The Corporate Practice of Medicine Doctrine: Still Alive and Kicking

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Introduction

Some health care providers may not be aware of the corporate practice of medicine doctrine (CPOM doctrine) and whether it is applicable in the state in which they want to structure a health care arrangement with a nonlicensee or nonmedical professional entity. At its core, the CPOM doctrine prohibits a nonphysician from interfering with the professional judgment of a physician by prohibiting nonphysician owned and controlled corporations from employing physicians to practice medicine and then charging fees for those professional services. 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. In practice, many states with CPOM laws permit professional service entities to practice medicine, but only if owned by physicians licensed in that state. Authority for state CPOM laws ranges from statutes and rules to case law and state attorney general opinions.

Health care providers must be careful to comply with local laws because violations of 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, since it can affect the structures of such ventures.

Background

The origins of the CPOM doctrine can be traced back to the American Medical Association’s issuance of its Principles of Medical Ethics and its efforts to distinguish physicians in the public eye from nonphysicians who offered their services or products as cures and remedies for various ailments and afflictions. Further fueling the AMA’s argument was the employment of physicians by corporations for the care of their employees. 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.

The CPOM doctrine is based on the policy that the patient’s need for treatment and care, and the physician’s related judgment, conflicts with the interest of the corporation in maximizing its profits and reducing its costs. Consistent with these ideals, the Illinois Supreme Court held that:

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1 See Painless Parker v. Board of Dental Examiners, 216 Cal. 285, 14 P.2d 67 (1932).
4 Id. at 247-248.
To practice a profession requires something more than the financial ability to hire competent persons to do the actual work. It can be done only by a duly qualified human being, and to qualify something more than mere knowledge or skill is essential. The qualifications include personal characteristics, such as honesty, guided by an upright conscience and a sense of loyalty to clients or patients, even to the extent of sacrificing pecuniary profit, if necessary. These requirements are spoken of generically as that good moral character which is a pre-requisite to the licensing of any professional man. No corporation can qualify.\(^6\)

Over the years, while some states have held steadfast to this policy, others have determined that the liability system and the state’s regulatory oversight provide sufficient safeguards to allow the practice of medicine to adapt to new business realities, and these states have either repealed their CPOM prohibition or provided a growing number of exceptions to the CPOM prohibition.

Determining whether a state actually has a CPOM prohibition is not always easy. Although it is straightforward if the state’s CPOM prohibition is statutorily created, in many states the CPOM doctrine is established through common law. Additionally, the CPOM prohibition in some states may derive from the state’s medical practice regulations.

**Current Incarnations of the CPOM Doctrine**

Today’s incarnations of the CPOM doctrine vary from state to state, but some generalizations can be made from examining the laws of various states. 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 nonphysician. For instance, in California:

... any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.\(^7\)

Certain states, such as Texas, permit arrangements whereby a nonphysician can enter into an independent contractor relationship with a physician and avoid ap-


\(^12\) Chapter 19.68 RCW.
General Considerations

The 2009 decision in In re Andrew Carothers, M.D., P.C., 888 N.Y.S. 2d 372 (N.Y. Civ. Ct. 2009), provides insight into the minefield that is the CPOM doctrine when structuring health care arrangements that involve licensees and nonlicensees to avoid a possible violation of the CPOM doctrine. While Carothers is a New York case, the lessons learned from the case are instructive across all jurisdictions and can be summarized in the seven points listed below, which is certainly not exhaustive:

1. Licensees should be solely responsible for making all clinical decisions regarding patient care;
2. Agreements between the (a) licensee or the professional entity and (b) the nonlicensee and the nonprofessional entity should be the products of arms-length transactions and should be in writing (which writing shall be followed and not ignored);
3. Nonlicensees should not exercise control over the professional assets of the professional entity;
4. Any advances made by the nonlicensees to the professional entity should not be deemed capital investments;
5. Nonlicensees should not hold themselves out as third parties as owners of the professional entity;
6. Nonlicensees should not have the ability to hire, fire, and/or determine the salaries of the professional entity’s licensed employees; and
7. The licensee(s) who are owners of the professional entity should not be absentee owners and should play a substantial role in the day-to-day and overall operation and management of the professional entity.13

Potential Penalties for Violations of the CPOM Doctrine

There are a number of penalties and other consequences that could be imposed as a result of 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 could even include 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 . . . .14

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.15 Insurance companies have been one of the most prevalent plaintiffs in recent CPOM doctrine litigation. In Allstate Insurance Co. v. Belt Parkway Imaging PC, insurance companies sued several provider entities, along with the licensee who was the owner of the entities on paper and the non-licensee whom the insurance companies alleged actually owned the entities.16 The court found that the entities were ineligible to receive no-fault benefits because they had engaged in illegal fee-splitting with nonlicensees and were unlawfully controlled and/or beneficially owned by a nonlicensee. More specifically, the court concluded, as a matter of undisputed fact, that (1) the nonlicensee completely controlled the entities, (2) the licensee permitted the nonlicensee to control and dominate the entities to the exclusion of the licensee or any other licensed physician, (3) the licensee and the non-licensee, as well as the entities, are liable for fraud, and (4) the insurers have no obligation to pay any pending, previously denied, or future no-fault claims submitted by any of the entities. The court allowed the insurance companies to recover all funds paid to the entities after April 4, 2002, and to personally seek relief from the licensee and the nonlicensee.17

Conclusion

Economic forces have changed the health care landscape in recent years. The recent influx of nonlicensed business people in the health care arena has brought the CPOM doctrine back to the forefront of discussion. When structuring business ventures with physicians and nonlicensees, the CPOM doctrine needs to be reviewed on a state-by-state basis to determine its possible impact on the venture.

13 This consideration is most important in New York as a result of BCL § 1507, which provides that a shareholder of a professional corporation actually must engage in the practice of the profession in that professional corporation that the corporation is authorized to practice.

14 63 PA. CONS. STAT. § 422.39.
17 Id.