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Robert P. Borsody

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PRACTICE MANAGEMENT CONTRACTS: STATE OF THE LAW

*Robert P. Borsody**

Management contracts are widely used to create a business relationship between a professional practice, usually a medical practice, and a practice management entity. Businessmen often want to “partner” with, or at least profit from, medical practices. Medical professionals, on the other hand, find themselves burdened with compliance requirements that are mandated by regulatory bodies at all levels. Such demands include billing changes, documentation and patient confidentiality requirements, and the increasing need to compete in a managed care environment, where payers compress fees while paperwork increases. At the same time, “miracles of modern medicine” are constantly being produced. From the latest drug to the latest medical instrument, device or procedure, doctors are expected to keep current on information in their field. Patients demand it; if it is not provided, these patients can become plaintiffs in malpractice actions.

It is not surprising, therefore, that practice management companies with their promise of relieving doctors from all but the clinical responsibilities of the medical practice have proliferated. There have been a number of large, publicly traded practice management companies such as Phycor and Medpartners, but there are many small management companies that provide services to as few as one medical practice. All have one thing in common: a contractual relationship between the medical practice and the management company which describes and delineates the business and legal relationship.

Management companies and their associated contracts are only needed in those states where the prohibition on the corporate practice of a profession do not allow a medical practice to be directly owned by anyone other than medical doctors. Several states allow a professional practice to be owned by an ordinary business

* Robert P. Borsody has been in private practice of law in New York City for 39 years. Before returning to private practice, he directed a federally funded project of health law research and test case litigation. Earlier he was affiliated with the New York firm of Sullivan & Cromwell. He chaired the Public Health Committee of New York State Bar Association for 4 years and then founded one of the largest health law firms in the country. He has written numerous article on his specialty of health law.

corporation that, in turn, may be owned by laypersons.¹ A few additional states allow limited liability corporations to practice medicine and to be owned by laymen. New York clearly upholds and enforces the prohibition against corporate practice of medicine,² as does New Jersey.³ This article will survey recent decisions in both states that have dealt with the conflicting issues surrounding management contracts and professional practices.

Lawyers, in crafting the contractual relationship between businesses and medical practices in both New York and New Jersey, seek to afford maximum protection to the practice management company, if that is their client, to ensure that the company will not lose the benefit of its time, expertise and investment expended on behalf of the medical practice. However, such a contractual relationship cannot exert excessive control over the professional practice or the relationship will trespass into the forbidden area of corporate practice of medicine. There has been paucity of case law in this area up until now and very little in the way of other legal guidelines. Recently in the last few years, however, decisions in this area of law have been handed down more frequently, including several agency rulings. The exploration of the conflict between medical and management contracts begins with an analysis of Ruling Letters from governmental agencies.

THE RULING LETTERS

While ruling letters are useful since they are expressions of opinion on the state of the law from government agencies that may be charged with enforcement of those laws, they are often limited, by their terms, to the specific state of facts presented or even to the specific person presenting the facts. Nonetheless, in an area with few legal beacons, even faint gleams are welcome.

On April 15, 1998, the Office of the Inspector General of the

¹ See generally, Sara D. Mars, *The Corporate Practice of Medicine: A Call for Action*, 7 HEALTH MATRIX 241 (1997); Judith Parker, *Corporate Practice of Medicine: Last Stand or Final Downfall?* 29 J. HEALTH & HOSP. LAW 160 (1996); Patricia F. Jacobson, *Prohibition Against Corporate Practice of Medicine: Dinosaur or Dynamic Doctrine?*, 1993 HEALTH LAW HANDBOOK 67; Arnold J. Rosoff, *The Business of Medicine: Problems with the Corporate Practice Doctrine*, 17 CUMB. L. REV. 485 (1987); Alanson W. Wilcox, *Hospitals and the Corporate Practice of Medicine*, 45 CORNELL L.Q. 432 (1960); Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VANDERBILT L. REV. 445 (1987); John Wiorek, *The Corporate Practice of Medicine Doctrine, An Outmoded Theory in Need of Modification*, 8 J. LEGAL MEDICINE 465 (1987).

² Francis J. Serbaroli, *Corporate Practice of Medicine: A Clear and Present Danger*, N.Y.L.J. Sept. 23, 1993 at 3.

³ Sara D. Mars, *The Corporate Practice of Medicine: A Call for Action*, 7 HEALTH MATRIX 241, 292 (1997).

United States Department of Health and Human Services issued one of its opinions.⁴ The ruling stated that if a management company provides services to a medical practice and the compensation of the management company was determined as a percentage of the gross or net revenues of the medical practice, then this type of contract would not be “safe harbored” under the federal laws.⁵

This theory is based on the notion that if the management company’s responsibilities included, in any way, production of patients through, for example, advertising, public relations or even negotiation of managed care contracts, then the management company would have an incentive to increase the number of patients in order to increase its compensation. This would be the case because, the management company would receive a percentage of the revenue of the medical practice that would increase with the number of patients. As a result, the management company would have an incentive to increase the number of patients to increase its revenue. This reasoning is similar to the basic premise of the Federal Self-Referral Statute.⁶ This prohibition bars referral of patients by a physician to a business with which the physician has a financial relationship. This is because the physician will derive income from his ownership interest and will, in theory, have an incentive to refer patients to the business to increase his own financial security.

Some of these ruling letters have expressed opinions as to the permissible parameters of management contracts. In an April 17, 1997 ruling letter by General Counsel Henry M. Greenberg,⁷ a hypothetical posed the legality of payments by physician’s professional corporations to management companies that would receive a per visit fee for each visit made to the P.C. The management company would be paid a fee at the end of each month determined by multiplying the fixed fee times the number of patient visits in that month. The management company would also be responsible for marketing and other management activities for the P.C.

⁴ Opinion No. 98-4 from the Office of Inspector General of the U.S. Dept. of Health and Human Services (April 15, 1998).

⁵ *Id.*

⁶ 42 U.S.C.A. § 1128 (b).

⁷ The opinion letters of the Office of Counsel General of the New York State Department of Health are not compiled or published in any generally available form, hence, there is no uniform system of citation. Efforts are underway to induce the Department to make them available on the Internet with an accompanying search engine.

The Office of Counsel disapproved of this method of compensation for similar reasons stated in the federal ruling letter; if the management company is providing the patients, the management company cannot be paid on a per patient basis.⁸

Another New York State opinion dated May 2, 1995 by Jerry Jasinski, Acting General Counsel, disapproved of a management contract relationship where the management company proposed to provide a broad spectrum of services including office space, all necessary equipment, and all non-clinical services. Referring to an earlier June 13, 1994 opinion, the proposed arrangement was viewed as an "establishment of a de facto diagnostic and treatment center. Control of the facility apparently rests primarily with the business corporation rather than with the professional corporation." The corporate practice prohibition was not mentioned or discussed, however, a basis for disapproval was the operation of an unlicensed diagnostic and treatment center.

A business corporation may be licensed under Article 28 of the New York Public Health Law to operate a diagnostic treatment center that may employ medical personnel and practice medicine and is, therefore, an exception to the prohibition against corporate practice. In this May 2, 1995 opinion letter, the New York State Department of Health could, therefore, be viewed as taking the position that provision of the above-described broad spectrum of responsibilities by a management company, leaving a practice with solely clinical responsibilities, raises significant corporate practice issues.

While letter rulings on both the state and federal level, as mentioned, can serve as useful guides, they are simply the opinions of lawyers; albeit lawyers charged with enforcing the laws about which they are issuing opinions. The more definitive and positive pronouncement of the law is, of course, the common law interpretation of decided cases.

THE CLASSIC CASES

Until recently, there had been only two cases that arose out of management contracts for medical services rendered. The first is a Texas case, *Flynn Brothers Inc. v. First Medical Associates* and the second is a New Jersey case, *Women's Medical Center v. Finley*.

⁸ Note that an earlier ruling letter dated February 3, 1993 by Peter I. Millock rendered to a New York State Department of Services, p. 2 paragraph 2, specifically provided that a "click fee" compensation provision by a medical practice to a provider of radiology equipment was permissible as a form of per use leasing.

1. *THE FLYNN BROTHERS v. FIRST MEDICAL ASSOCIATES*

Flynn Brothers, Inc. v. First Medical Associates,⁹ was a proceeding brought by the Flynn brothers, owners of a management company, against First Medical Associates, a medical practice, for monies due for provided management services. The medical practice defended against the claim on the ground that the management contract was unenforceable because it was legally defective. The legal defect was alleged to be a percentage compensation provision in the contract which provided that the Flynn brothers would be paid two-thirds of medical practice's gross revenues.

The Texas Court of Appeals agreed that the percentage compensation provision was a fatal defect because it violated the Texas Medical Practice Act, Tex. Rev. Civ. Stat. Ann. 4495 (b), against fee splitting between a professional and a non-professional.¹⁰ Since the contract contained this fatal defect, the Flynn brothers were unable to collect fees for provided services. The Appellate Court held that the fee splitting provisions and other broad contractual rights granted by the professional corporation to the management company "indirectly allowed [the Flynn brothers] to provide medicine without a license."¹¹ This case sheds little light on the management contract phenomenon.

2. *WOMEN'S MEDICAL CENTER v. FINLEY*

Women's Medical Center v. Finley,¹² was an appeal from a New Jersey Department of Health decision that reversed the finding of an administrative law judge. The administrative law judge had found that the appellants, three gynecological practices specializing in first trimester abortion services, were not required to be licensed and regulated under the New Jersey Health Care Facilities Planning Act, N.J.S.A. 26:2H-1, et. seq., but were, rather, private practices as defined under N.J.S.A. 26:2H-2(b). The New Jersey Health Commissioner, Joanne Finley, argued that the appellants were not private practices but, rather, "health care facilities" within the meaning of the New Jersey Health Care Facilities Planning Act because they had each contracted with a management company for the provision of a "full range of non-professional office management services".¹³

⁹ 715 S.W. 2d 782 (Tex. App., 1986)

¹⁰ *Id.* at 783.

¹¹ *Id.* at 785.

¹² 469 A.2d 65 (N.J. Super. Ct. App. Div. 1983, *cert. denied*, 475 A.2d 578 (1984).

¹³ *Id.* at 67.

The Appellate Division extensively analyzed and quoted the language in the management contract, noting that the language specifically reserved to the medical practice the right to exclusive control over all clinical aspects and patient relationships while carefully limiting the management company to business and financial aspects only. The court then ruled that the contract properly preserved the respective rights and duties of the parties, limiting the medical practice to the medical area and the management company to the business area.

It is noteworthy that the Court approved of the structure and the content of the management contracts although it noted that “patient fees are paid to [the management company] and deposited to its account. Only it has the authority to draw on that account. It pays all expenses and issues weekly checks to the physicians, providing them with year-end 1099 forms.”¹⁴ It was further noted that all the office equipment was owned by the management companies which also leased the premises to the physicians who, it was noted, had made no capital investment in the office.

Supportive of the concept of management contracts generally, the Court disagreed with the Commissioner’s argument that a management company might exercise excessive pressure on a managed medical practice “by encouraging the physicians to provide medical care which is unnecessary or too speedily delivered.”¹⁵ The Court countered that argument stating, “those physicians who need to recoup their office capitalization costs and who may be operating their offices on a less economically efficient basis because of their direct and time-consuming involvement in non-professional office management details might have an even greater incentive to insure the gross profitability of their practices.”¹⁶

Although this seminal management contract case appears to provide clear cut guidelines for management company relationships with physician practices, there are two major considerations which militate against its utility. The first is that the Court did not consider the legal question of whether the nature of the relationship was consistent with corporate practice prohibition principles but, rather, whether the professional practice was required to be regulated as a health care facility under the State Certificate of Need laws by virtue of its relationship with a management company.

¹⁴ *Id.* at 69.

¹⁵ *Id.* at 73.

¹⁶ *Id.* at 74, n. 1.

The second major distorting factor, which is noted in the Appellate Division opinion, is that the Commissioner's attempt to exert regulatory control over the practices may have been caused by "the nature of the medical services rendered by these practices".¹⁷ The Court went on to observe in the footnote that the Commissioner had in the past expressed "special administrative concern for first trimester abortions" and had attempted to impose extensive regulations over such procedures which were later deemed unconstitutional.¹⁸

For many years, these cases were the only guidelines for lawyers seeking to draft contracts describing the relationship between a practice management company and a medical practice. There are now a number of cases providing a great deal more guidance; unfortunately, some of the cases are conflicting.

THE CURRENT CASES

Few of the current cases actually discuss permissible (or impermissible) phrases or wording in management contracts, as was the case in *Women's Medical Center v. Finley*. The cases do, however, discuss other permissible parameters of the relationship between a business entity and a medical entity including other corporate mechanisms that are used to protect the investment and business relationship of the management company with the medical practice.

THE NEW JERSEY CASES

The New Jersey cases were decided first and, although they deal with similar subject matter, they were not cited as precedent by the New York courts. Indeed, they were distinguished by a later New York case.

*Allstate Ins. Co. v. Schick, et al.*¹⁹ was an action brought against numerous defendants including businessmen and their management companies, medical professional corporations and the medical doctors who owned them, as well as chiropractors who worked for the medical PCs and some of whom also owned the management companies. The plaintiff insurance company sought to enjoin all arbitrations, pending and future, brought by the defendant professional corporations and the disgorgement of some \$14,200,000 already paid to the defendants plus treble damages

¹⁷ *Id.* at 74.

¹⁸ *Id.* at 74, n. 2.

¹⁹ *Schick*, 328 N.J. Super. 611, 746 A.2d 546 (1999).

under the New Jersey Insurance Fraud Prevention Act.²⁰

Plaintiff charged that defendants created a series of sham professional corporations that appeared to be owned by New Jersey licensed physicians but were actually controlled by defendant management companies through management contracts and other corporate devices. The corporate control devices alleged and attacked by plaintiffs included the fact that the medical doctor owners of the professional corporations did not work in the professional corporations and resided outside the state (although licensed in New Jersey). Further, these doctors signed “undated resignation letters and undated stock assignment agreements. . . .”²¹

The Court found that these devices, along with the management contract, allowed defendant management companies to exercise unacceptable amounts of control over defendant professional corporations.

Defendants argued that if services were reasonable, necessary and performed by a plenary licensed physician, then the insurance company plaintiffs should, nonetheless, be required to make payment under the New Jersey No-Fault Law despite any finding that the corporate structure was defective.

Judge Villanueva held, however, that in order to be eligible for payment, a provider must comply with other elements of the state law.²² The court said that in order for a provider to be eligible for payment, medical services rendered, in addition to being reasonable and necessary, “must conform with pertinent norms as a precondition for eligibility under the Act” and that an insurer may deny benefits “based upon a health care provider’s failure to comply with the administrative regulations governing the practice of healthcare in the State.”²³ The failure of a medical provider or service to adhere to the regulation requiring; ownership by a physician with a plenary license, interpretation of test results by such a physician; and compliance with any other significant state statute or agency regulation, renders that provider ineligible for reimbursement under the No-Fault Act.²⁴

²⁰ N.J. STAT. ANN. §17:33 A-5 (1983).

²¹ Schick, 328 N.J. Super. At 617, 746 A.2d at 549.

²² See *Allstate Ins. Co. v. Orthopedic Evaluations, Inc.*, 300 N.J. Super. 510, 693 A.2d 500 (App. Div. 1997), *cert. granted*, 697 A.2d 541 (1997), *aff’d*, 700 A.2d 372 (1997); *Thermographic Diagnostics, Inc. v. Allstate Ins. Co.*, 593 A.2d 768 (N.J. 1991), 125 N.J. 491; *Prudential Prop. & Casualty Ins. Co. v. Midlantic Motion X-Ray, Inc.*, 737 A.2d 711, 325 N.J. 54 (N.J. Super. L. 1999).

²³ *Id.* at 620.

²⁴ N.J. ADMIN. CODE tit. 13, §35:2.5 (1997). It sets forth three distinct elements that a medical screening or medical diagnostic testing facility must satisfy. The prac-

The defendant's motion for summary judgment was denied because the court found evidence that raised factual issues to support the plaintiff's claim that the defendants may have created sham medical corporations that appeared to be owned by plenary licensed physicians. The defendants, through management contracts, apparently controlled these corporations, in an attempt to circumvent administrative prohibitions against plenary licensed physicians from being employed by chiropractors.²⁵ As a lens on the law of management contracts in New Jersey, the Schick case is clouded by the claims of impropriety against the defendants.²⁶ Nevertheless, the decision clearly holds that where there has been a finding of excessive control by a non-licensed entity over a licensed entity, an insurer is excused from any legal responsibility to pay claims to the licensed entity.

In the second New Jersey case, *Allstate Ins. Co. v. Northfield Medical Center*²⁷, allegations of excessive control by a management company over a medical practice came before Judge Villanueva once again. Two motions for summary judgment made in this case were both denied based on findings of fact and conclusions of law similar to *Schick*.

On the motion to dismiss, the court, in *Northfield*, addressed the detailed wording of the contractual relationship between the management company and the medical practice, which it found defective under New Jersey law. The Court found the lease between the management company and the medical practice, which did not allow termination by the medical practice but provided for automatic yearly renewal at the discretion of the management company, evidence of "sham ownership" of the medical P.C.

Further, the court found that the management services contract was defective where the management company solely calculated compensation and there was no termination option for the medical practice. Furthermore, Judge Villanueva noted that the owner of the medical practice lacked signature authority over the

tice "shall be owned and under the responsibility of one or more physicians each of whom holds a plenary license from the State Board of Examiners; the testing shall be performed under the authority of a designated responsible physician who shall establish a protocol and a quality assurance program and the results shall be interpreted by a physician holding a plenary license in the state.

²⁵ *Schick*, 328 N.J. Super. at 629.

²⁶ *Id.* at 614, n.1. "...[A]gents from New Jersey's Office of Insurance Fraud Prosecutor ("OIFP") raided the facilities of six of the defendant chiropractic and rehabilitation facilities. ...[and]also arrested several individuals alleging that they were part of a fund ring conspiring to defraud the insurance industry."

²⁷ No. MRS-L3228-99 (N.J. Sup. Ct. Morris Co.) (filed on Oct. 18, 1999).

bank account of the medical practice, which alone was sufficient to defeat the motion of the management company to dismiss the action.²⁸ Moreover, the owners of the professional corporation, which owned the medical practice, did not invest any money or make any capital contribution. Comparing *Northfield* to *Women's Medical Center v. Finley* case is tempting, but the passage of time and changed political and social contexts are more significant.²⁹ More striking is the contrast with the recent New York Federal Court decisions discussed below. Before reviewing these cases, however, some background in the relevant New York case law would be useful.

THE NEW YORK CASES

Although management contracts for medical practices have been used in New York State for many years, only recently have they been litigated. The oldest case on record is *Necula v. Glass*.³⁰ This appeal involved a doctor who had been excluded from the Medicaid program after a hearing before the State Department of Social Services. The hearing officer determined that the doctor had engaged in illegal fee splitting because the contracts the doctor had entered into with management companies, under which the companies were to provide the doctor with "facilities, supplies, equipment and non-physician staff necessary to operate his radiology practice, and the [doctor] was to pay the companies a fixed percentage of his receipts for billing services and a fixed dollar amount for each procedure performed."³¹ The Appellate Division upheld the exclusion on the grounds that the doctor had engaged in illegal fee splitting since the doctor's payments to the companies were a percentage of or otherwise dependent upon his income or receipts. The record on appeal included opinion letters from the

²⁸ *Finley*, *supra* note 12, at 69; *see also supra* note 14, *infra* text at 306.

²⁹ *See Material Damage Adjustment Corp. v. Open MRI of Fairview*, 799 A.2d 731 (N.J. Super. L. 2002). In this case, summary judgment was granted to plaintiff insurer for all fees paid to defendant MRI facility on the ground that the defendant was not properly licensed according to the State regulatory requirements for an MRI facility when the fees were paid. The court cited and relied upon the same case, *Allstate Ins. Co. v. Orthopedic Evaluations, Inc.* (*see infra* n. 22), as Judge Villanueva in the *Northfield* case and for the same principle: that failure to comply with regulations disqualifies a provider from receiving insurance payments. There was no management contract in the *Material Damage Adjustment Corp.* case. The defendant was a business corporation owned by two non-licensed persons. (*see slip. op.* at 21) There was no discussion of any corporate practice violations arising out of non-licensed persons acquiring a corporation that provided medical services and had no license.

³⁰ *Necula*, 647 N.Y.S. 2d 501 (A.D. 1 Dept. 1996), 231 A.D. 2d 457.

³¹ *Id.* at 501.

New York State Department of Health, Office of the Counsel which included those discussed above. The letters expressed disapproval of the percentage compensation arrangement for a management contract but did not express disapproval of the per use fee approach.

The next case to be decided involving management market contracts was an unreported Supreme Court decision in Nassau County, *State Farm Insurance Co. v. Medical Health Office of Stony Brook, P.C.*³² This case involved the denial of an application by the insurance company petitioner to stay arbitration of certain bills submitted by respondent on the grounds that the P.C. was illegally controlled by a management company. The defects alleged by the petitioner insurance company included the fact that a chiropractor, who was a shareholder of the management company, was the secretary of the respondent professional corporation. This allegation was dismissed by the court with reference to section 1501(e) of the New York Business Corporation Law, which says that the term “officer” does not include the secretary of a corporation having only one shareholder.³³ The court further found that the fact that the management company “has utilized the address of [the professional corporation] and it possesses a security interest in the [professional corporation’s] accounts receivable does not reflect ownership or transfer of ownership. Rather, it reflects, as [the professional corporation] urges and supports by evidence, that [the management company] provides management services for [the professional corporation] with respect to matters other than medical care, such as hiring non-medical personnel and maintaining and providing equipment.”³⁴

The next case is *Martone v. Healthsouth Holdings, Inc.*,³⁵ which involved a management company that was owned by Healthsouth, but managed by a professional corporation owned by Martone, a physical therapist. Healthsouth had contracted to purchase the plaintiff’s practice and employ her as a physical therapist. While Healthsouth exercised significant control over her practice, Martone was listed as an employee of another physical therapist in another office, who was unaware of this arrangement. Healthsouth as it operates in other states, where ordinary business corporations

³² State Farm Ins. Co., Index No. 007828/99 by Judge Burton Joseph (N.Y. Sup. Ct., Nassau Co., May 10, 1999).

³³ N. Y. Bus. Corp. Law § 1501 (e) (McKinney).

³⁴ State Farm Ins. Co., Index No. 007828/99 at 2 (N.Y. Sup. Ct. Nassau Co., May 10, 1999).

³⁵ 222 N.Y.L.J., Dec. 23, 1999, at 29 (1A Part 6,) (N.Y. Sup. Ct., Dec. 23, 1999).

may employ physical therapists, may have mistakenly thought it was entitled to employ Martone as a physical therapist in New York. However, this purchase took place after the New York State Office of the Professions issued an advisory that warned that general business corporations were not authorized to provide physical therapy services in the New York State. When Martone became aware of the impropriety of the situation, she resigned and requested that HealthSouth stop using her provider number on insurance reimbursement claims. The court stated that “HealthSouth may have falsely represented to the public that it operated a number of physical therapy offices in the State” despite knowing that it “could not lawfully provide physical therapy services in the State [and] may have engaged in a deliberate scheme to avoid that prohibition.”³⁶

In *Mainline Medical Services, Inc. et al., v. Thomas Teyibo, et al.*,³⁷ the management company sued a medical P.C. it managed for non-payment of services. Defendant claimed that the management company “controlled all primary indicators of ownership; including management of money, billing, collection receivables and had absolute discretion with respect to paying the bills.”³⁸ Therefore, defendant maintained that the contracts were void and unenforceable because they unlawfully controlled the defendant P.C. and plaintiff’s claim for compensation should be denied. However, the management company argued “arrangements for lay people to provide financial services to a medical P.C. are both proper and lawful.”³⁹

Judge Gammernan denied the management company’s motion for summary judgment because issues of fact were raised as to whether the medical doctor “actually owned or controlled” the professional corporation and whether the contracts with the management company “were a scheme by the [management company] to and intended to create an appearance of compliance with the statute.”⁴⁰

In *Fordham Medical and Pain & Treatment, P.C. v. State Farm Mu-*

³⁶ *Id.* at 30. Because HealthSouth acknowledged it knew prior to its purchase of Martone’s practice of the prohibition on the legality of its services, the court forwarded a copy of its decision to the Office of the Professions for that office to take appropriate action. Further, because it appeared that HealthSouth might have engaged in false representation to the public, the court also forwarded a copy of its decision to the Attorney General for appropriate action to be taken against HealthSouth.

³⁷ Index No. 602614/00 (N.Y. Sup. Ct. N.Y. Co., Nov. 20, 2000).

³⁸ *Id.* at 3-4.

³⁹ *Id.* at 5.

⁴⁰ *Id.*

tual Insurance Company,⁴¹ a management company-operated medical P.C. brought an action for payment for medical services against State Farm Insurance Company. Payment had been denied because State Farm charged that the P.C. was formed and operated in violation of Article 15 of the New York Business Corporation Law which governs professional corporations.

State Farm also raised the argument in opposition to plaintiff's motion for summary judgment. The court failed to discuss the management contract arrangement which existed in this case but, rather, discussed the corporate organization and operation of the claimant's business. The court noted a number of defects in the organization and operation of the corporation citing certain newspaper quotes which included statements made by an attorney for the doctor asserting that the doctor had no authority to write checks for the P.C. and was "basically an employee" of the P.C.⁴² The court also noted that the same doctor had been involved in insurance fraud with another P.C. Subsequently, the court denied plaintiff's (P.C.'s) motion for summary judgment noting that the plaintiff "cannot be allowed to benefit from the fraudulent activity described. . . ."⁴³

In 2000, a massive lawsuit was filed against over 100 provider defendants. The case *Progressive Northeastern Insurance Co. v. Advanced Diagnostic & Treatment Medical, P.C.*,⁴⁴ charged that a group of physicians had sold the use of their names and licenses to form sham corporations which were used by certain defendants to defraud plaintiff owners. Plaintiff owners brought claims under the State Consumer Protection Law as well as under the RICO statute.⁴⁵ The action sought \$60,000,000 in damages.

In response to Defendant's motion for summary judgment, the trial court dismissed certain claims, including the State Consumer Protection Act claim. However, the court refused to dismiss the claims of improper formation of the defendant's professional corporations, finding that the Business Corporation Law does not "[prevent] a plaintiff from challenging the legitimacy of a corporation."⁴⁶

⁴¹ *Fordam Medical Pain & Treatment, P.C. v. State Farm Mutual Insurance Company*, Index No. 600403/00 (Judge Marilyn Shafer) (N.Y. Sup. Ct., Jan. 11, 2001).

⁴² *Id.* at 4.

⁴³ *Id.*

⁴⁴ *Progressive Northeastern Insurance Co. v. Advanced Diagnostic & Treatment Medical*, Index No. 601112/00 (N.Y. Sup. Ct., 2001).

⁴⁵ 18 U.S.C. section 1962(d).

⁴⁶ *Id.* at 14.

Judge Gammernan refused to dismiss the complaint in the *Progressive* case just as he also refused to grant summary judgment to the plaintiff in the *Mainline Medical Services, Inc. v. Tybo* case. In the *Progressive* case, the decision could be read to mean that proof of excessive management company control of a managed P.C. could be sufficient reason to permit an insurance company not to pay. The *Mainline* case is almost the reverse factual situation, and his decision there could be read to mean that such excessive control would allow a medical P.C. to avoid having to pay a management company for services the management company had rendered.

The holding of a recent case in this area in the Federal Court in the Eastern District of New York decided on September 20, 2001 is significantly variant from most of the cases discussed heretofore.

In *State Farm Mutual Automobile Insurance Co. v. Robert Mallela*,⁴⁷ State Farm sued approximately thirty-six medical practices, the owners of the medical practices, and various business persons. Claim was made for the return of some \$6,000,000 in payments made to the practices based on the alleged illegal structure of the practices. The motion for summary judgment by defendants claimed that defendants' corporations' ". . . structure does not relieve plaintiff of its obligation to pay for reasonable and necessary medical treatments provided by licensed professionals and that no private right of action exists to enforce New York's corporate form requirements."⁴⁸ The Court agreed with this argument noting "[t]he prohibition on the corporate practice of medicine is designed to protect consumers of health services, not insurers who pay for those services."⁴⁹ The Court went on to observe that "plaintiff has cited, and the Court has discovered, nothing in the legislative history of the relevant Business Corporation Law provisions that indicates that the legislature intended to create a private right of action to enforce these provisions"⁵⁰ and concluded, therefore, that "plaintiff has no private right of action to enforce New York's corporate law requirements."⁵¹

⁴⁷ Mallela, 175 F. Supp. 2d 401 (EDNY 2001).

⁴⁸ *Id.* at 413.

⁴⁹ *Id.* at 416, citing Adam Freiman, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency Into the Modern Health Care Environment*, 47 EMORY L.J. 697 (Spring 1998); *E & B Mktg. Enters. Inc. v. Ryan*, 209 Ill. App. 3d 626 (App.Ct.1991).

⁵⁰ *Id.*

⁵¹ *Id.* at 417, citing *Deutsch v. Health Insurance Plan of Greater New York*, 573 F. Supp. 1443 (SDNY 1983).

The Court also observed “plaintiff was not damaged by its payment of claims that it was required to pay and which, in any event, were for reasonable and necessary medical expenses performed by licensed health professionals for covered persons and arising out of covered accidents.”⁵² The Court also noted that New York courts were reluctant to require a party to return money paid for lack of a “statutorily required license,” citing *IHS Acquisition XV, Inc. v. Kings Harbor Healthcare Center*.⁵³

In *IHS Acquisition XV, Inc.*, a plaintiff sued for fees for services rendered to the defendant nursing home by licensed physical therapists that were employed by IHS, a business corporation. In that case, the Southern District noted “[o]ne area in particular where courts have been reluctant to give effect to the public policy defense is where a contracting party is not licensed, but where the individuals performing the work, and the individual supervising the work are in fact licensed.”⁵⁴

The court in the *State Farm Mutual Auto. Ins. Co. v. Mallela* case also noted that “[t]he violation at issue here is not evil in itself and plaintiff plainly seeks to use the P.C. defendants’ violations as a sword for personal gain in order to recoup payments that it would, but for the alleged violations of the Business Corporations Law, indisputably have been required to pay. Regulatory sanctions that are available to the [S]tate ‘quite complementarily and proportionately protect the underlying public policy,’ especially since licensed healthcare professionals performed all services.”⁵⁵

In his twenty-two page decision, Judge Sifton analyzed and distinguished Judge Gammernan’s decision in *Progressive Northeastern Insurance Company v. Advanced Diagnostic and Treatment Medical, P.C.* finding that that decision decided, only two months’ previously, actually supported this holding. Judge Sifton quoted from the *Progressive Northeastern* decision stating that there the insurer plaintiffs “‘are not seeking to deny claims as a result of the corporate structure of the [service providers], rather, plaintiffs seek to recover for fraudulent claims which plaintiffs allege were facilitated by the ille-

⁵² *State Farm Mutual Auto Ins. Co.*, 175 F.Supp.2d at 419.

⁵³ *Id.*, citing *IHS Acquisition XV, Inc. v. Kings Harbor Healthcare Center*, No. 98 CIV 7621 (LBS), 1999 WL 223252 (S.D.N.Y. Apr. 16, 1999).

⁵⁴ *IHS Acquisition XV, Inc.* at 2. To the same effect *See*, *Senior Life Management v. Dowling*, 650 N.Y.S. 2d 437, 440 (App. Div. 3d Dept. 1996).

⁵⁵ *State Farm Mutual Auto Ins. Co.* at 419-20, citing *Lloyd Capital Corp. v. Pat Henchar, Inc.*, 80 N.Y.2d 124, 129 (1992).

gal corporate structure.⁵⁶ The facts in *Progressive Northeastern* that, if proved, would render the claims fraudulent were that the service providers submitted false claims for equipment that was not used and for services that were not provided.”⁵⁷

Judge Sifton also distinguished the case of *Fordham Medical Pain and Treatment, P.C. v. State Farm Mutual Insurance Company*, discussed above, noting that “the court, stating only that ‘[o]bviously [the professional corporation] cannot be allowed to benefit from the fraudulent activity described’ by the insurer, held that the insurer could deny a claim on the basis of the healthcare provider’s improper ownership and control. The fraudulent activity described by the insurer included, however, billing for unnecessary services”.⁵⁸

The two New Jersey cases discussed above, *Allstate v. Schick*⁵⁹ and *Allstate v. Northfield Medical Center*⁶⁰, were both also distinguished “because those decisions do not consider New York’s statutory and regulatory ‘maze’ of a No-Fault scheme”.⁶¹

The *Mallela* case has been followed in part, and distinguished in part by subsequent federal court cases in New York. A New York State Court has also specifically rejected it, and one has followed it.

In the case of *Universal Acupuncture Pain Services, P.C. v. State Farm Mut. Auto. Ins. Co.*,⁶² Judge Scheindlin, writing for the Southern District of New York Federal Court, followed the basic legal principles set out in Judge Sifton’s opinion from the Eastern District Federal Court. The facts of the case were interestingly different. A licensed acupuncture practitioner incorporated the plaintiff, Universal Acupuncture Pain Services, P.C. The person, who State Farm argued exercised excessive control over the private corporation, was Dr. Dipak Nandi, a licensed physician in the State

⁵⁶ *Progressive Northeastern*, Index No. 6C01112/00, at 20 (N.Y. Sup. Ct., July 25, 2001) (emphasis added).

⁵⁷ *Id.* at 417.

⁵⁸ 175 F. Supp. at 417, n.12.

⁵⁹ 746 A.2d 543 (1999).

⁶⁰ No. MRS-L03228-99 (N.J. Sup. Ct. Apr. 27, 2001).

⁶¹ *Id.* There have been a number of arbitration decisions in this area, one of which is worth mentioning because of its prefiguring of the holding in Judge Sifton’s decision. This was a master arbitration decision of November 18, 1998, *Med. Health Office of Stony Brook v. Peerless Ins. Co.* (Case No. 17R 970 21235/98). The Master Arbitrator noted “the arbitrator below, on her own volition, raised the issue of the propriety of the corporate structure of the corporation. . . .” The Master Arbitrator overturned the denial of claim for payment by the provider corporation holding “the matter may very well be one for the New York State Public Health Department, but not for a No-Fault arbitrator.”

⁶² 196 F. Supp.2d 378 (S.D.N.Y. 2002).

of New York, who later also became licensed to practice acupuncture. Under New York Business Corporation Law §§1503(b) and §1503,⁶³ a medical doctor cannot own a private corporation that practices acupuncture, unless he is also licensed to practice acupuncture. Additionally, State Farm alleged that Dr. Nandi previously “controlled” several medical professional corporations, which were incorporated in the name of the same Dr. Mallela who was a defendant in Judge Sifton’s case.

State Farm denied obligation to pay for acupuncture services provided by the plaintiff, Universal Acupuncture Pain Services, arguing that Universal had fraudulently obtained “licenses and certificates required under New York Law.”⁶⁴

Judge Scheindlin commenced her legal analysis with a review of the substantive New York State law stating that is clearly unsettled in this area.⁶⁵ She found that “several recent decisions of New York’s lower courts have held that an insurer has no obligation to pay no fault benefits for services performed by an unlawfully incorporated health care provider.”⁶⁶

The Court then reviewed the relevant federal law and discussed the Sifton decision as follows:

A recent decision from the Eastern District of New York, however, held that a PC’s unlawful incorporation is irrelevant to its eligibility to sue for no fault benefits assigned to it by an insured. (*See State Farm v. Mallela*, 175 F.Supp.2d 401 (E.D.N.Y. 2001)). In that case, State Farm sued several professional corporations including Urban Medical for a declaratory judgment that “a professional corporation that is unlawfully licensed has no standing to bring a claim for benefits under the No-Fault law.” (*Id.* at 407-

⁶³ N.Y. BUS. CORP. LAW §§ 1503-1503(b) (McKinney 1983).

⁶⁴ *Universal Acupuncture Pain Services, P.C. v. State Farm Mutual Auto. Ins. Co.*, 196 F. Supp.2d 378, 382 (S.D.N.Y. 2002).

⁶⁵ She cited the following recent cases. *See*, *State Farm Ins. Co. v. N. Bronx Med. P.C.*, Index No. 117539/01, at p.2 (Sup. Ct. N.Y. Co. Jan. 17, 2002) (Wetzel, J.), Ex. C-39 to Appendix to Defendant’s Opposition to Plaintiff’s Motion to Dismiss (“Def. Opp.”); *Millennium Med. Diagnostics v. Nat’l Grange Mut. Ins. Co.*, Index No. 44600/00 (Sup. Ct. Queens Co. Sept. 14, 2001), Ex. C-34 to Appendix to Def. Opp.; *see also* *Fordham Med. Pain & Treatment, P.C. v. State Farm*, Index No. 600403/00, at p.3 (Sup. Ct. N.Y. Co. Jan. 4, 2001), Ex. C-33 to Appendix to Def. Opp. (upholding use of standing or eligibility defense against unlicensed professional corporation’s suit for assigned no fault benefits against an insurer); *Advanced Care of New York, Inc. v. John Friscia et al.*, Index No. 32528/99, at p. 8 (Sup. Ct. Kings Co. Feb. 22, 2000) (dismissing action brought by professional corporation for no fault benefits because the corporation did not refute defendants’ allegation that it was not licensed to provide physical therapy services under N.Y. EDUC. LAW § 6509-A, and therefore “is not entitled to recover payments under no-fault law”).

⁶⁶ 196 F. Supp. 2d at 385.

08.) In reaching its holding, the court reasoned that “the alleged fraudulent ownership of the PC Defendants does not affect the question whether plaintiff’s insureds incurred and incur basic economic loss that plaintiff is required to compensate”.⁶⁷

Plaintiff, citing the *Mallela* case as precedent, sought to dismiss State Farm’s counterclaim for a declaratory judgment for non-payment for services rendered. However, the Court denied the motion, stating:

Subsequently, a New York state court explicitly rejected *Mallela*, stating that “[t]his Court chooses not to follow the decision of Judge Sifton in the [Eastern District], *State Farm v. Mallela*, [because] it is in conflict with the established law in the New York State Courts.” *North Bronx*, Index No. 117539/01, at p. 2. Because *Mallela*’s holding regarding eligibility is now in conflict with several state court rulings and a growing number of arbitral decisions, declaratory judgment would help clarify the rights and obligations of insurers and professional corporation. Therefore, defendant has stated a cause of action for declaratory relief.⁶⁸

Following the reasoning in *Mallela*, however, the Court did dismiss a counterclaim seeking damages based on a violation of the New York State Business Corporation Law. The Court made a distinction between prosecution of an alleged cause of action for violation of statutory requirements, which it said was not supported by New York substantive law, and use of such a violation as a defense in an action for payment.

The Southern District Court also followed the Eastern District in denying a claim for unjust enrichment by the plaintiff, quoting Judge Cardozo:

‘[T]he law may at times refuse to aid a wrongdoer in getting that which good conscience permits him to receive[,] it will not for that reason aid another in taking away from him that which good conscience entitles him to retain.’ *Schank v. Schuchman*, 212 N.Y. 352, 359, 106 N.E. 127 (1914). Universal may not have been eligible for the benefits in the first place, but good conscience entitles it to retain the money paid for services rendered. Plaintiff’s motion to dismiss Counterclaim III is granted.⁶⁹

⁶⁷ *Ibid.*

⁶⁸ *See id.* at 386. Adding to the conflict and confusion in this area, a later New York Supreme Court case cited *Mallela* with approval without mentioning the *North Bronx* case cited by Judge Scheindlin. That case, the most recent in this area, is *Kerman v. Deutschman*, N.Y.L.J. April 24, 2003, p. 20, col. 6.

⁶⁹ *See id.* at 387-388.

State Farm had admitted in Paragraph 38 of its counterclaim that “acupuncturists, all of whom are either licensed or certified”, provided all of the acupuncture services.⁷⁰

Two later Eastern District decisions by Judge Wexler, while not rejecting the *Mallela* decision, did not view it as controlling. The cases by Judge Wexler were decided only a few days apart and involved the same plaintiff, Great South Bay Medical Care, P.C., but different defendants.

In the first case, *Great South Bay Med. Care, P.C. v. Allstate Ins. Co.*,⁷¹ the defendant asserted that the federal court should abstain from exercising jurisdiction because “the same issues raised in the lawsuit are the subjects of pending state court litigation involving the same parties.”⁷² The pending state court litigation is *Progressive Northeastern*, discussed above pending before Judge Gammernan. In *Great South Bay*, the Court analyzed several requirements for abstention and concluded that they had been satisfied because:

Not only is there a complete absence of any federal law in this case, the state law at issue is novel, unsettled, and currently winding it’s way through the lower courts of the State of New York. The issue of how corporate formation relates to the right to receive payment is one that is particular to the law of the State of New York. The decision by the state courts in this unsettled matter is preferable to this court exercising its “best bet” as to how New York law should be interpreted.⁷³

Judge Wexler dealt with the plaintiff’s reliance on the *Mallela* case summarily as follow:

Not only is this court not bound by *Mallela*, the facts therein are distinguishable from those asserted here. Here, as in [*Progressive Northeastern*], it is alleged that the fraudulent incorporation “facilitated” fraudulent billing practices. Denying the particular defense asserted in *Mallela*, Judge Sifton commented that nowhere in that action did the insurer allege that non-professionals provided services. *Mallela*, 175 F. Supp. at 407. Thus, *Mallela* stands for the narrow proposition that corporate formation, standing alone, is not a proper basis for denial of payment. While this may or may not be the ultimate interpretation of state law by the courts of that state, its application here would not be dispositive.

Allstate’s allegations of improper and fraudulent billing

⁷⁰ See *id.* at 382.

⁷¹ *Great South Bay Med. Care v. Allstate Ins.*, 204 F. Supp. 2d 492 (E.D.N.Y. 2002).

⁷² *Id.* at 493.

⁷³ *Id.* at 498.

here (and in [Progressive]) are broader than the allegations of impropriety set forth in *Mallela*. In both actions it is alleged that [plaintiff] billed at higher medical rates for non-medical services and that unnecessary procedures were performed. Thus, even if this case remained in this forum, *Mallela* would in no way mandate the result sought by [plaintiff].⁷⁴

It is noteworthy that in *Mallela* the defendants filed an amended complaint asserting fraudulent actions by the providers which was also dismissed by Judge Sifton.⁷⁵

A few days later Judge Wexler again ruled against the same plaintiff using virtually the same reasoning and similar language. In this case, *Great South Bay Medical Care, P.C. v. State Farm Mut. Auto. Ins. Co.*,⁷⁶ the court denied plaintiff's motion to dismiss defendant's counterclaim and distinguished *Mallela* on the facts saying:

First, this court is not bound by the decision in *Mallela*. Moreover, State Farm has cited numerous New York State cases and arbitration decisions with holdings contrary to *Mallela*, upon which this court could rely. Even if this court agreed with the holding in *Mallela*, however, the result sought by [plaintiff] would not necessarily follow. This is because the facts in *Mallela* are distinguishable from those asserted in support of State Farm's counterclaim.

State Farm alleges not only that [plaintiff] violated New York State law when incorporating but also, that this fraudulent incorporation was used to facilitate fraudulent billing practices.

⁷⁴ *Id.* at 499.

⁷⁵ Writing a forty-three page opinion, he noted that plaintiffs had not actually alleged any new factual allegations of fraud but, instead, only "new legal arguments in support of plaintiff's central claim that the 'previously alleged' fact that P.C. defendants were actually owned by individuals without licenses justifies plaintiff's refusal to pay benefits claims submitted by P.C. defendants" (Slip Op. p. 32). He noted further that the violations charged by the plaintiff were not "*malum in se*" observing that "Plaintiff has alleged no deficient treatment of patients or submission of charges for treatment that was unnecessary or not performed and has given the Court no reason to believe that ownership of P.C. defendants by non-physicians is evil in itself" (Slip Op. p. 38, N.11). The Court cited and discussed a federal government ruling by the Health Care Financing Administration permitting entities "with corporate structures similar to P.C. defendants to qualify as 'group practices'". *Ibid.* The Court also noted that there are many reasons for challenging the license of a professional corporation including failure to hold an annual meeting or pay licensure renewal fees and, in the case of individual medical providers, failure to pay child support which, under New York law, is grounds for revocation of a professional license. *Id.* at 24. (C.V. - 00 - 4293) (cps) (November 21, 2002). A notice of appeal from Judge Sifton's second decision has been filed.

⁷⁶ *Great South Bay Medical Care, P.C. v. State Farm Mutual Auto. Ins. Co.*, CV-01-690 (E.D.N.Y. May 28, 2002) (Slip Opinion).

These allegations of fraud along with a broad violation of the no-fault insurance law, distinguishes this case from *Mallela* and states an appropriate claim for relief. (*See, Mallela*, 175 F. Supp. at 407 (noting that insurer nowhere alleged that services were provided by non-professionals)).⁷⁷

Thus, with the exception of *Mallela* and *Universal Acupuncture*, the cases indicate that while an allegation of improper corporate structure, standing alone may not suffice as a sword to attack a provider of services, when pleaded as a device to “facilitate” a fraudulent billing scheme, it will stand at least as a shield to an action by a provider to recover payment for services.

Judge Gammernan’s latest ruling supports this view in *Oxford Health Plans (N.Y.) Inc. v. Better Care Health Care Pain Management & Rehab. P.C.*⁷⁸ In denying defendants’ motions to dismiss a large portion of the plaintiff’s case, the Judge stated:

I have allowed common law fraud claims to proceed where fraudulent activity has been facilitated by improper corporate structure. Plaintiffs here do not seek recovery for the improper corporate structure alone, but rather maintain that the corporate structure served as a foundation by which defendants could readily engage in fraudulent activities. In *Progressive Northeastern Insurance Co. v. Advanced Diagnostics and Treatment Medical, P.C.*, No. 601112/00 (Sup. Ct., July 25, 2001), I held that an insurer could raise issues relating to improper corporate form where the ‘plaintiffs seek to recover for fraudulent claims, which plaintiffs allege, were facilitated by the illegal corporate structure.’⁷⁹

When addressing and subsequently dismissing plaintiff’s argument based on the two federal court cases (*Mallela* and *Universal Acupuncture*) Judge Gammernan noted that those cases “. . . are in harmony with my ruling in *Progressive*. . .”⁸⁰ He then quoted Judge Sifton from *Mallela* as follows:

Progressive Northeastern, relied on by plaintiff, supports this court’s holding(. . .)the *Progressive Northeastern* court stated that the insurers are not seeking to deny claims as result of the corporate structure of the [service providers], rather plaintiffs seek to recover for fraudulent claims, which plaintiffs allege were facilitated by the illegal corporate structure.⁸¹

⁷⁷ *Id.* at 7.

⁷⁸ *Oxford Health Plans (N.Y.) Inc. v. Better Care Health Care Pain Management & Rehab. P.C.*, N.Y.L.J. 21, (col. 2) (Sept. 19, 2002).

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

Furthermore, in discussing and distinguishing *Universal Acupuncture*, Justice Gammernan noted that that federal court had ruled that there was no cause of action for violation of the General Business Corporation Law alone, and that:

. . . where damage or injury can be established independent of the statutory violations, claims relating to improper corporate structure should not be dismissed.

Here, plaintiffs assert that the improper corporate form utilized by the defendants allowed them to facilitate their various fraudulent billing schemes. Plaintiffs may not assert a cause of action for the violation of Business Corporations Law §§ 1503, 1507, and 1508 alone. However, plaintiff's complaint does not rely on the violation of these provisions as the sole basis for the fraud and resultant injury claims. Plaintiff's complaint alleges that the improper corporate form utilized by defendants was a mechanism by which the fraudulent activities could be carried out and perpetuated. Plaintiffs seek to recover damages for the submission of fraudulent claims, not for the alleged statutory violation. As such, plaintiffs should not be precluded from basing portions of their fraud claim on the alleged improper corporate structure of the defendant corporations.⁸²

Therefore, it appears, at least in the New York State courts, that pleading (and presumably proving) allegations of fraudulent billing must accompany claims of defective or faulty corporate structure in order to prevail.

There have been a number of other cases filed by insurance companies against healthcare providers claiming recoupment of payments made and denial of payments pending, based on defects in corporate structure. One of them is *Allstate Ins. Co., et al. v. Nandi, et al.*⁸³ While this case makes claims of staged accidents, payment for referral of patients and other egregious and improper activity, there were also claims of illegal and improper control over defendant medical providers "in violation of Article 15 of the Business Corporation Law ("BCL"), which governs the corporate practice of medicine in New York State and requires any corporation

⁸² *Id.*

⁸³ *Allstate Ins. Co., et al. v. Nandi, et al.*, S.D.N.Y. 01 CV 5231 (Judge Kimba Wood). A motion to dismiss is subjudice in this case. *See also* Valley Physical Med. and Rehab. v. Allstate Ins. Co., CV99-5697 (LDW) (WDW) (5-16-01 E.D.N.Y.) granting a discovery motion for documents and information relating to plaintiff's "licensure and corporate structure" and N. Bronx Med. P.C. v. State Farm Mut. Auto. Ins. Co. 105 274/01 (Sup. Ct. N.Y. Co. 4-16-01) denying a motion by the P.C. plaintiff to enjoin the insurance company defendant from challenging the P.C.'s licensing and operating status as a medical professional corporation in several pending arbitrations brought by the P.C. against the insurer for payment.

that provides physician medical services to do so as a professional corporation ("P.C.") owned and controlled exclusively by physicians.⁸⁴

In addition, in *United States v. Orlander* an indictment was brought against a management company, chiropractors, and medical doctors.⁸⁵ Although the thrust of the indictment was fraudulent billing, in paragraph 29(a), it was alleged that the chiropractor converted his practice into a medical practice and through a management company, he "maintained control over the finances, assets, management, professional and lay personnel, hiring, firing and the policies governing treatment of patients of the professional corporation. Through a series of contractual arrangements between the newly formed professional corporation and management company [the defendants] received all profits from the operation of [the medical practices]." The indictment further alleged that the defendant chiropractor maintained control of the medical practices through a series of contractual agreements, separate for each of the facilities, which "gave to the management company the responsibility of the professional corporation's day-to-day operation which funneled all the proceeds of the P.C., with the exception of payment of the salary of the physicians and certain limited incidental costs such as malpractice insurance, to the management companies."⁸⁶ This is the first known use of this theory in a criminal context. The defendants pled guilty to the fraudulent billing counts.

CONCLUSION

The form of business operation discussed in these cases is prevalent throughout the country. It is a response to the increasing complexity of the health care delivery system and, specifically to several trends. Medical doctors for some time have had to be increasingly concerned with the rapid advance of science and technology in their particular fields. While it is a full-time job to provide patients' treatment, it is also very time-consuming to read the medical literature, attend conferences and lectures and simply keep up with ongoing developments in any specialty. Increasingly, doctors are looking for ways to unburden themselves of the business aspects of medicine so that they may not only remain doctors, but also currently competent doctors.

⁸⁴ See *id.*

⁸⁵ *United States v. Orlander*, No. 01 CR 491 (S.D.N.Y. Jan 29, 2001)

⁸⁶ *Id.* Indictment at paragraph 29(q) (Judge Barrington D. Parker, Jr.)

Unfortunately, concurrent with the above pressing need is the increasing complexity of the business of medicine. Managed care, third party reimbursement, utilization review and concern about increasing regulation generally, have taken a toll on the practice of medicine, removing it increasingly to an institutional setting of hospital's outpatient departments, HMO clinics, etc. where a large administrative staff is provided to deal purely with administrative duties.

The medical practice management company is part of the widespread trend of doctors, medical groups and other medical entities to engage competent business assistance for dealing with aggressive managed care and insurance companies and the business aspects of medicine generally. Moreover, management companies can allow small practices and even individual practitioners to continue to exist, offering a more cost-effective option to the health care consumer, not to mention the ability of the practice to operate in areas that would otherwise not be medically served. As individual practices are acquired by hospitals and drawn into the orbit of the major medical empires in the metropolitan area, the consumer has less choice and the choice that exists is far too expensive. Care in a hospital clinic, for example, is not just incrementally expensive, but a multiple of what care in a private practice setting costs. As one state Board of Medical Examiners noted in 1992:

Physicians have historically practiced medicine individually or in partnerships or professional corporations wholly owned by physicians. In the recent past, however, and particularly in the last 25 years, alternatives to the traditional model have been created or proposed in response to a number of socio-economic developments in our nation's health care delivery system. Affiliations between physicians and other components of the health care system - other health care providers (institutional and individual), payors, and other organizations - have been promoted by some as a means of enhancing the quality and accessibility of care, reallocating the economic and financial risks of providing services and decreasing the cost of health care.⁸⁷

Crafting the relationships between the professionals and the businessmen is difficult without some kind of legal guidelines. The cases discussed above give conflicting signals that, hopefully, will be harmonized in the near future.

⁸⁷ LA. STATE BOARD OF MED. EXAMINERS, STATEMENT OF POSITION: EMPLOYMENT OF PHYSICIAN BY CORPORATION OTHER THAN A PROFESSIONAL MEDICAL CORPORATION (March 21, 2001).