examples utilizing the applicable methodology should be set forth in the agreement. If any part of the physician's compensation will be productivity-based, the agreement should specify when the incentive compen-



sation will be paid to the physician. For instance, if this form of compensation is calculated on an annual basis, the physician should propose that his or her bonus will be paid no later than a certain date after the end of the applicable year in one lump sum. Further, if the bonus calculation is based on collections, the agreement should make clear that if the physician is terminated during or at the end of a contract year, the physician is credited for collections received during a specified number of months after the termination of his or her employment (i.e., three, six, nine, twelve months). Moreover, if the bonus is based upon collections, the physician should add a covenant that patients shall be scheduled equitably, so that the employer does not cherry pick based upon procedures and payor mix, and that the employer will use its best efforts to collect all fees. The employer should provide, on a periodic basis, a detailed statement setting forth the billings that the physician has generated. Finally, the physician should be aware of any requirement that he or she must be employed to receive payment of the bonus as this practice is common in employment agreements.

Fringe benefits are a major portion of a total compensation package. Typical benefits include vacation; continuing medical education (CME); expense reimbursement (e.g., cell phone, pager, personal data assistant, fees, dues, journals, and periodicals); automobile allowance; health, life, dental, disability, and malpractice insurance (see below); moving expenses; maternity leave; and retirement plans. Generally, the physician makes the decision whether the proposed benefits are adequate and acceptable. Nonetheless, the attorney should provide some guidance to

the physician. For instance, the attorney may suggest that unused vacation be paid out or carried over to succeeding years.

Duties and Work Schedule

The agreement should contain a detailed job description, including projected hours (all evenings?), the days on which those hours will be worked (all weekdays?), and the exact locations at which the physician is expected to practice. Will the physician be practicing internal medicine, performing procedures, or specializing in a particular practice area such as gynecology? If the agreement specifies a minimum number of work hours per week, such number should be an average taking into account vacation days and days for CME. If the practice has more than one office, the agreement should specify the offices at which the physician will practice. Typically, an agreement should indicate the hospitals at which the physician will be required to maintain staff privileges. The attorney should attempt to limit any reassignment of the physician to other offices or hospitals without the physician's consent, as the offices and hospitals to which the physician is assigned may have an effect on the restrictive covenant set forth in the agreement (see below). These decisions will affect the physician's quality of life.

The agreement should also clearly spell out coverage and on-call obligations. The attorney should also include a provision indicating that if the physician's on-call obligations exceed the parameters set forth in the agreement, the physician will not have to work the excess on-call schedule or will have some leverage with which to negotiate additional compensation.

Malpractice Insurance

The agreement should set forth whether the employer will provide malpractice coverage for the employee and whether the policy is claims-made or occurrence-based. An occurrence-based policy provides insurance coverage for a loss that "occurred" during the policy period, no matter when the claim is brought against the insured. A claims-based policy provides coverage for a claim that is brought within the policy period, no matter when the loss occurred. For example, a physician is covered by a claims-made policy through all of 2010, but then is terminated on December 31, 2010. As of January 1, 2011, the physician is no longer covered by any malpractice policy. In February 2011, the physician is sued for malpractice based upon an act that occurred in September 2010. Because the claim is brought after the policy terminated on December 31, 2010, the physician is not insured for malpractice unless he or she has tail coverage, which can be very expensive.

The amount of malpractice insurance should be specified in the agreement. Additionally, if the applicable policy is claims-made, the agreement should identify which party will be responsible for obtaining tail coverage upon the physician's separation from the practice. The attorney should attempt to shift the burden for paying for tail coverage to the practice, and, if successful, the agreement should require the practice to present evidence of this tail coverage to the physician. When representing the employee

physician, an attorney should try hard to make the practice responsible for paying for tail coverage if it terminates the physician without cause or the physician terminates her employment with the practice for cause. Payments for tail coverage can run into tens of thousands of dollars, and, if an attorney does not negotiate an agreement that has the practice paying for tail coverage, the attorney may have a very unhappy client.

Termination

In the absence of a specific provision in the agreement, employment may be "at will," depending on state law, and can be terminated by either party without notice for any reason. The agreement should contain proper notification requirements for termination. The physician should be aware of provisions whereby the employer may unilaterally terminate him or her for any reason with little or no notice. Any clause for termination without cause should be mutual and should require a period of written notice that is acceptable to the physician. Events that may allow the employer to terminate the physician immediately for cause should be specifically set forth in the agreement, and the physician should be provided with an opportunity to cure a for-cause violation.

Importantly, the physician should understand that if the practice can terminate his or her employment without cause, the employment agreement's term has effectively been reduced to the notice period. In other words, if the term of the agreement is three years but the practice may terminate the physician without cause upon ninety days of notice, the practice has essentially turned a three-year agreement into a ninety-day agreement.

Ownership Opportunities

The attorney should discuss with the physician client whether or not he or she expects to have the opportunity to purchase an ownership interest in the employer, as well as the timing, conditions, and method of calculation of the purchase price of such an ownership interest. The physician may wish to consider a "sweat-equity" arrangement and to incorporate standards for performance evaluation. Although the employer may be reluctant at this stage to promise ownership status and the new physician may even be hesitant to accept such an offer even if presented, the agreement should set forth the parameters of any deal in the agreement. The agreement should outline: when the physician can expect the opportunity to buy in; what shareholder status includes; valuation of the ownership interests; and how the physician will pay for his or her shares.

Moonlighting

The attorney should ask the physician client whether or not he or she expects to work elsewhere while working for the employer. If the physician does, the attorney should ensure that the agreement states that outside professional activities are permitted and that the physician may retain income from such activities. Common examples include teaching, speaking, writing, and testifying. If the agreement contains a general prohibition on outside activities,

the agreement should specifically exempt the activities in which the physician wishes to engage. The physician should be aware of any requirement in the agreement that gives the employer the right to approve or reject any outside professional activities.

Restrictive Covenant

Provided that they are permitted in the state where the physician will be employed, most employment agreements include some form of post-termination restrictive covenant. Such covenants commonly include both non-competition and non-solicitation elements. Upon termination of the physician's employment, the physician may be prevented from competing with the employer in a particular geographic area for a specific period of time and/or from soliciting patients, referral sources, and employees of the employer.

An attorney should first determine if restrictive covenants are enforceable in the state in which the physician will be employed; some states prohibit them. In states in which they are enforceable, the attorney should clearly explain the details of the covenant and its possible impact on the physician. Whatever the form, restrictive covenants should be reasonable in scope and duration, should not be injurious to the public at large, and should not prohibit the physician from pursuing activities not engaged in by the employer. What is "reasonable" will vary based upon many factors, but the authors suggest that the duration of a restrictive covenant should not exceed the lesser of time employed or one year. With respect to the geographical distance, the agreement should specify that the radius of any restrictive covenant only extends from any office or hospital at which the physician saw patients. If the physician saw patients at two of the practice's offices, but the practice has four offices, the restrictive covenant should only include the two offices at which he or she saw patients, not all four offices.

In addition, the physician may wish to carve out certain patient and referral relationships developed in prior employment. An attorney and the physician should discuss in detail what the physician would like to do should the employment relationship not work out. The physician may benefit by negotiating a liquidated damages provision, whereby the precise amount owed upon violation of a restrictive covenant is determined in advance.

The agreement should clearly state whether the restrictive covenant is applicable if the physician's employment is terminated with or without cause. If the covenant is effective upon termination without cause, the attorney should make sure that the physician understands that he or she may be terminated without cause, that the employment may only last for the applicable notice period, and that she would then be bound by a post-termination restrictive covenant. For example, if the applicable notice period for termination without cause is sixty days and the length of the restrictive covenant is two years, the physician is guaranteed employment for sixty days but subject to a restrictive covenant that is twelve times as long. Accordingly, the attorney should seek to make the restrictive covenant inapplicable if the employer terminates his or her employment without cause and/

or if the physician is not offered an ownership opportunity by the practice.

Conclusion

Attorneys representing a young physician becoming employed for the first time will likely have a great impact on the physician's future professional career. The decisions made at this time may have far-reaching effects for the physician, such as where he or she chooses to live, and should not be undertaken lightly. An employment agreement governs the most important aspects of this initial relationship. By signing such an agreement, the physician agrees to be legally bound by its provisions. With a little planning, many of the above issues may be resolved in the physician's favor.

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When is the Physician-Patient Relationship Formed? The Oregon Court of Appeals Clarifies, But Questions Remain

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When is the physician-patient relationship formed? In the present era of telephonic consults and remote records review, can a physician form a relationship with a patient whom the physician has never even met? Case law on this issue is still catching up to the quickly changing pace of modern healthcare.

Oregon law has historically offered little in the way of an answer to the question of when the relationship between physician and patient is formed. But a recent Oregon Court of Appeals case decided on October 28, 2009, *Mead v. Adler*, goes to the heart of the formation question.¹ *Mead* clarifies that a duty of care and a physician-patient relationship are formed when a physician “affirmatively undertakes to diagnose or treat”² the patient. Such a broad standard of care could lead to potential liability in many situations that previously would not have risen to the level of a physician-patient relationship. *Mead*’s putative expansion of physician liability also begs the question: when may a physician reasonably sever ties with his or her patient?

Oregon Case Law Fairly Limited Before *Mead v. Adler*

Historically, the provider-patient relationship arose under a theory of express or implied contract.³ A person would seek treatment from a physician, and the physician would accept the person as a patient by initially examining the patient and rendering a diagnosis or treatments. Mutual consent was required. That contract-based approach, although still one way to assess formation of the physician-patient relationship, has been essentially overtaken by a tort-based approach focusing on the existence of a special relationship arising from the physician’s actions—even in the absence of mutual consent, a meeting of the minds, or other traditional indicia of a contract.⁴

Until recently, Oregon law did not address the question of when a physician-patient relationship was formed. Indeed, the relevant statutes and regulations make no reference at all to the formation of the physician-patient relationship. The closest approach to articulating the elements of a physician-patient relationship in Oregon tort law was expressed in 1985, in *Sullenger v. SETCO Northwest, Inc.*⁵ In *Sullenger*, a minor child was cared for and admitted to the hospital by the patient’s attending physician, who testified that he did not seek: the defendant pediatri-

cian’s opinion; the defendant’s consultation; and the defendant’s approval of treatments being rendered.⁶ Rather, the case described the facts such that while exiting the patient’s room, the attending physician asked the defendant pediatrician if he would take the child’s case, and the defendant pediatrician declined. The plaintiff did not challenge these facts. The facts also showed that the defendant pediatrician did not examine the patient, review charts, or review nurses notes, x-rays, or any other tests results. On this basis, the Oregon Supreme Court affirmed the defendant physician’s motion for summary judgment, finding that no physician-patient relationship existed that could give rise to a duty of care.⁷

Physician-Patient Relationship is Formed in the Context of an On-Call Physician Consulting by Telephone

In *Mead*, the plaintiff presented to an emergency room (ER) physician, who ordered an MRI, the results of which led her to believe that the plaintiff was developing cauda equina, a very serious neurological condition related to a herniated lumbar disk. The ER physician then called the defendant neurosurgeon for a consultation. The two physicians disagreed about the contents of the phone conversation, but the trial court found the following facts undisputed: (1) the defendant was the on-call neurosurgeon; (2) the defendant took the ER physician’s call and listened to a description of plaintiff’s symptoms; (3) the defendant felt that plaintiff did not need neurosurgical treatment; and (4) the defendant thought that plaintiff should be admitted by her primary physician for observation and pain management. The plaintiff’s condition deteriorated over the ensuing four days, until the defendant ultimately performed surgery. The plaintiff did indeed have cauda equina and suffered permanent impairment.⁸

The plaintiff filed suit for medical malpractice against the hospital, a consulting neurologist, and the neurosurgeon. At trial, the plaintiff moved for a directed verdict on the issue of whether, by undertaking to evaluate and diagnose the patient, even by phone, the defendant impliedly consented to the formation of a physician-patient relationship, which thereby created a duty of due care. The trial court denied the plaintiff’s motion for directed verdict and permitted the question of whether a physician-patient relationship existed to go to the jury. The jury issued a verdict in favor of the defendant neurosurgeon. On appeal, the Court of Appeals reversed and remanded for a peremptory instruction to the jury that a physician-patient relationship existed as a matter of law.⁹

The Oregon Supreme Court affirmed the lower court, finding that, “In the absence of an express agreement by the physician to treat a patient, a physician’s assent to a physician-patient relationship can be inferred when the physician takes affirmative action with regard to care of the patient.”¹⁰ The high court went on to discuss the novel question under Oregon law of whether an on-call physician’s advice to an emergency room physician over the telephone concerning a specific patient will give rise to a physician-patient relationship. After much review of case law from other states, the court held:

In summary, the consensus of the jurisdictions that have considered the question is that a physician-patient relationship can arise by implied consent of the physician based on indirect contact between the physician and patient through telephone communication between a hospital emergency room physician and an on-call physician concerning the care of an emergency room patient; *the pivotal inquiry is whether the on-call physician affirmatively participates in the care of the patient.* That affirmative participation exists if the on-call physician undertakes to diagnose or treat the patient. . . . [W]e also conclude that an on-call physician who affirmatively undertakes to diagnose or treat an emergency room patient over the telephone has impliedly consented to a physician-patient relationship for purposes of negligence liability.¹¹

The Court found that the advice rendered by the defendant was not “merely casual or informal advice to a colleague.”¹² The defendant neurosurgeon was contacted by the ER physician because of his on-call status, and the defendant rendered an opinion on the appropriate course of care. The court did find the *Mead* facts distinguishable from the more casual “curbside consult” that one physician may provide to another as a professional courtesy.¹³

Is a Physician-Patient Relationship Formed When an On-Call Physician Merely Issues an Order or Prescription Without Personally Seeing the Patient?

A developing area of the law—now reinforced by the *Mead* case—is when a physician/patient relationship may be established, even where the physician does not personally see the patient. Many jurisdictions—Oregon now included—have ruled that if a physician is on call, a physician-patient relationship may exist between a patient seeking services in a hospital ED and the on-call physician. Indeed, that “special relationship” may exist even when the on-call physician refused to see the patient or was unavailable to attend the patient.¹⁴ The *Mead* case is an example of a special relationship arising from on-call status and a consultation in the physician’s on-call capacity.

However, other more-fleeting physician contacts, still may give rise to a physician-patient relationship, depending on the facts:

Florida

A physician on inactive courtesy staff, home sick at the time, merely permitted an acquaintance to use his name to seek admission to the hospital for emergency treatment. The court found a triable issue of fact as to whether physician “accepted” decedent as a patient and reversed summary judgment in favor of defendant physician.¹⁵

Georgia

The defendant physician placed prescriptions by phone as an accommodation to plaintiff, an extended family member who subsequently developed glaucoma. The plaintiff testified that

he asked the physician about the eye drops and drug in question; he sought out physician’s counsel, and the physician gave him certain advice regarding diet and fat intake. The physician testified that during his first conversation, he warned the plaintiff that he did not like the plaintiff using the drug and advised him to see his ophthalmologist. The appeals court found a triable question of fact as to whether a physician-patient relationship existed, which precluded summary judgment. The appeals court denied the defendant physician’s petition for reconsideration, and the Georgia Supreme Court denied *certiorari*. The public record contains no further history, and the author assumes the matter was settled after remand.¹⁶

Georgia

A physician-patient relationship was *not* created where the plaintiff telephoned the defendant physician, who had treated her previously for an unrelated condition, and the physician: (1) listened late at night to her recital of symptoms; (2) told her that she would have to wait to see him in the morning; and (3) recommended that she continue the immediate course of treatment prescribed by another physician.¹⁷

Pennsylvania

The sole contact between patient and physician was a telephone call in which the physician informed patient’s husband of the hospital’s admission policies. In accordance with the hospital’s standard procedure, the physician, after ascertaining that the woman had a private physician and the private physician’s diagnosis, informed the husband that she could not be admitted unless arrangements were made for admission by the private physician. The husband was then unable to re-contact the private physician or the hospital physician. The woman subsequently suffered another attack, sustaining a cerebral hemorrhage. The court affirmed summary judgment for the hospital physician and the hospital, finding that no physician-patient relationship had been formed because the hospital physician did not undertake to render medical service.¹⁸

Texas

A doctor husband did not have physician-patient relationship with his wife on the night that she died, even though he had been treating his wife for stress and anxiety for four years and had prescribed medications as recently as two months before, where the wife did not seek medical care, advice, or medication from her husband on the actual night of death. The doctor testified that he was not acting as her physician but as her husband that night. He did not see her take any medication, and any medication she took that night was without his input. Plaintiff estate’s take-nothing judgment in negligence action against the doctor husband was affirmed.¹⁹

There is no “majority rule” on these issues and the Florida case referenced above, *Giallanza v. Sands*, seems to set the lowest bar for formation of a physician-patient relationship.

What Constitutes Patient Abandonment?

A good distillation of the common law concerning physician abandonment states the following:

A claim for ‘abandonment’ involves the termination of the professional relationship between the physician and the patient at an unreasonable time or without affording the patient the opportunity to procure an equally qualified replacement. It is a corollary to the physician’s right to withdraw from a case upon giving proper notice that he is under a duty to continue his attendance upon the patient until all the conditions for his rightful withdrawal are complied with, and that a breach of this duty may render him liable. . . . Absent good cause to the contrary, where the doctor knows or should know that a condition exists that requires further medical attention to prevent injurious consequences, the doctor must render such attention or must see to it that some other competent person does so until the termination of the physician-patient relationship.²⁰

Thus, patient abandonment is generally characterized as a breach of duty under tort law analysis.

Not surprisingly, Oregon does not have any case law on point, nor is patient abandonment directly addressed in Oregon statute or administrative rules.²¹ However, other jurisdictions are instructive. In 1998 in California, the Court of Appeals considered the matter of a physician’s refusal to treat an indigent woman in labor while inquiring about her ability to pay. Because the defendant physician initially admitted the plaintiff patient to the ER and transferred her to the labor and delivery floor before inquiring on her ability to pay, he had accepted the patient for treatment and could not abandon her.²²

In a Utah Supreme Court decision from 1937, the defendant physician hospitalized and treated the plaintiff patient for an infected finger. Against the physician’s advice, the patient left the hospital. The physician instructed the patient to return for further treatment if the infection worsened. When the infection worsened, the physician examined the patient and told him to return to the hospital. Once at the hospital, the physician refused to treat the patient because of a previously owed bill. The patient underwent an operation at another hospital and his finger was eventually amputated, leading to his malpractice suit. The court found that the physician, upon undertaking the operation during the patient’s second admission, was under a duty to continue his attention as long as the case required.²³ The Utah court also found the physician’s duty is to provide continuing care until the physician has properly withdrawn from the relationship. The court noted that the physician’s ongoing duty of care may be terminated by: (1) the cessation of the necessity that gave rise to the relationship; (2) by the discharge of the physician by the patient; or (3) by the withdrawal from the case by the physician *after giving the patient reasonable notice so as to enable the patient to secure other medical attention*.²⁴ A physician has the right to withdraw from a case, but if the case requires further medical or surgical attention, the physician must either provide care or,

before withdrawing from the case, give the patient sufficient notice so that the patient can procure other medical attention if the patient so desires.²⁵

1 231 Or. App. 451 (2009).

2 *Id.* at 462.

3 See 61 AM. JUR. 2D *Physicians, Surgeons & Other Healers* § 130 (2008) (“The relationship of physician and patient is [formed] if the professional services of a physician are accepted by another person for the purposes of medical or surgical treatment. Because this relationship may result from an express or implied contract, the voluntary acceptance of the physician-patient relationship by the affected parties creates a prima facie presumption of a contractual relationship between them.”).

4 *Id.*; see also *Mead*, 231 Or. App. at 459-60.

5 74 Or. App. 345 (1985).

6 *Id.* at 347.

7 *Id.* at 348-49 (“The duty to aid another person arises out of a relationship between the actor and the other.”).

8 321 Or. App. at 456.

9 *Id.* at 456-57.

10 *Id.* (citing *Adams v. Via Christi Regional Medical Center*, 19 P.3d 132, 140 (Kan. 2001)) (emphasis added).

11 *Id.* at 461-62 (emphasis added).

12 *Id.* at 464.

13 *Id.*

14 *Hiser v. Randolph*, 126 Ariz. 608 (Az. Ct. App. 1980). In *Hiser*, plaintiff’s decedent entered the ED in a diabetic coma and the defendant on-call physician in the ED refused to treat her, stating that she should be treated by her regular physician who had seen her in the ED the previous night. The patient died the next day. The Arizona court found that the defendant physician, by assenting to the hospital bylaws and accepting payment from the hospital to act as the on-call emergency room doctor, personally became bound to insure that all patients treated in the emergency room receive the best possible care. *Id.* at 777.

15 *Giallanza v. Sands*, 316 So.2d 77 (Fla. Dist. Ct. App. 1975).

16 *Walker v. Jack Eckerd Corp.*, 209 Ga. App. 517 (1993), *cert. denied* (Oct. 29, 1993).

17 *Clanton v. Von Haam*, 177 Ga. App. 694 (1986).

18 *Fabian v. Matzko*, 236 Pa. Super. 267 (1975).

19 *Rampel v. Wascher*, 845 S.W.2d 918 (Tex. App. 1992).

20 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 218 (2008).

21 *But see* Oregon’s Death With Dignity Act, OR. REV. STAT. § 127.625(d) (“If there is no health care representative for an incapable patient and the health care decisions are not in dispute, the health care provider shall, *without abandoning the patient*, either discharge the patient or make a reasonable effort to locate a different health care provider and authorize the transfer of the patient to that provider.”) (emphasis added).

22 *Hongsathavij v. Queen of Angels/Hollywood Presby. Med. Ctr.*, 62 Cal. App. 4th 1123, 1138 (Cal. Ct. App. 1998) (“A physician cannot just walk away from a patient after accepting the patient for treatment. A physician cannot withdraw treatment from a patient without due notice and an ample opportunity afforded to secure the presence of another medical attendant. [Internal citation omitted]. In the absence of the patient’s consent, the physician must notify the patient he is withdrawing and allow ample opportunity to secure the presence of another physician.”).

23 See *Ricks v. Budge*, 91 Utah 307, 314 (1937) (“The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention. A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires.”).

24 *Id.*

25 *Id.*

Attend the Business Law and Governance *and* Physician Organizations Joint Annual Luncheon

Sponsored by Sullivan Cotter and Associates Inc.

Monday, June 28, 2010

Grand Hyatt Seattle

Seattle, WA

at the

2010 AHLA Annual Meeting

Prospects for New Delivery Systems and Reimbursement Models

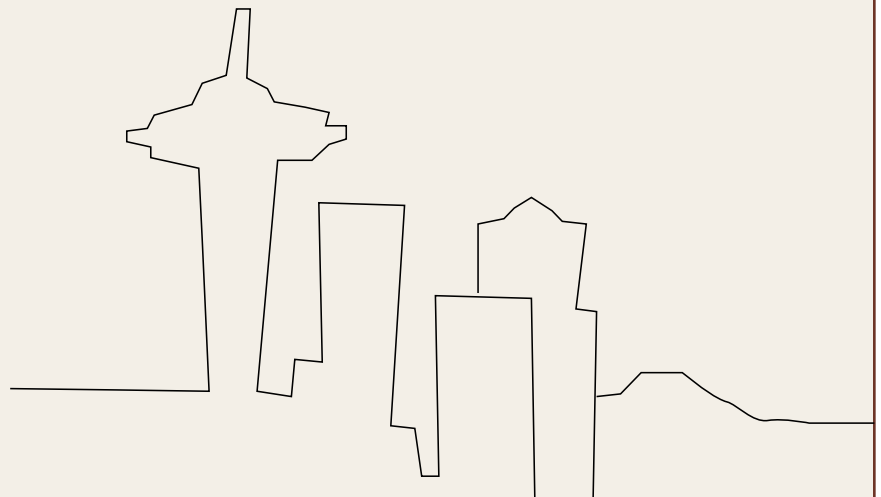
Healthcare reform has dominated the national discourse, and it will remain a predominant theme even with the reform legislation's enactment. This luncheon program will consider the development of new models in the healthcare delivery system and payment methodologies brought about due to reforms. The discussion will also cover suggested provisions for demonstration projects that are expected to guide future changes in an effort to encourage cost efficiencies and quality of care.

Panelists:

Patrick Hagan, MHA, President and Chief Operating Officer, Seattle Children's Hospital, Seattle, WA

Rick D. Woods, Esquire, Executive Vice President and General Counsel, Group Health Cooperative, Seattle, WA

Kim H. Roeder, Esquire (Moderator), King & Spalding LLP, Atlanta, GA



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To register for the luncheon only, please call (202) 833-1100, prompt #2.

Upcoming Webinars

Graduate Medical Education Payment Implications of the Healthcare Reform Law: Congress Steps Into the Fray

Tuesday, June 8, 2010

1:00-2:30 pm Eastern

Co-sponsored by the In-House Counsel; Regulation, Accreditation, and Payment; and Teaching Hospitals and Academic Medical Centers Practice Groups

With the passage of the healthcare reform law, academic medical centers and other teaching hospitals are now facing significant changes to graduate medical education payment, along with the other numerous, unprecedented changes heralded by the legislation. This webinar outlines many of those changes and discusses the legal, operational, and financial challenges and opportunities resulting from these changes. Among the topics are the following:

- Changes to the non-hospital site rule requirements pertaining to bearing the costs of preceptor supervisory services;
- Changes to the rules regarding didactic and research time, and the implications for current litigation;
- Reallocation of residency positions from closed hospitals; and
- The impending redistribution program for unused residency positions.

Presenters: Ronald S. Connelly, Esquire, Partner, Powers Pyles Sutter & Verville PC, Washington, DC; Lori K. Mihalich-Levin, Esquire, Senior Policy Analyst, Association of American Medical Colleges, Washington, DC

Moderator: Andrew D. Ruskin, Esquire, Partner, Morgan Lewis & Bockius LLP, Washington, DC

Hospital-Physician Integrations—Advanced Case Study of Legal and Valuation Issues Raised in Hospital-Physician Integration Transactions (Advanced)

Wednesday, June 9, 2010

1:00-2:30 pm Eastern

Co-sponsored by the Business Law and Governance; Hospitals and Health Systems; and Physician Organizations Practice Groups

Using a simulated case study approach, we will highlight legal issues commonly raised in hospital-physician integration transactions. This will be an “advanced” session, we will presume that participants have a working knowledge of the Anti-Kickback Statute (AKS); Stark Law; tax laws and regulations affecting tax-exempt organizations; and other applicable state and federal statutes, laws, rules, and regulations. We will

concentrate on identifying and exploring AKS, Stark, and other issues raised under the facts of the case study in connection with the negotiation and structuring of the acquisition transaction, the physician employment model, the physician compensation plan, and the fair market value appraisals that will support the practice purchase price and the projected physician compensation under the compensation plan. Each member of the panel will close with a “Top 10” list of “Do’s” and “Don’ts” compiled from each panelist’s experiences in working on physician-hospital acquisition and integration transactions.

Presenters: R. Michael Barry, Esquire, Member of the Firm, Epstein Becker & Green PC, Atlanta, GA; Richard M. Cameron, Principal, EthosPartners, Chesterfield, MO; Shane P. Goss, Director, Wellspring Partners, Chicago, IL

Moderator: Daniel J. Mohan, Esquire, Partner, Kilpatrick Stockton LLP, Atlanta, GA

Social Media: The Opportunities and the Challenges in Healthcare

Wednesday, June 16, 2010

1:00-2:30 pm Eastern

Sponsored by the Health Information and Technology Practice Group

The explosion of social media has created both opportunities and challenges in the healthcare industry. This webinar offers a practical approach to navigating the legal issues inherent in the use of technology tools like blogs, wikis, Twitter, Facebook, and other social media-driven technology. The webinar will examine the impact that social media is having on healthcare organizations and the industry.

Designed for both newcomers and seasoned users of social media, participants will benefit from the real-world experiences and insights of speakers actively engaged in advising clients regarding social media initiatives. The webinar will address: (1) the use of social media in the healthcare industry; (2) legal issues of particular interest to healthcare institutions (e.g., privacy, security, regulatory compliance, intellectual property, professional liability, litigation, discovery, etc.); and (3) tips for drafting effective social media policies and procedures. The speakers will utilize actual hands-on experiences to illustrate how best to reconcile the social media business goals of healthcare institutions with the legal issues inherent in pursuing those goals.

Presenters: Robert L. Coffield, Esquire, Attorney, Flaherty Sensabaugh & Bonasso PLLC, Charleston, WV; Daniel S. Goldman, Esquire, Legal Counsel, Mayo Clinic, Rochester, MN

Moderator: Linda S. Ross, Esquire, Healthcare Department Chair, Honigman Miller Schwartz and Cohn LLP, Detroit, MI

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