



KSDB Health Law INSIGHTS

Kalogredis, Sansweet, Dearden and Burke, Ltd.

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2008 physician fee schedule proposes Stark II changes

By Michael R. Burke, Esquire

On July 12, 2007, the Centers for Medicare and Medicaid Services ("CMS") published in the Federal Register its proposed 2008 Medicare Physician Fee Schedule ("Fee Schedule"). In addition to proposing payment rates for 2008, CMS proposed several changes to Stark II and to rules governing the billing of diagnostic tests. These changes may not be finalized in the final Fee Schedule. Given that the changes are proposed and not final, this article will highlight some of the key items so that you are aware of how they may affect your arrangements.

Diagnostic tests

Several changes were proposed to billing Medicare for diagnostic

tests that would significantly affect the manner in which physician practices and other entities utilize professionals to interpret diagnostic tests. The proposed rules would expand the existing rule which prohibits the mark-up of the technical component of a diagnostic test to also apply to prohibit mark-up of the professional component of tests. This prohibition would apply regardless of whether the purchased professional component is considered to be "reassigned to" or "purchased by" the physician or group practice. As an example, if

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Bill Kalogredis named a Pennsylvania Super Lawyer

Bill was listed in the June 2007 issues of *Philadelphia Magazine* and *Pennsylvania Super Lawyers* magazine as a Pennsylvania Super Lawyer, for the third consecutive year. The honorees were selected by Pennsylvania attorneys. Only 5 percent of Pennsylvania attorneys received this distinction.



Front row: Jeff, Bill, Dave Back row: Susan, Mike, Karilynn, Leif

Proposed Stark II changes

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this rule were to become finalized, a physician group that pays a radiologist \$30.00 to interpret an MRI and then collects from Medicare \$40.00 for such an interpretation would only be permitted to

Changes were proposed to billing Medicare for diagnostic tests. bill Medicare \$30.00 for it. The proposed changes to the rules related to billing for diagnostic tests also include clarifications

to the existing prohibition on marking up the technical component of diagnostic tests. CMS would consider the use of part-time employees and independent contractors to be “outside suppliers,” with the provision of services by these individuals to be considered to be a “purchased” technical component. In most existing arrangements, these individuals would be considered part of a physician practice’s staff and not part of an outside supplier providing a technical component to a physician or group practice.

Possible specific changes

In the Fee Schedule, CMS proposes several specific changes to Stark II and solicits comments on other changes that it would like to make but did not “officially” propose. The following Stark II issues are addressed in the Fee Schedule:

- CMS proposes to narrow the exception for space and equipment leases to prohibit unit-of-service payments to a physician lessor for services rendered by the entity which leases such space or equip-

ment from the physician to patients who are referred by the physician lessor.

- While CMS reaffirms that percentage based compensation arrangements for personally performed physician services are acceptable where the percentage is based on the revenues directly resulting from the physician services, CMS proposes that percentage compensation arrangements would not be permitted in other types of arrangements (e.g., space and equipment, rentals and management agreements).
- CMS proposes to significantly alter the ability of “under arrangements” joint ventures to continue by revising the definition of “entity” under Stark II. In order to address concerns that hospitals were entering into “under arrangements” joint ventures where the hospital had previously provided the services alone, CMS proposed revising the Stark II definition of entity to include both the entity that submits the claim for the provision of a designated health service as well as the entity that performs the designated health service for the entity which bills such service.
- CMS proposed to alter the analysis of indirect ownership arrangements where an entity that provides designated health services owns or controls another entity that provides designated health services to which a physician refers patients. CMS proposes to “collapse” the two entities for purposes of analyzing the ar-

angement between the entities and the physicians who refer to the entities, making it harder to meet an exception for these arrangements.

- CMS proposes that an entity submitting a claim for payment of a designated health service bears the burden of establishing that the service was not furnished as a result of a prohibited referral under Stark.
- CMS discusses, but does not propose, changes to the in-office ancillary services exception, which is used by most physicians and group practices to provide designated health services in their offices in compliance with Stark II. CMS is concerned that use of the exception has grown beyond its original intention for services that were closely connected to the physician’s practice. In the Fee Schedule, CMS solicits comments on whether certain designated health services should no longer qualify for the in-office ancillary services exception, whether changes are necessary to the requirements of where designated health services are performed, and whether in-office ancillary

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services should be limited to those that are needed at the time of an office visit.

It is important to stress again that the foregoing changes are only proposed and that they may

not be finalized in the final Fee Schedule. Similar changes were proposed in the 2007 Fee Schedule to the reassignment rules and to the “centralized building” definition of the in-office ancillary ser-

vices exception, but were never implemented. However, it is important to be aware of CMS’ thought process on these issues, as they may end up being addressed in future regulations. ■

The use of criminal records in employment

By David R. Dearden, Esquire

Current computer and Internet technology has made the discovery of employees’ criminal records much easier to locate. The automation of records and the improvements in computing power have enhanced the compilation and distribution of criminal records so that they may be retrieved from our computer screens rather than by making a trip to the courthouse.

The criminal records maintained by the Pennsylvania State Police may now be accessed through its “PATCH System.” The PATCH website is located at www.psp.state.pa.us. In addition, the Administrative Office of the Pennsylvania Courts (“AOPC”) is planning to make the criminal record information maintained in its computer system more readily available to the public. It has established a web site at www.ujspportal.pacourts.us.

Increased scrutiny of applicants

Employers have become more interested in performing criminal background checks for a number of reasons. The safety demands in the post-September 11, 2001 environment have encouraged many employers to become more security conscious. Certain federal laws, such as The Patriot Act, and state laws that regulate employees

who work with the elderly and with children, have made criminal record checks by employers mandatory. Employers who desire to minimize risk and loss, avoiding theft and reducing the potential for negligent hiring law suits, have also increased the demand for criminal record information.

The administrative boards regulating professionals in Pennsylvania are also interested in criminal record information during the licensure process. Chiropractors, dental hygienists, midwives, osteopathic physicians, physician assistants, podiatrists and speech pathologists all may have their licenses revoked for felony convictions or crimes of moral turpitude that relate to their profession. Dentists, nurses, medical doctors, social workers, pharmacists, physical therapists, psychologists and veterinarians will have their license revoked if they have a felony conviction.

Care in using criminal record data

The ease of making a criminal record search and the increased use of criminal record information by employers has made it more difficult for individuals who have a criminal record to obtain employment. In some circumstances, because errors occasionally develop in the record keeping process, em-

ployees seeking employment are falsely accused and disqualified from employment.

Employers should use due care using criminal record searches to determine whether or not a person qualifies for employment. Under Pennsylvania law, an employer may use felony and misdemeanor convictions to disqualify an employee from employment only when the conviction relates to an applicant’s suitability for employment. In other words, there must be a causal connection between the crime and the concern that the employer is looking out for or else the employee may have a cause of action against the employer under state law.

An employer may not use an arrest record to disqualify individuals from employment because arrest records are not necessarily reliable and may have an adverse disparate impact on certain classes of individuals.

Identity theft and other anomalies have resulted in a false criminal profile for some job applicants. There are consumer protections in place when employers use commercial vendors to search for criminal records and other infor-

Employers should use due care using criminal record searches

mation such as credit history. The Federal Credit Reporting Act applies to such employers. That Act has several simple requirements. When an employer is intending to use a commercial source to search for criminal and credit history, the employer must provide to the employee clear written notice that it intends to request such a report and should obtain written autho-

rization from the employee so that it is clear the employee is notified that such authorization is a condition of employment. In the event that the employer intends to use information that is returned by the vendor, a copy of the report must be given to the employee so that the employee has an opportunity to correct any errors on the form before an adverse action is taken against the employee.

We recommend that when an employer conducts its own criminal background check it should use due care to make sure that information is not misused. This means that an authorization form should be secured by the employer for each employee and the results of the search must be provided so the employee has notice and opportunity to correct the record. ■

There are no perfect contracts

By Jeffrey B. Sansweet, Esquire

When I meet with a physician who is either completing his or her training and about to join a practice as an employee or finishing his or her employment phase and about to become a partner, I often feel as if my client is seeking perfection. They have talked to all of their acquaintances who are either going through the same process or have already done so, and feel as if their deal should be a combination of the best of all.

Of course, that is not realistic and it is my job to explain that each practice and each deal is unique. The best I can offer is to explain the wording of the proposed contract(s), compare the deal to others I have seen over my 22 years of practice in the healthcare field, and try to negotiate as many favorable revisions as possible under the circumstances.

A very important factor in how successful negotiations may be is what the practice has done in its recent past. If my client is the first doctor the practice has hired in the last ten years or is the first doctor offered partnership, we could have much more bargaining

power than if my client is the third doctor in the last five years that has been hired or offered partnership. In the latter situation, the practice will claim it does not want to upset the apple cart by presenting a better deal than the previous deals. Of course, if my client has a unique and lucrative subspecialty, such as electrophysiology or interventional cardiology for a general cardiology practice, this may lead to more leverage.

Conversely, when a group practice client asks me to prepare a contract, I am sometimes asked "Isn't there a boilerplate document you can spit out and send me to look over to fill in the blanks?" We certainly do not start drafting from scratch for each "ordinary" transaction. However, each deal is unique and the "master" documents are merely a starting point.

New doctor contracts

In a new doctor contract, the hours may be spelled out if it is a part-time arrangement. The office locations at which the new doctor may practice may be included if the practice has several offices. Call coverage may be specified.

The compensation may be expressed as an annual salary which may or may not change each year, a daily rate, an hourly rate or a percentage of collections. There may be a discretionary bonus, no bonus, a bonus based upon collections above a certain threshold, or a bonus based upon whether the practice owners do better financially than before the new doctor was employed. The bonus may be payable quarterly, semi-annually, or only after the doctor has completed a full year of employment. The fringe benefits and expenses to be paid by the practice can vary considerably, and may include health insurance for the doctor only, health insurance for the doctor and his or her dependents, disability insurance, life insurance, a profit sharing/401(k) plan, a signing bonus, a moving expense reimbursement, malpractice insurance, 3-4 week's vacation/meeting absences, sick pay, maternity leave, professional society dues, meetings and conferences, and an automobile allowance.

A new doctor should not necessarily focus on the exact details of the compensation and perks

when comparing two or more practice opportunities. Which practice feels right in terms of personality of the other doctors, location and long-term financial outlook is more important. For example, if a doctor's starting salary is \$160,000 with fabulous perks, but the partners are making \$250,000 per year, is that a better offer than a starting salary of \$135,000 and the partners are making \$325,000 and the anticipated buy-in is reasonable? The answer may be yes if the doctor is looking for a short-term "job" instead of planning on staying long-term.

Two of the most contentious issues in new doctor contracts are the restrictive covenant and the malpractice "tail" coverage provisions. Except in a few states where restrictive covenants are not enforceable against physicians by statute, almost all contracts contain restrictions and/or penalties for competing with the practice after termination, so it is unrealistic to take the position that you will not join a practice that has such a provision. In order to be enforceable, the time and geographic restrictions must be "reasonable" as determined by a judge or jury under the particular circumstances. A reasonable area may be 10 miles in the Philadelphia suburbs, 30 miles in a rural area, and a number of blocks in Manhattan. Not many cases are tried and/or appealed as alleged violations of the covenant are sometimes not pursued by the practice in order not to generate negative publicity and legal fees and many other times the case is settled prior to trial with a financial payment. The covenant also

often acts as a deterrent in that the doctor does not want to be sued even if he or she might be successful in arguing it is not reasonable and prospective employers also tend to shy away from making an offer to someone who may be subject to a covenant so as not to be involved in a lawsuit for interfering with contractual relations.

Since malpractice insurance premiums have skyrocketed and many companies will no longer write "occurrence" policies, the issue of who is responsible for the payment of the required "tail" premium when a doctor leaves a practice and no longer is insured by that company should be addressed in the contract. Some practices will take that responsibility in any event and other contracts will require the doctor to pay. Other contracts provide that the payment will be shared equally. Another common way to deal with this issue is to require the practice to pay the tail if it terminates the doctor without cause or does not offer partnership after 3 years, and to require the doctor to pay if he or she quits or is terminated for cause.

Partnership deals

Partnership deals are more complicated and vary more greatly than basic employment arrangements. Some practices, but not many, take the position that if a doctor works hard for three years at a set salary, they have paid their dues and require a buy-in to the value of the tangible assets only. Other practices charge a significant amount to also buy-in to the goodwill and accounts receivable. One must try not to compare his

or her deal with an acquaintance as the circumstances may be completely different. For example, the deal with no buy-in may lead to net take-home pay after factoring in the buy-in that is less than a deal with a large buy-in if the latter practice is more lucrative.

The tax structure of the partnership arrangement is also a very important variable. In a majority of cases, the junior doctor pays for his or her stock (if the practice is a corporation, and if not, his or her partnership interest or membership interest) out-of-pocket based upon the

value of only the tangible assets, and "pays" for the goodwill and receivables on a pre-tax basis by means of a salary shift to the senior doctors. In other cases, the buy-in is entirely for stock and therefore all on a post-tax basis. Thus, a stock buy-in for \$300,000 could actually cost more than a stock buy-in of \$20,000 and a pre-tax salary shift of \$400,000.

Finally, practices vary considerably on how much the initial employment contract deals with partnership. Many do not mention it at all; some include a vague reference to partnership; others state that partnership will be considered after two or three years and occasionally mention the buy-in terms; and very rarely partnership is guaranteed if the doctor is still employed as of a certain date. Sometimes there is a separate letter of intent setting forth likely

Practices vary considerably on how much the initial employment contract deals with partnership.

parameters of the partnership deal if such deal is actually offered.

In conclusion, it is important to keep in mind that each employment and partnership deal is unique and cannot always be easily compared to other deals. In ad-

dition, a new doctor must be reasonable when asking for certain changes to the contract and the practice should expect such requests and respond in a reasonable manner. The doctor should not expect perfection and the prac-

tice should not be close-minded. Partnership deals should be presented on a timely basis and negotiations should be kept as "friendly" as possible. ■

Proposed disciplinary expert testimony change

By Karilynn Bayus, Esquire

The Pennsylvania State Board of Medicine ("Board") recently introduced a proposal to amend the current regulations for physicians who can testify as experts in disciplinary actions before the Board. The proposed regulations would set the same requirements for experts as are required under the Mcare Act for medical professional liability actions. This proposal would shift the current practice of the Board from simply enumerating lists of licensed physicians and surgeons who can be used as medical consultants to a criteria-based method.

Like the Mcare Act requirement, the proposed regulations establish that an expert must possess an unrestricted physician's license and be engaged in or have retired within the last five years from clinical practice or the teaching of medicine. These criteria can be waived, except in standard of care testimony. For standard of care testimony, the expert must also be familiar with the specific care given at the time of breach, practice in the same specialty and subspecialty (or a subspecialty with a substantially similar standard of care for the specific care in question) as the respondent physician and be board certified

by the same board, if applicable. There are certain, limited, waivable elements to these criteria in particular scenarios.

The rationale underlying the new regulations is to enhance the quality of testimony given at Board hearings. Conversely, from a practical standpoint, finding these specified experts may prove to be difficult and expensive. Of the organizations that commented on the proposed rule, the Hospital and Healthsystem Association of PA and the Pennsylvania Medical Society both supported the

proposed changes. The Pennsylvania Academy of Family Physicians supported the proposed rule, but suggested that the standards only apply to experts testifying against the physician and not those testifying on a physician's behalf. The Board ultimately decided against this proposal, in favor of improving testimony for the whole proceeding. Comments on the proposed rule can be sent to Gerald S. Smith, Senior Counsel in Charge, Department of State, P.O. Box 2649, Harrisburg, PA 1705-2649. ■

Take your practice's vital signs

By Dorothy R. Sweeney

How healthy is your practice? In the crush of putting out day-to-day fires and getting through the daily routines, physicians and managers sometimes fail to review a practice's "vital signs." With the reams of month-end computer reports, it's often too easy to overlook the very things that are important to a practice's on-going success. While there certainly are variations because of specialty, size, number of providers and locations, here are some indicators to review monthly.

Practice volume

A practice may feel overwhelmed with patients, but what

do your patient numbers actually show and which ones are relevant to monitor? Keep track by month and year-to-date (with comparison numbers from the previous year if possible) for:

Total number of patient visits by provider and by location

Number of new patients (not existing patients who just haven't been seen for awhile) by provider and by location

Number of consults by provider and by location

If you are a specialty practice, track patient visits sent to you by your major referrers, so you may spot any changing trends in referral patterns and take steps to deal with any problem.

Monitor monthly your benchmark statistics so you may make adjustments quickly if need be. For example, pediatricians should know the number of newborns in their practice each month; ophthalmologists should know the number of cataract patients; primary care should know the number of physicals; ob-gyns should know the number of new ob patients, and so on. Determine what your benchmark items are and then review those numbers monthly. Recognize there will be monthly variations because of vacations, seasonality and so on, but by analyzing the numbers you can see if you are on track. If not, you can be proactive to determine what you need to do.

Similarly, if you provide any ancillary services (lab, physical therapy, special testings), look at those numbers to determine if they continue to be a viable adjunct to your practice.

Another overlooked area of patient statistics is the number of no-shows and/or cancellations. For those practices that routinely schedule somewhat farther in advance, review the number of patients who cancel or simply do not show. These are lost opportunities for you, but also could point out underlying problems in your practice's business systems. If you are having cancellation problems, look at the timing of the next available appointment, perhaps by provider and by patient type (new patient, existing patient, certain procedures). You may need to adjust your scheduling template.

Financial management

You can easily monitor your practice's gross receipts each

month and year-to-date (again with a comparison to the same period last year if possible). It is better to analyze your practice's vital signs, however, if you monitor this information by provider; by any ancillary services and by location. Look critically at each part of your practice to determine its overall financial health.

Your total practice expense (excluding physician salary and fringe benefits) is your operating overhead. This may be expressed as a percentage of your receipts. Recognize there will be monthly variations in your overhead ratio, depending on when some larger expenses are paid. Your year-to-date overhead ratios will give you a truer picture of your overhead costs. Depending on specialty, overhead ratios average from the mid-40% range to the mid-60% range. To give you a more valid picture of your operating "profit," break down expenses along the same lines as you categorize practice revenues – by provider; ancillary services and location.

Keep track of your accounts receivable on a monthly basis, monitoring:

- **The aging of your various accounts receivable.** Days in A/R is an important category. With claims filed electronically, the average days in accounts receivable is now about 40 days as a benchmark. Insurance companies are under pressure to shorten the payment cycles. Know your average number
- **Insurance pending categories.** Review your largest insurers to make sure they are not playing games with your

money! How long are they taking to pay you and are they complying with their contracts about payment?

- **Contractual disallowances.** This helps you focus on your fees. If you are being paid too close to your billed amount, you could be losing money and may need to raise your fees. And, as a result of looking at this category, your manager should spot check your EOBs to be sure you are being paid the contractual amount from your major payors.
- **Other write-offs.** Is your policy too generous, or are you writing off amounts you should be sending to collection?
- **Amounts to collection agencies.**

You take your patient's vital signs at each visit. Do the same with your business at least monthly. ■

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Jeffrey B. Sansweet will speak at the American Academy of Ophthalmology Annual Meeting on November 11 and 12, 2007 on Employment Agreements and Partner Deals in New Orleans. Jeff wrote an article on "How to Divide the Practice

Pie" in the July 2007 issue of *Physician's New Digest*.

Bill Kalogredis spoke to dermatology residents and fellows at Geisinger in Danville, PA on September 18, 2007 on Employment Agreements. Bill will speak in Quebec City on October 9, 2007 to pediatric neurology fellows on Employment Agreements. He will speak to the American Academy of Cardiology-Pennsylvania Chapter at its annual meeting on October 12, 2007 on contracts. On October 21, 2007, Bill will speak to practicing dermatologists at the Clinical Dermatology Conference in Las Vegas on "Five Legal Tips." Bill will present in Philadelphia at the American

Epilepsy Society Meeting on November 30, 2007 on Employment Contracts and Running the Medical Practice as a Successful Business. He will also talk in San Antonio at the American Academy of Dermatology Practice Management Symposium on January 31, 2008 on Employment Agreements, Negotiation Tips, and Five Practical Tips. Bill has also been authoring a monthly article on healthcare law for the *Legal Intelligencer*, the oldest law journal in the Philadelphia. Bill has authored an article for an upcoming issue of *Physician's News Digest* on "Would a Practice Merger Be Right for You?"