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—from a declaration of the American Bar Association

The Corporate Practice Of Medicine Doctrine: Is it Applicable to Your Client?

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Introduction

Many clients are not sure if the state in which they want to form their medical practices has adopted the Corporate Practice of Medicine Doctrine (CPOM Doctrine), and if it has, whether it is applicable to their particular practices' corporate structure. The rapid and complex changes in the healthcare delivery system have led to a renewed focus by federal and state governments and insurance companies on the corporate structure of medical entities that could complicate the establishment of such entities and even lead to potential violations by your client's current corporate structure.

Under the auspices of protecting the public, the American Medical Association (AMA) promulgated the initial version of the CPOM Doctrine.[1] In simple terms, the CPOM Doctrine essentially bans unlicensed individuals and entities from engaging in the practice of medicine by restricting them from employing licensed physicians.[2] In practice, many states with CPOM laws permit professional service entities to practice medicine, but only if owned by physicians licensed in that state.[3] Authority for state CPOM laws ranges from statutes and rules to case law and state attorney general (AG) opinions.

Healthcare providers must be careful to comply with local laws because violating these laws could result in a provider's loss of license and repayment of all revenue for billed services to insurance companies and the government. It is also important for parties that enter into ventures with physicians to understand the CPOM Doctrine because it can affect the structures of these types of relationships (i.e., employment versus independent contractor).

Background

In the nineteenth century, the AMA created the CPOM Doctrine to protect the public and the professional status of medical doctors.[4] To protect its membership from the alleged threat posed by others claiming to practice medicine, the AMA warned the public of the "dangers" of corporations practicing medicine, regardless of the reason and structure of such a corporation.[5] States followed the AMA's warning and promulgated statutes to restrict the practice of medicine to licensed physicians and to empower physicians as the sole legitimate professionals to provide medical care.[6] This resulted in an amalgamation of state laws and regulations shielding medical doctors from outside control, especially by corporations.[7]

The rationale for prohibiting employment of physicians by corporations is derived from the concept that individual physicians, not entities, should be licensed to practice medicine.[8] The basic premise is that there is a divided loyalty between the interests of a corporation and the needs of a patient. Simply stated, the patient's need for treatment and care and the physician's related judgment conflicts with the corporation's interest in maximizing its profits and reducing its costs. Consequently, the CPOM Doctrine's intent was to ensure that only licensed professionals could provide medical care and that lay persons and entities would not be able to influence treatment decisions. Patients would thereby be protected from potential abuses because commercialized medicine could not interfere with the physician's judgment and, by extension, the patient's treatment. Consistent with these ideals, the Pennsylvania Supreme Court held that:

> A corporation as such cannot possess the personal qualities required of a practitioner of a profession. Its servants, though professionally trained and duly licensed to practice, owe their primary allegiance and obedience to their employer rather than to the clients or patients of their employer. The rule stated recognizes the necessity of immediate and unbroken relationship between a professional man and those who engage his services.[9]

In recent years, most states have repealed CPOM laws in favor of other means to protect the medical profession's integrity. Many states' laws simply require that an individual must be licensed to practice medicine. However, other states such as Texas still employ a detailed CPOM statutory scheme, albeit with many exceptions.[10] Appendix A identifies which states still use some form of the CPOM Doctrine and the statutory citation, case law, or AG opinion that is the primary CPOM authority in that state.

The CPOM Doctrine's Current Incarnations

The CPOM Doctrine's current incarnations vary from state to state, but some generalizations can be made from examining the various states' laws. The CPOM Doctrine is an overall prohibition on non-licensed persons, lesser-licensed persons, or corporations (or other entity-types) from employing physicians to practice medicine, restricting the delivery of medical services to those entities owned and controlled only by licensed professionals, and prohibiting the division or splitting of professional fees between licensed medical doctors and non-licensed or lesser-licensed individuals or entities. In many states, physicians remain prohibited from entering into relationships with lesser-licensed professionals or non-physicians where the physician's practice of medicine is in any way controlled or directed by, or fees shared with a non-physician. For instance, in Pennsylvania:

> . . . no person other than a medical doctor shall engage in any of the following conduct except as authorized or exempted in this act: (1) practice medicine and surgery; (2) purport to practice medicine and surgery; (3) hold forth as authorized to practice medicine and surgery through use of a title, including, but not necessarily limited to, medical doctor, doctor of medicine, doctor of medicine and surgery, doctor of a designated disease, physician, physician of a designated disease, or any abbreviation for the foregoing; or (4) otherwise hold forth as authorized to practice medicine and surgery.[11]

States such as Texas allow physicians to enter into independent contractor arrangements with non-physicians and avoid application of the CPOM Doctrine.[12] The question of whether an independent contractor situation exists is a question of law and attendant facts. The mere designation of a physician as an "independent contractor" is not dispositive. It is important to review the Internal Revenue Service's guidance for determining whether an individual is an employee or an independent contractor, but such classification remains very fact-specific.[13]

In states such as Indiana, an exception to the CPOM Doctrine allows hospitals to employ physicians because hospitals are formed for the specific purpose of treating patients and providing healthcare services and are themselves licensed entities. The Indiana statute provides that "this article, as it relates to the unlawful or unauthorized practice of medicine or osteopathic medicine, does not apply to . . . a hospital licensed under [Indiana Code § § 16-21 or 12-25]."[14]

States such as New Jersey allow physicians to provide medical services through a professional corporation or limited liability company (LLC), but generally each shareholder or member of the corporation or LLC must be a licensed physician. The New Jersey statute permits the following professional corporation practice forms.

Solo

A practitioner may practice solo and may employ other licensed practitioners with the same license or a license with a smaller scope than that of the employing practitioner.[15]

Partnership, Professional Association, LLC

The entity must be composed solely of licensed practitioners authorized to perform the same service or a "closely allied professional service" including but not limited to chiropractic, dentistry, nursing, nurse midwifery, optometry, physical therapy, podiatry, psychology, social work, etc.[16]

Associational Relationship With Other Practitioner or Professional Entity

However, a plenary-licensed practitioner may not be employed by a practitioner with a limited license. Plenary-licensed practitioners are MDs and DOs.[17]

Shareholder or Employee of a General Business Corporation

This form is permitted only if the corporation is:

- Licensed by the New Jersey Department of Health and Senior Services as a health maintenance organization, hospital, long or short-term care facility, ambulatory care facility, or other type of healthcare facility; or
- A medical clinic providing first aid to customers or employees and/or for monitoring the health environment of employees; or
- A nonprofit sponsored by a union, social, religious, fraternal-type organization providing services to members only; or
- An accredited educational institution that maintains a medical clinic for healthcare service to students and faculty; or
- Licensed by the New Jersey Department of Banking and Insurance as an insurance carrier.[18]

A Professional Practice That is a Limited Partner to a General Business Corporation That has an Agreement With the Practice

However, the corporation may only provide non-professional services.[19]

In conjunction with the CPOM Doctrine, many states prohibit fee-splitting, a form of corporate practice that encourages payments for referrals, whether from one physician to another physician or from a corporation to a physician. This fee-splitting prohibition also bars physicians from sharing their reimbursement for services with any non-licensed person or entity. For instance, in Wisconsin:

> Except as otherwise [permitted under the statute], no person licensed or certified under this chapter may give or receive, directly or indirectly, to or, from any person, firm or corporation any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a licensee in a professional capacity, or for any professional services not actually rendered personally or at his or her direction.[20]

The CPOM Doctrine exists in various forms throughout the country, but the next section outlines some general ideas that should be reviewed when structuring a medical practice in any state where the CPOM Doctrine is in effect.

General Considerations

When setting up a medical practice, the following points should be considered to avoid a possible violation of the CPOM Doctrine:

Ensure That a Medical Doctor has Complete Control Over Certain Decisions

There are several types of decisions that are unequivocally in the purview of medicine and should be made by a medical doctor. The Medical Board of California provides some examples of these decisions:

- Determining what diagnostic tests are appropriate for a particular condition;
- Determining the need for referrals to or consultation with another physician/specialist;
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient;
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work;
- Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a California-licensed physician;
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff, and medical assistants;
- Setting the parameters under which the physician will enter into contractual relationships with third-party payors;
- Decisions regarding coding and billing procedures for patient care services; and

- Approving of the selection of medical equipment and medical supplies for the medical practice.[21]

The Type of Entity Chosen Must Comply With That Particular State's Requirements

States such as Nevada require physicians who form practice entities to use a specific type of entity or not to use certain types of entities. For example, in Nevada no corporation can practice medicine except a professional corporation owned by licensed physicians and incorporated under Nevada's professional corporation act.[22]

The Physician Must be Able to Make Medical Decisions Without Being "Controlled" by a Non-Physician

Physicians should be able to make medical decisions free from the control of non-physicians, including a lesser-licensed individual or a corporation's board of directors. The corporate organizational documents should reflect this premise, but this consideration must also be employed in practice. The CPOM Doctrine is premised on the idea that the physician-patient relationship should be preserved free of taint by corporate interests. This is the main idea to keep in mind when structuring a medical practice.

Research the Appropriate Employment Relationship

States such as Texas will allow providers to work around the CPOM Doctrine by having providers contracted as independent contractors as opposed to employees. All attorneys should research this issue with the applicable state's statute and regulations and, most importantly, case law, for guidance on this particular issue. However, the employment relationship must really be one of principal-contractor as opposed to employer-employee, and not just principal-contractor in name only. In *Flynn Brothers, Inc. v. First Medical Associates*, a Texas appellate court found that the practical effect of an employment contract between a lay entity and medical professionals was that of employer-employee, not independent contractor.[23]

Case Study

The following is a case study for the application of the CPOM Doctrine's general ideas.

Facts

C is a licensed chiropractor. P is a licensed physician. L is a LLC. L's business principally consists of providing physical therapy, chiropractic, and pain management services to patients. Orally, P and C agree that they will work hand-in-hand with equal input in

Editor's Notes

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Friends and Colleagues,

Welcome to the latest issue of *Business Law & Governance*. In this issue, we are once again "spanning the globe" to bring you the wide world of healthcare transactions and corporate governance. Michael Schaff and Glenn Prives take us on a cross-country tour of the corporate practice of medicine doctrine, taking on a renewed importance in the next generation of physician-hospital integration. Karen Gledhill moves us inside the boardroom to discuss the lawyer's role in the business aspects of joint ventures. Dale Van Demark takes us to the metaphysical plane, with an update on avoiding ambiguity in contract drafting. Finally, Gordon Schatz guides us through China, where a different version of healthcare reform offers opportunities for U.S. healthcare companies.

Indeed, healthcare business lawyers face a wide world of challenges—and opportunities—today. With the capital markets still unsettled, with healthcare reform changing everyone's game plan, with the enforcement authorities continuing to ramp up their scrutiny of provider transactions and relationships, it has never been more important for healthcare lawyers to stay one step ahead of the curve.

And that is what the Business Law and Governance Practice Group (BLG PG) wants to help you do. Through our newsletters, Member Briefings, Executive Summaries, email alerts, webinars, and our Affinity Group activities, we want to give you the insights and tools that you need to help your clients navigate today's turbulent tides.

To do that, we need your help. Please share your knowledge, expertise, and predictions for the future with your fellow BLG PG members. Write an article for the newsletter or contribute to one of our other publications. Get involved in an Affinity Group. Post a question (or an answer!) on our discussion list. Share a webinar idea, or let us know what you would like to see us cover in a tutorial. Your colleagues in the BLG PG need you to help all of us make this the best PG it can be.

Best of all, come join us in Seattle at the AHLA Annual Meeting. We will have a great lunch. We will enjoy top-notch Continuing Legal Education. We will network with friends. We will share ideas on how to make 2010-2011 the best year yet for AHLA's newest PG. I hope that we can count on seeing you there.

In the meantime, enjoy this issue, and let us hear from you.

Best,

Bill

managing L, C being mainly responsible for running the day-to-day business operations of L while P would devote all of his time to the treatment and supervision of treatment of patients.

According to the operating agreement of L, C owned 60% of the ownership interests and P owned 40%. The operating agreement provided for the annual election by the members of a Non-Medical Manager and a Medical Manager, and designated C as the initial Non-Medical Manager and P as the initial Medical Manager. C and P are the two members of L and their votes, in their capacities as members, are based on their ownership percentages. According to the operating agreement, the Non-Medical Manager and the Medical Manager would each have one vote on all matters other than certain matters designated as "plenary licensure matters."

C exercises control over all of L's affairs, including medical matters. P and C meet periodically to discuss office management issues, such as hiring and terminating employees, employee salaries, office protocols, and certain expenditures and business opportunities. However, no vote is ever taken on any matter. Additionally, C and P each have employment agreements with L, but C's employment agreement provides for compensation based on a share of L's profits, while P is to be compensated with a base salary only.

Application of the CPOM Doctrine

The limited control rights that P has under the operating agreement create the appearance of control, but in reality it could be argued that P is but a mere employee of C. Consequently, P does not have the power to control L's affairs, which generally violates the CPOM Doctrine. The arrangement of L permits C to have control over plenary licensure matters, thereby allowing him to practice medicine. Although the operating agreement declares that the Medical Manager will have the sole vote on "plenary licensure matters," an argument could be made that by owning 60% of L, and thereby controlling who was appointed as Medical Manager, C essentially had control over plenary licensure matters. By controlling which physician had the power to manage the medical affairs of L, C, in effect, had control over the diagnosis and treatment of illness or injury, which is clearly a plenary licensure matter.

Moreover, the contrast in salary structure between P and C supports the idea that P is a mere employee. C receives a percentage of the gross profits of L, while P simply receives a base salary. This arrangement is more analogous to one of employer and employee, as opposed to co-owners. An argument could be made that this is a CPOM Doctrine violation.

Potential Penalties

There are a variety of penalties and other adverse effects that could flow from a physician's involvement individually and/or with an entity that violates the CPOM Doctrine. Such penalties vary from state to state, but generally involve fines, civil penalties, actions against licenses, and even imprisonment. For example, in Pennsylvania:

> Any person, or the responsible officer or employee of any corporation or partnership, institution or association, who violates [the statutory CPOM prohibition] commits a misdemeanor of the third degree and shall, upon conviction, be sentenced to pay a fine of not more than $2,000 or to imprisonment for not more than six months, or both, for the first violation. On the second and each subsequent conviction, he or she shall be sentenced to pay a fine of not less than $5,000 nor more than $20,000 or to imprisonment for not less than six months nor more than one year, or both. In addition to any other civil remedy or criminal penalty provided for in this act, the [Pennsylvania State Medical Board] . . . may levy a civil penalty of up to $1,000 on any current licensee who violates [the statutory CPOM prohibition] or on any person who practices medicine and surgery or other areas of practice requiring a license, certificate or registration from the board without being properly licensed, certificated or registered to do so . . . . [24]

Although some states may have CPOM prohibitions that have not been enforced in recent years, the lack of enforcement should not be viewed by providers as tacit approval to ignore these laws. Consequently, providers must structure their practices accordingly. In addition, insurance companies have used violations of the CPOM Doctrine to avoid paying providers and to seek reimbursement of all monies previously paid to a violating provider.[25]

Besides criminal and civil penalties, courts have applied the CPOM Doctrine to void improper employment contracts. For instance, in *Vera E. Carter-Shields, M.D. v. Alton Health Institute*, the Supreme Court of Illinois voided Dr. Carter-Shields' employment agreement with Alton Health Institute because Alton Health Institute, as an entity, was not licensed to practice medicine inasmuch as Illinois law provides that a corporation cannot practice medicine.[26] Thus, because a corporation cannot employ a physician who practices medicine in Illinois, the contract between Carter-Shields and Alton Health Institute was invalid.[27]

Conclusion

Economic forces have changed the healthcare landscape in recent years. The industry has exploded into a proliferation of corporate entities, ranging from solo physicians to mid-sized ambulatory surgical centers, to large for-profit hospitals. Nonetheless, the CPOM Doctrine and associated regulations continue to affect the structuring of relationships with physicians.

Some states have no CPOM Doctrine, and many healthcare lobbyists are attempting to eliminate the doctrine altogether. However, CPOM laws are still alive in many states. In any association or transaction with physicians, attorneys need to research the current status of the CPOM Doctrine in the applicable state.

Appendix A

State	CPOM Doctrine	Primary Legal Authority
Alabama	No	Declaratory Ruling of the Medical Licensure Commission, Oct. 21, 1992
Alaska	No	N/A
Arizona	Yes	Ariz. Rev. Stat. §§ 10-2201 *et seq.*
Arkansas	Yes	Ark. Code §§ 4-29-301 *et seq.*
California	Yes	Cal. Com. Code §§ 2400 *et seq.*
Colorado	Yes	Colo. Rev. Stat. §§ 12-36-134
Connecticut	No	N/A
Delaware	No	8 Del. C. § 6-101
District of Columbia	No	N/A
Florida	No	N/A
Georgia	Yes	Ga. Code § 33-18-17
Hawaii	No	N/A
Idaho	No	N/A
Illinois	Yes	*Carter-Shields, M.D. v. Alton Health Inst.*, 777 N.E.2d 948 (Ill. 2002)
Indiana	Yes	Burns Ind. Code § 25-22.5-1-2
Iowa	Yes	Iowa Code §§ 147.1101 *et seq.*
Kansas	Yes	Kan. Stat. Ann. §§ 65-2801 *et seq.*
Kentucky	Yes	Ky. Rev. Stat. Ann. §§ 311.560 and 311.565
Louisiana	No	La. Rev. Stat. Ann. § 37:1271-101
Maine	No	Me. Rev. Stat. Ann., tit. 32 § 3270-101
Maryland	Yes	Md. Code, Health Occ. Law §§ 14-101 - 14-702 and Corps. and Ass., § 5-104
Massachusetts	Yes	Mass. Gen. Laws, ch. 112 § 2-101 and ch. 156A § 2-101
Michigan	Yes	Mich. Att'y. Gen. Op. No. 6592 (Jul. 10, 1989) and Mich. Att'y. Gen. Op. No. 6770 (Sep. 17, 1993)
Minnesota	Yes	Minn. Att'y. Gen. Op. No. 92-B-11 (Oct. 5, 1955)
Mississippi	No	State Board of Medical Licensure "Policy as to the Corporate Practice of Medicine in Mississippi" (May 16, 1996)
Missouri	No	N/A
Montana	Yes	Mont. Code Ann. § 37-3-322
Nebraska	No	N/A
Nevada	Yes	Nev. Rev. Stat. Chs. 78 and 89
New Hampshire	No	N/A
New Jersey	Yes	N.J.A.C. § 13:35-6.16(f)
New Mexico	No	N/A
New York	Yes	N.Y. Educ. Law §§ 6521 and 6527
North Carolina	Yes	33 N.C. Att'y. Gen. Rep. No. 43 (1955)

State	CPOM Doctrine	Primary Legal Authority
North Dakota	Yes	N.D. Cent. Code § 43-17-42
Ohio	Yes	Ohio Rev. Code §§ 4731 *et seq.* and § 1785.02
Oklahoma	No	Okla. Stat. tit. 59 § 510
Oregon	Yes	*State ex rel. Sisemore v. Standard Optical Co.*, 182 Or. 452, 188 P.2d (1947)
Pennsylvania	Yes	63 Pa. Cons. Stat. §§ 422.1 *et seq.*
Rhode Island	No	N/A
South Carolina	Yes	*Ezell v. Ritholz*, 188 S.C. 39, 198 S.E. 419 (S.C. 1938)
South Dakota	Yes	S.D. Codified Laws § 36-4-8.1
Tennessee	Yes	Tenn. Code Ann. § 63-6-201
Texas	Yes	Tex. Rev. Civ. Stat. Ann. art. 4495b, §§ 3.06 - 3.08, § 5.01
Utah	No	Utah Code Ann. § 58-1-501
Vermont	No	N/A
Virginia	No	1992 W. Va. Att'y. Gen. Op. No. 147
Washington	Yes	Wash. Rev. Code Ann. § 18.71.021 and §§ 18.100 *et seq.*
West Virginia	Yes	W. Va. Code § 30-3-15(b)
Wisconsin	Yes	Wis. Att'y. Gen. Op. No. 39-86 (Oct. 21, 1986)
Wyoming	No	N/A

1 *See* Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 Health Matrix: Journal of Law-Medicine 243, 245-249 (2004) (citing Am. Med. Ass'n, 1922 Report of the Judicial Council (interpreting Section 6 of the Principles of Medical Ethics), *abstracted in* Principles of Medical Ethics 40 (1960)).

2 *Id.* at 243.

3 *See* U.S. Dep't of Health & Human Svcs., Office of Inspector General, State Prohibitions on Hospital Employment of Physicians, Document No. OEI-01-91-00770 (Nov. 1991), *available at* http://oig.hhs.gov/oei/reports/oei-01-91-00770.pdf.

4 *See* Huberfeld, *supra*, at 245-46.

5 *See* Craig A. Conway, *Legislative Update: Texas' Corporate Practice of Medicine Doctrine*, Health law perspectives, Health Law & Policy Institute, University of Houston Law Center (October 2009), *available at* www.law.uh.edu/Healthlaw/perspectives/2009/(CC)%20CorpPractice.pdf (last visited Mar. 15, 2010).

6 *See* Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 Vand. L. Rev. 445, 447 (Mar. 1987).

7 *See e.g.*, N.Y. Educ. Law § 6522 (2006) ("only a person licensed or otherwise authorized under this article shall practice medicine.") and N.Y. Educ. Law § 6527 (2006) ("a non-profit medical or dental expense indemnity corporation or a hospital service corporation may employ licensed physicians.").

8 *See Painless Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932).

9 *Neill v. Gimbel Brothers Inc., 330 Pa. 213* (1938).

10 *See* Tex. Rev. Civ. Stat. Ann. art. 4995b §§ 3.06 - 3.08 and 5.01 (Vernon 2009).

11 *See* 63 Pa. Cons. Stat. § 422.10.

12 *See* Texas Med. Board, *Corporate Practice of Medicine, available at* www.tmb.state.tx.us/professionals/physicians/licensed/cpq.php (last visited Feb. 28, 2010).

13 *See* Internal Revenue Service, *Independent Contractor or Employee . . . , available at* www.irs.treas.gov/pub/irs-pdf/p1779.pdf (last visited Feb. 28, 2010).

14 Burns Ind. Code Ann. § 25-22.5-1-2(a)(21).

15 N.J.A.C. § 13:35-6.16(f)(1).

16 N.J.A.C. § 13:35-6.16(f)(2). *See also* N.J.S.A. § 14A:17-3 (stating that professional corporations may be formed among members of "closely allied professional services," including "any branch of medicine and surgery").

17 N.J.A.C. § 13:35-6.16(f)(3).

18 N.J.A.C. § 13:35-6.16(f)(4).

19 N.J.A.C. § 13:35-6.16(f)(5).

20 Wis. Stat. Ann. § 448.08(1).

21 Med. Board of California, Department of Consumer Affairs, *Corporate Practice of Medicine, available at* www.medbd.ca.gov/licensee/corporate_practice.html (last visited Feb. 28, 2010).

22 *See* Op. Nev. Atty. Gen. 219 (Oct. 3, 1977).

23 *Flynn Brothers, Inc. v. First Medical Associates*, 715 S.W.2d 782, 785 (Tex. 1986). The parties acknowledged that they drafted the contract with the hope of avoiding CPOM Doctrine violations. *Id.*

24 63 Pa. Cons. Stat. § 422.39.

25 *See Allstate Insurance Company v. Northfield Medical Center*, PC, 2001 WL 34779104 (N.J. Super. L. 2001).

26 201 Ill. 2d 441, 460 (2002).

27 *Id.*