



# KSDB Health Law INSIGHTS

Autumn 2009

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## Doctor compensation arrangements

*By Vasilios J. Kalogredis, Esquire*

Particularly when the financial realities of the health care field, not to mention the general economic environment, become more difficult and tight, we find more doctors and their employers and/or "Partners" focusing much more critically on their remuneration undertakings. When times are good, there is plenty of money to spread around and people are less inclined to start fighting about their respective shares of that pie. However, when times are tight, and the available funds for the doctors becomes lower, it can become much more of a "battle royale."

This is not a "one size fits all" thing.

Each practice situation will have a different resolution of the issues

involved in this important economic area. In a practice setting, each Group will arrive at what's best for it and its physicians based upon the totality of the dynamics of the practice. Where one is dealing with an entity employing physicians, the philosophy of the employer and how it best aligns with those of its doctors will dictate what works best.

There are many factors involved. They include the practice's philosophy about medicine; the practice's goals; the values of the practice and its principals; the economics of the practice; the trends of the practice; the relative equality of contribution to the practice by the participants; and the culture of the practice.

There are various ways of splitting the pie.

One "extreme" would be to go with an "equal split" of net income or an otherwise pre-arranged and agreed to percentage split (for example, 60% to Dr. K and 40% to Dr. W). Generally, business expenses of

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### KSDB Super Lawyer Honors

We are pleased to announce that Bill Kalogredis and David Dearden were each listed in the June 2009 issue of *Philadelphia Magazine* and *Pennsylvania Super Lawyers* magazine as a Pennsylvania Super Lawyer. The honorees were selected by Pennsylvania attorneys. Only five percent of Pennsylvania attorneys received this distinction.



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

## Compensation arrangements

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the practice would come off the top in such an arrangement and the physicians would share what is left in the pre-agreed to percentages. The pros of this approach are that it is simple and straightforward; engenders an “all for one and one for all” attitude and does not foster intra-group competition. The cons are that it does not recognize large variations in productivity/work level and other contributions to the practice; there is no “direct responsibility” for costs; there is no “direct responsibility” to bring in revenue; and it may not be reflective of the perceptions or the realities of what each doctor is contributing to the practice. It also does not incentivize and reward one for harder work. Oftentimes, this approach ends up with the participants going to the “lowest common denominator” relative to what work levels each will be willing to provide if he or she is not going to directly benefit economically from that harder work. This is particularly true when the perception or reality is that some of the doctors are not carrying their weight.

The other “extreme” involves a more individualistic compensation model.

In that approach, each doctor is at financial risk and reward for his/her personal performance. One example of a simple approach would be to pay a physician, say 40% of his/her collections as his/her compensation. Another popular approach would be to allocate the pool available for physician compensation on the basis of the “relative productivity” (which

may be measured by collections, charges, RVUs) of the doctors. Under this approach, each doctor is truly treated as a separate economic unit from a compensation standpoint. A physician’s revenue minus his/her share of overhead would equal that doctor’s compensation.

Some groups will allocate the physician compensation pool totally on the basis of relative productivity, thereby allocating overhead in the same ratio. Others will allocate the “top line” revenue aspect totally on the basis of what comes in from what that doctor produces but then allocates overhead in a different fashion. Some will allocate that overhead on a totally equal basis; others on an otherwise agree to split ratio; others on a “strict cost accounting” approach (for example, directly allocating one’s own used staff, space, etc. to that doctor); others on the basis of full or partial relative productivity; others may allocate fixed overhead items equally and variable overhead items on the basis of relative productivity with physician specific items directly allocated to that particular doctor who benefits from them. Those physicians’ specific items might include things such as CME, malpractice insurance, retirement plan contributions, other fringe benefits, and the like.

Among the pros of this more individualized approach is that it promotes a feeling of personal responsibility to generate revenue and to pay for overhead. Some call it an “eat what you kill” approach. Oftentimes it is perceived as fairer by all parties involved. You produce less, you make less. You pro-

duce more, you make more.

There are several cons, however. It tends to discourage a “team” perspective; it encourages “me” thinking; it is more likely to raise “Stark” issues; it encourages intra-practice competition; it may cause arguments as to how work and patients are allocated; it encourages more micro-management of expenses; and it does not factor in other contributions to the practice which may not be measurable by pure dollars and cents. These include things such as management, coverage, hard-working/not highly reimbursed service doctors (for example, medical ophthalmologists in a surgically oriented ophthalmology practice providing cases for the surgeons).

Many practices go to an approach which combines both the team and individualistic concepts.

A common example is one whereby some percentage of the physician compensation pool is equally split with the balance split on relative productivity. Another variation, particularly in an employment model, might provide each physician with a pre-determined base annual salary, with any physician bonus pool monies being paid on the basis of rela-

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tive productivity. These approaches attempt to balance the pros and cons of the team oriented and individualistic models to arrive at the proper balance for the practice. Once again, each group of doctors and each practice situation is different and no one can tell any group of doctors which way is the only way for them to go. As a matter of fact, a successful compensation model is one that is continually reviewed to see if it is properly aligning the practice's and individual doctor's incentives and goals in the proper fashion. It should be viewed as a "living thing."

Once one decides how compensation is to be formulized in a practice setting, one needs to agree as to what portion of the pot is to be allocated in such fashion. Some will only focus on W-2 compensation. Others will look at W-2 compensation, plus fringe benefits and certain business expenses.

Among the "ordinary and necessary business expenses" which an employer may pay for its em-

ployees are things such as malpractice insurance, CME, professional dues, legitimate business-related automobile expenses, marketing/promotion/entertainment, and professional books and journals. If paid for by a business, these items are more fully deductible than they would be if an employee were to try to pay these items personally and deduct them on their personal returns. As a general rule, individual tax deductibility of unreimbursed employee expenses are limited and only that the portion equal to or greater than 2% of one's Adjusted Gross Income plan may be deducted at all. There are also further reductions in deductibility for higher income earners under the present tax laws.

Fringe benefits (such as disability insurance, health insurance, retirement plans, and the like) are also much more deductible if paid for by one's employer than they would be (if at all) by an individual.

In evaluating any compensation arrangement, one needs to also look at the Federal Anti-Kickback Statute as well as the Stark laws. This is something that we do as part of an evaluation process for anyone considering such arrangement.

Generally, I have found, that it is not uncommon for every doctor in a group to feel that he/she is underpaid in relation to what others in that group are getting. It is probably human nature. Oftentimes, the best way to come to an equitable resolution of issues such as this these is to sit down with each doctor privately and get his/her honest answers as to what he/she believes his/her contribution to the practice is in relation to others. That input, combined with a "look" at the practice's economics and the relative dollar contributions and time contributions of the parties involved allows us to make recommendations as to what might work best in that particular setting. ■

## Medicare's recovery audit contractors

*By Michael R. Burke, Esquire*

In the Medicare Prescription Drug Improvement and Modernization Act of 2003, Congress required the Center for Medicare & Medicaid Services ("CMS") to implement a three year demonstration program (conducted in California, Florida and New York) using recovery audit contractors ("RACs") to determine whether RACs could be a cost-effective means to uncover overpayments and underpayments in the Medicare system. Because of

the large number of improper payments that the RACs uncovered during the demonstration project, the Tax Relief and Health Care Act of 2006 made the RACs program permanent and required its expansion across the nation by January 1, 2010.

RACs will determine the health care providers that will be reviewed for overpayments or underpayments based on their own proprietary software and systems as well as their knowledge of Medicare rules and regulations (to

determine what areas to review). RACs will use two methodologies to determine whether an overpayment or underpayment exists: automatic reviews and complex reviews. In automatic reviews, RACs will not make a medical record request, but will instead use information technology developed by the RACs to determine whether overpayments have been made and will utilize clear policy serving as the basis for denial, such as statutes, regulations, National Coverage Determinations

and Local Coverage Determinations. Complex reviews consist of chart reviews made by individuals engaged by the RACs, and RACs are required to employ a staff consisting of nurses, therapists, certified coders and a physician certified medical director in this regard.

All RACs review claims on a post-payment basis. RACs will not be able to review claims paid prior to October 1, 2007, and as time goes by, will not be able to look back more than three years from the date a claim was paid.

CMS has limited the number of medical records that can be requested by RACs. A RAC can only make a request for the following medical records from physicians (defined to include physicians, podiatrists and chiropractors): sole practitioner – 10 medical records per 45 days per NPI; partnership (2 to 5 individuals) – 20 medical records per 45 days per NPI; group (6 to 15 individuals) – 30 medical records per 45 days per NPI; and large group (16+ individuals) – 50 medical records per 45 days per NPI.

The bad news for physicians and other health care providers is that RACs are paid on a contingency fee basis based upon the amount of overpayments that they recover, giving them extra incentive to push for overpayment recoveries. RACs also are permitted to use statistical sampling and to extrapolate the results of their findings to calculate an overpayment. However, providers still have the full regular Medicare appeal process to contest an overpayment demand made by a RACs. In addition, after receiv-

ing the demand notice initially issued by a RAC for an overpayment, the provider may request a meeting with the RAC to discuss the RAC's determination, which is not part of the formal appeal process. Please note that this discussion stage does not delay or stay the need to file an appeal within the appropriate time frames from the date of the overpayment determination.

Diversified Collection Services has been selected to be the RAC for Pennsylvania, New Jersey and Delaware (among other states). RAC reviews were slated to begin as early as August, 2009 in these areas. RACs will not replace all current payment review

entities, and Medicare carriers and the Office of Inspector General will still independently review provider claims.

RACs become another arrow in the quiver of Medicare in its battle against incorrect payments and billing fraud. As has been the case with overpayment requests made by Medicare carriers in the past, overpayment requests made by RACs should be reviewed carefully, and if you have any questions with regard to the nature of the review or the determination that has been made by a RAC, please feel free to contact our Firm for assistance in dealing with these RAC audits. ■

## Keeping pace with the Red Flags Rule

*By Karilynn Bayus, Esquire*

By now, many of you may have heard mention of a federal government regulation known as the Red Flags Rule (the "Rule"). Some of you may have already begun to implement a plan to bring your practice into compliance. Others may still be wondering what exactly you are required to do. Perhaps you are wondering when the FTC will actually begin enforcing this Rule. This article seeks to bring you up to speed on what the Rule is and the status of its enforcement.

### What is it?

The Rule is actually a set of regulations required to be created by the Fair and Accurate Credit Transactions ("FACT") Act of 2003. The goal of the Rule was to have covered entities create programs designed to detect, prevent and mitigate identity theft.

The overarching goal is to reduce identity theft instances and mitigate the damages relative thereto.

The Rule requires compliance by every "financial institution" or "creditor" that maintains "covered accounts." This means that two steps must be taken to determine if you are subject to the Rule: 1) determine if you are a "creditor" or financial institution and 2) determine if you maintain covered accounts.

"Covered accounts" is defined broadly under the Rule. There are two types of "covered accounts." First, there are those that a financial institution or creditor "offer or maintains, primarily for personal, family, or household purposes, that involves or is designed to permit multiple payments or transactions..." The second is an account for which there is a foreseeable risk of identity theft.

For purposes of this article, the definition of “financial institution” is not relevant. However, a “creditor” is defined as “any entity that regularly extends, renews, or continues credit; any entity that regularly arranged for the extension, renewal, or continuation of credit...” There is no minimum number of employees or owners for a practice to be considered a “creditor.” The FTC has determined that because physician and dental practices allow patients to defer payment of a bill for services rendered (often until a portion of the claim has been paid by a third party payor), they are “creditors” under the FACT Act and Rule. Because of the broad definition of “covered account,” it is likely that if you are a “creditor” you are subject to the Rule. There is a civil monetary provision for failure to comply with the Rule.

### What must I do?

Assuming that medical and dental providers continue to fall under the Act’s definition of “creditor,” they will have to comply with the Rule’s requirements.

The Rule generally requires that “creditors” create a written program that includes “reasonable policies” to accomplish four goals: (i) identify relevant Red Flags for the covered accounts of that creditor and incorporate those identified Red Flags into the program; (ii) detect the Red Flags that have been incorporated; (iii) respond to the detected Red Flags in order to “prevent and mitigate” identity theft and (iv) update the program periodically to reflect changes in risk. The written program must be approved by the

entity’s Board of Directors (or, if there is no Board, a senior employee). Appropriate training on the policy must be provided to the workforce. Employees may require different training on their responsibilities under the program, depending on their role in the organization. In addition, providers must take care that third parties who are granted access to the covered accounts either comply with the entity’s program or have policies in place to comply with the Rule.

The program must be updated periodically. The individual in charge of the program should report at least annually to the board of directors or other appointed senior management regarding the efficacy of the program.

Such a program may be tailored to the “size and complexity” of the creditor. Thus, for smaller practices with a well-known patient base, it is likely that a less detailed and rigorous program would be necessary than that of, for instance, a hospital or bank.

There are certain considerations that you must take into account in developing your program. You must determine the categories of warning signs (the “Red Flags”) of identity theft that may affect your type of business. Your program must be designed to identify and address the types of Red Flags that may come up in your practice. The Rule suggests various types of Red Flags that are common for identity theft. Such Red Flags include identifying information that appears altered or forged, inconsistent personally identifying information and notification by a cus-

tommer of unauthorized transactions on their account.

There are other regulations to which your practice may be subject if you utilize consumer reports.

### Getting your program started

There is some guidance that has been made available to aid entities in the start of putting together a program to comply with the Rule. You should review the Rule carefully prior to creating your program.

In order to help lower-risk entities get started with a program, the FTC has created a web site for the Red Flags Rule that includes information about it along with a basic template for such entities. This template may not be usable for larger or more risk-prone practices, but it allows for a start. This information may be found at <http://www.ftc.gov/redflagsrule>.

In addition, the American Medical Association (“AMA”) has posted a draft program on its web site for physician practices as well as information about the Rule. The AMA information may be found at <http://www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml>. The American Dental Association also has posted materials for its members at <http://www.ada.org/prof/index.asp>.

Any such document, would, of course, have to be tailored to the particular practice and its covered accounts as there is no “one size fits all.” In creating your program, it may be necessary to involve your legal counsel, IT department, compliance officer and other departments or personnel in

order to create a program that is viable for your practice.

### Where does it stand?

The initial implementation date of the Red Flags Rule was set for November 1, 2008. Because the FTC is not an entity that typically regulates professional service providers, many providers did not even know of the Rule's existence. The AMA and others began a dialogue with the FTC, arguing that medical providers are not "creditors" and should not be subject to the Rule. On October 22, 2008, the FTC announced that due to "confusion and uncertainty within major industries under the FTC's jurisdiction about the applicability of the [R]ule," it would delay enforcement of the Rule for six (6) months — until May 1, 2009.

As the May deadline approached, the FTC again delayed enforcement of the Rule — this time for an additional three (3) months (until August 1, 2009). In the most recent development, the FTC granted another extension for its enforcement of the Rule — until November 1, 2009. The FTC has also promised additional guidance for entities with a "low risk" for identity theft.

It is unknown whether this November 1 deadline will stick or not. The AMA, ADA and other groups continue to lobby against the inclusion of professional service providers to the definition of "creditor." The FTC previously stated that this would be a change that Congress would have to make. In the meantime, it is safest to prepare as though the deadline will go into effect. We at KSDB will continue to follow the developments. ■

## Naming a trust as the beneficiary of your retirement plans

By *Stephanie P. Kalogredis, Esquire*<sup>1</sup>

While working with my estate planning clients, I often find that a substantial amount of their net worth is held in IRAs or other retirement plan accounts [401(k), 403(b), etc. — "Qualified Plans"] and that they have named their spouse as the primary beneficiary and their children as contingent beneficiaries of those plans. As our meetings progress and the clients clarify their overall estate planning goals and concerns, I often question whether they have made the appropriate choice of beneficiaries, not at the first death, but after both clients die. Do they really want their child to have unfettered access to a \$2M IRA when he or she turns eighteen? Usually, the answer is no.

Much has been written about how to "stretch" your IRA to allow a beneficiary to use his or her age when calculating each year's Required Minimum Distribution ("RMD"). This allows the account to grow tax deferred until the beneficiary is required by law to take a distribution. Generally, if an individual is named as the beneficiary of an IRA, the RMD will be based on the beneficiary's remaining life expectancy, allowing them to stretch the IRA accordingly. This however, is not to say that the beneficiary of the IRA will withdraw only the yearly Required Minimum Distribution. While this may be the smart tax

approach, in reality nothing can be further from the truth. Too often, beneficiaries view the IRA as "found money" and withdraw the money in one lump sum or at a very accelerated pace. No consideration is given to the income tax consequences of their actions until they are faced with a large tax bill the following April 15th.

One way to control imprudent distributions from an IRA is to name specially designed trusts as the beneficiary of your retirement plan. These trusts are known as "see-through trusts" because the beneficiaries of the trust are treated as "qualified beneficiaries" and the retirement plan can be distributed in annual installments over the life expectancy of the oldest trust beneficiary. If the trust does not qualify as a see-through trust, the retirement benefits must be distributed based on the participant's remaining life expectancy. When the participant's children are the intended beneficiaries, using a see-through trust allows for greater tax deferral than if the trust does not qualify as a see-through trust.

There are two main types of see-through trusts. They are commonly referred to as conduit trusts and accumulation trusts. To be a conduit trust, the trustee must distribute any and all distributions received from the retirement plan to the current trust beneficiary or beneficiaries. Each year when the

<sup>1</sup>Stephanie P. Kalogredis is an attorney with Lamb McErlane PC in Bryn Mawr, Pennsylvania and practices in the fields of estate and trust planning and administration, pre and post nuptial agreements and related areas. She can be reached through our office or directly at 610-527-9200 or [skalogredis@chescolaw.com](mailto:skalogredis@chescolaw.com).

trustee withdraws the RMD and any other amount from the IRA, the full amount must be distributed to the current beneficiary or beneficiaries. Nothing may be held back for future distribution. While a beneficiary is young, the RMD is small and the requirement that all withdrawals from the IRA must be distributed is usually inconsequential. Further, if the trust is to provide for the child's needs — health, education, support and maintenance, the necessary trust distributions will most likely exceed the RMD. However, as the beneficiary ages, the amounts that must be distributed from the IRA and the trust increase dramatically.

Compare this to the accumulation trust, which does not require the trustee to distribute all of the retirement plan benefits that are withdrawn from the plan. The trustee is permitted to accumulate the RMDs and any other distributions from the plan. In the future the plan withdrawals can be distributed between or among any of the trust beneficiaries in accordance with the terms of the trust document. This ability to accumulate funds comes at a cost. When determining the RMD of an IRA payable to an accumulation trust, the age of the oldest possible beneficiary of the trust is used. This class of beneficiaries includes not only the current beneficiaries, but any and all remainder beneficiaries.

The difference between the conduit and accumulation trusts is more easily understood by the following example. Dr. K set up a trust for his daughter, Katherine, who is 30 years old when Dr. K dies. The funds, including his sub-

stantial IRA, are to be held in trust until Katherine is 35 years old at which time the trust terminates and the remaining assets are to be distributed to Katherine. The trust document further provides that if Katherine dies before the trust is fully distributed, the trust would be distributed to Dr. K's older sister, Martha, or if she is not living to Katherine's children. If the trust qualifies as a conduit trust, Katherine, the current beneficiary, is viewed as the oldest beneficiary and her life expectancy is used to determine the annual required distributions. On the other hand, if it is an accumulation trust, all of the beneficiaries of the trust must be considered: Katherine, Martha, and Katherine's children. Even though it is unlikely that Martha will receive anything from the trust, she will be considered the oldest beneficiary of the trust and her remaining life expectancy will be used to determine the RMD for the IRA, even after the trust terminates and Katherine is the sole, outright, beneficiary of the IRA. The fact that Martha no longer has any right to the funds does not alter the distribution requirements.

What type of trust is best? It all depends on the client's purpose for the trust: Is the trust to be the major source of support for the beneficiary, or is it only to provide extra spending money? How many people do you want to benefit from the IRA? Are they to be treated equally or could one of the beneficiaries require more money on an irregular basis? Is the IRA the sole asset of the trust or will other funds be held in the trust as well? How long will the trust ex-

ist? Is it for the lifetime of the beneficiaries or until they reach a certain age? Is the client's goal to make sure the funds provide for the beneficiary's own retirement? What is the income tax impact of accumulating distributions? Is there a reason why the beneficiary should not have a right to the funds? Does the intended beneficiary receive public funds for medical support? Does the beneficiary have a drug dependency problem? The answer to these questions and more will help you and your attorney determine the type of trust that best meets your estate planning goals. ■

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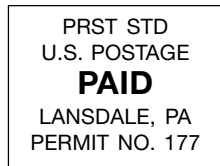
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## NEWSLETTER Autumn 2009

### Speaking and Writing Information and Website

We have extensive experience in speaking and writing on topics of interest to healthcare practitioners. Whether it be your local, state or national society; a group of residents/fellows; or a study group, we would be interested in talking to you about speaking and/or writing opportunities. For more information on our areas of expertise please visit our Website at [www.KSDBHealthlaw.com](http://www.KSDBHealthlaw.com).

Bill Kalogredis spoke to the American Academy of Dermatology Practice Management Symposium for Residents in San Francisco, California on "Employment Contracts and Negotiating Tips" on March 5, 2009. He spoke to the Department of

OB-Gyn at Reading Hospital in West Reading, Pennsylvania on "Negotiating Tips" on May 14, 2009. He spoke at the PICPA Healthcare Conference in Hershey, Pennsylvania on Recruitment and Retention of Physicians on June 2, 2009. Bill will speak at the PA Chapter of American College of Cardiology on "Negotiating Your Employment Contract" at Skytop, Pennsylvania on October 3, 2009. Also, Bill will speak at the American Epilepsy Society Meeting on Negotiating Your Employment Contract in Boston on December 4, 2009.

Bill has also been authoring a monthly article on healthcare law for the *Legal Intelligencer*.

He has also authored an article entitled "Potential Traps in a Practice Sale or Purchase" which will be published in an upcoming issue of *Physicians News Digest*.

Jeffrey Sansweet will be presenting a course entitled "Anatomy of Your First Employment Agreement" at the American Academy of Ophthalmology Annual Meeting in San Francisco on October 27, 2009.

Michael Burke will speak at the 2009 Annual Assembly of the American Academy of Physical Medicine and Rehabilitation on October 23, 2009 on "Negotiation Strategies for Optimal Outcomes".