



Starting a Medical Practice

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Starting a new business is certainly not for the faint of heart, but starting a new medical practice can certainly be a daunting task. The physician starting a practice needs to earn a living, pay off loans, run a medical practice and provide quality care to his or her patients. It is essential that both new and more experienced physicians have a comprehensive understanding of the necessary elements of a medical practice. Many consider obvious elements such as selecting the right location to avoid over saturation in the market, getting phones set up and the anticipated cost of establishment. However, the elements necessary to establishing a medical practice are significant and far-reaching. In addition to running a new business, the health care industry is one of the most regulated industries in the United States.

It would take several articles to cover the issues and considerations for the formation of and successful operation of a medical practice. This article will discuss some broad areas of consideration but it is recommended that you interact with professionals to assist in the formation of the practice. The important people to consider part of your advisory team are an accountant, attorney and management consultant. It is important that you not lull yourself into thinking that since you are highly intelligent and skilled at medicine, you can just “figure” out the formation and operation of a medical practice by reading an article or as you go along. All the decisions that you make have ramifications and must not be considered lightly.

Below are some broad areas of consideration in starting a medical practice or joining an existing medical practice.

I. Forming the practice and Entity Choice

It is essential to have an understanding of the various types of legal entities available (corporation, LLC, partnership, etc.), and the liability and tax consequences associated with each entity choice. Depending upon your interest in capitalization, plans for future growth and the size of the entity, some entities may be more appropriate for your needs than others. It also is helpful to understand anti-trust and security law ramifications, as well as more general issues, such as registering and maintaining compliance with state regulations. Your governance documents are very important to ensure that your practice has a road map to operate. Consultation with an accountant as well as legal counsel who understands business and corporate law as well as health law is very important from the outset.



II. Employees/ Employment Contracts

After forming the practice, the issue then shifts to how employees will be structured. A physician must consider salaries, bonuses, annual increases, benefits and restrictive covenants, such as covenants not to compete. Consideration needs to be given to the type of personnel necessary to operate your practice, contracting with other physicians and the compensation requirements and regulatory considerations for the use of physician extenders such as physician assistants and nurse practitioners. Questions regarding partnership, admission of new owners, termination of owners and employees, buy outs of owners are examples of issues that need to be considered and addressed.

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III. Operation of the Practice

This broad category encompasses everything from staff issues, billing services, adverse incident reports, subpoenas, compliance programs and lease arrangements to designating a HIPAA privacy officer, maintaining HIPAA compliance policies and procedures, email policies, managed care contracts, credentialing, and call coverage. Many practitioners opt to have office policies and procedures for employees to assist in maintaining compliance and in effectuating termination policies, if necessary. Some providers outsource their billing to companies that specialize in these services. Some providers choose to participate with certain managed care networks. Risk management is always important as well.

IV. Additional considerations

You cannot forget the elemental issues like malpractice insurance coverage and asset protection. A physician is advised to weigh the costs and benefits of having coverage versus going "bare." Additionally, it is urged that physicians become educated about regulations on compensation, investment and financial relationships, such as the Stark Self-Referral Laws, federal and state anti-kickback laws, and Florida laws such as the Patient Self Referral Act, the Anti-Kickback Statute and Fee-Splitting laws, the Medical Practice Act, (Chapter 458), the Osteopathic Medical Practice Act, (Chapter 459), Florida Statutes, and the rules published by the Boards of Medicine thereunder, as well as Florida's Patient Brokering Act.

Finally, physicians must be sure to properly apply for and comply with Medicare and Medicaid guidelines, if they wish to be a participating provider. This will entail being assigned a group number and a NPI number and complying with coding guidelines and requirements. Becoming familiar with the requirements for coding and ensuring excellent documentation will put you on the right track to

minimizing an audit, which can be devastating to a practice. There is no substitute for proper documentation whether it be a third party payer audit, a Department of Health investigation or a medical malpractice lawsuit.

Legal Case Review



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Case Summary: *St. Anthony Hospital v. U.S. D. H. H. S., (10th Cir. 2002)*

This is a case involving "reverse dumping" under EMTALA. Reverse dumping occurs when a hospital emergency room inappropriately refuses to accept transfer of a patient who requires the specialized capabilities of a hospital.

In this case, the patient, R.M., was involved in an automobile accident near Oklahoma City and was taken to the emergency room (ER) of Shawnee Regional Hospital (Shawnee). Shawnee is a small hospital 35 miles from Oklahoma City that does not have the capability of performing complex medical procedures. The ER physician diagnosed R.M. with a neurological injury and arranged for an appropriate transfer to University Hospital in Oklahoma City. While en route, the patient's condition deteriorated and the ambulance was forced to return to Shawnee. Dr. Spengler, Shawnee's ER physician and a third-year resident, determined that the patient in fact had suffered an injury to his abdominal aorta, a life-threatening injury requiring immediate surgery. Dr. Spengler contacted University Hospital to advise that the patient's condition

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required immediate care, at which time University Hospital responded that it already had two emergency surgeries to perform and lacked capacity to provide immediate care. Shawnee proceeded to call other hospitals, including St. Anthony Hospital, (St. Anthony), a modern facility in Oklahoma City. St. Anthony refused to accept R.M. R.M. was ultimately air lifted to another facility in Oklahoma City.

Appellate Process: The case was first reviewed by a peer review organization (PRO), followed by a hearing before an Administrative Law Judge (ALJ), then to the Department Appeal Board (DAB), and finally the Circuit Court of Appeals. The Court relied upon the findings of the PRO, ALJ and DAB in rendering its decision.

Allegation: St. Anthony's hospital refused transfer of an unstable patient despite having capacity and capability.

Analysis: The PRO relied upon the medical record and other documentation in reviewing the case to determine whether the transfer refusal merited an EMTALA violation against St. Anthony. The PRO found that the patient suffered from an emergency medical condition, and although the patient's condition was critical, the risks of transfer were outweighed by the benefits. Shawnee's on-call surgery list was provided to the PRO, which indicated that Shawnee physician Dr. Howard was credentialed to perform vascular surgery and repair of an occluded aorta. It appeared that Shawnee did have the staff, services and equipment to provide the necessary medical services to stabilize R.M. However, Shawnee was permitted to provide additional documentation. Shawnee provided the PRO with affidavits supporting the fact that Dr. Howard had not performed abdominal vascular surgery in at least one year and that he did not feel capable of performing such surgery. Based on this additional documentation, the PRO concluded that, from a practical standpoint, Shawnee did not

have the capability to provide further stabilizing treatment in the form of vascular surgery.



St. Anthony requested a hearing before an ALJ. The ALJ found that St. Anthony's ER physician, Dr. Buffington, deferred to the judgment of Dr. Lucas, St. Anthony's on-call thoracic and vascular surgeon as to whether to

accept the emergency transfer. Dr. Lucas and Dr. Spengler discussed R.M.'s condition with Dr. Lucas ultimately refusing to accept R.M. as a patient. The ALJ's findings include that "Dr. Lucas told Dr. Spengler that he was not interested in taking R.M.'s case. He told Dr. Spengler that the case was University Hospital's problem." In addition, the ALJ made findings that "none of [St. Anthony's] operating rooms were in use on that evening and that St. Anthony "possessed the specialized capabilities and facilities, as well as the capacity, to treat R.M." The ALJ additionally concluded that an individual's medical stability is irrelevant for purposes of determining whether St. Anthony engaged in unlawful reverse-dumping. The ALJ imposed civil monetary penalties of \$25,000 on St. Anthony. St. Anthony appealed to the Department Appeal Board (DAB).

While the DAB overruled the ALJ's conclusion that R.M.'s medical stability was irrelevant when determining whether St. Anthony engaged in reverse-dumping, it upheld the ALJ's findings that R.M. was, in fact, not stabilized when the transfer was requested. The DAB ruled that this finding was supported by substantial evidence, citing to specific physician testimony in the record and subsequently increased the civil monetary penalty from \$25,000 to \$35,000.

The Court analyzed the definition and use of "stabilized" as defined in the medical profession versus "stabilized" as defined under EMTALA. The Court held that "stabilized" under EMTALA means

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that “no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.” After its analysis of the use of “stabilized,” the Court upheld all lower tribunal decisions regarding R.M.’s unstable condition at the time of the request for transfer.

The Court additionally addressed the part played by medical judgment in holding that “it is appropriate to consider the informed medical judgment of both the transferring physician(s) and potential receiving physician(s). We note that as a practical matter, however, “any hospital with specialized capabilities of facilities that refuses a request to transfer an unstabilized patient risks violating [EMTALA] to the extent that it chooses to second-guess the medical judgment of the transferring hospital.” The Court further concluded that Dr. Buffington had actual authority to refuse the transfer and, when he deferred this decision to Dr. Lucas, who refused to accept transfer of the patient, Dr. Buffington “effectively refused to accept R.M.’s transfer.” The Court held that St. Anthony was bound by this refusal.

Risk Reduction Strategies:

When a transferring hospital’s ER contacts any Shands facility that has specialized capabilities, the call should be placed directly to the ED. The ED physician should not defer the decision on whether to accept the patient to the on-call specialist physician. Further, if the call is being placed from another smaller facility, the physician from that facility should call the receiving facility’s ED, not a specialist that the transferring physician may know. When receiving a call from a transferring facility physician, the medical staff should not second guess the transferring physician’s judgment as to whether (1) the patient has an emergency medical condition, or (2) the transferring hospital has the capacity or capability to perform the stabilizing treatment for the patient. The best results will be

achieved by accepting the transfer of the patient, then if after transfer, the facts warrant an investigation, contact Risk Management. If, after an investigation, Shands Legal determines the transferring hospital violated EMTALA, a report of suspected EMTALA violation will be made to AHCA.



**Sweet Repeat!!
Congratulations Gators!**

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