THE BIGGEST MISTAKES THAT DOCTORS MAKE WITH RESPECT TO MANAGING THEIR MEDICAL PRACTICES AND INVESTMENTS

Alan S. Gassman, Esquire
Gassman, Bates & Associates

A thriving and successful medical practice can quickly be pulled under by one catastrophic incident that destroys its financial solvency, its credibility, or both. How and why do such catastrophes occur, and what are their most common forms? The author of this piece has represented several hundred medical practices over the last 23 years. A review of prior experience reveals a number of avoidable mistakes that are the most common causes of fatal errors for medical practices and investment portfolios.

1. Failure to Maintain and Appropriately Use Independent Professional Advisors. Many of the calamities described below will be avoided if a medical practice has experienced advisors on board. The practice should consult with its advisors when making major practice decisions, and to confirm that appropriate procedures and safeguards are in place.

(a) CPA: Quite often the quarterback of the advisor team will be a good, caring Certified Public Accountant who does extensive medical practice work. CPAs are often well-versed in investments, business matters, and theft-proofing a medical practice from a financial standpoint.

CPAs should prepare quarterly or monthly financial statements for the medical practice; these statements should involve a review of accounts receivable, cash flow and general practice financial information.

(b) Attorney: An experienced lawyer who represents a number of medical practices should have sufficient experience to help physicians avoid terrible problems before they occur.

Just as physicians advise patients to have an annual check-up, and may wisely require this before prescriptions are renewed beyond 12 months, a medical practice should confer with its lawyer on a periodic basis. Commonly the primary lawyer for the practice will refer matters to appropriate sub-specialist attorneys in a number of different areas. Often this happens in conjunction with a CPA meeting.

(c) Other Advisors: Other advisors commonly and appropriately used by a medical practice group will include a qualified pension plan advisor, who is also preferably an actuary, as well as a banker who is knowledgeable as to practical business expense and loan-associated planning, and a reputable and conservative financial advisor or advisors who assist with pension planning, various insurances, and other practice-associated financial instruments. Good advisors should be honest and always let the physician and the rest of the team know of questions, concerns, or the need to bring in additional experts to handle any particular matter or situation. Advisors who show up to sell a single product or scheme commonly cause problems, as described in Section 4 below.

2. Failure to Maintain Medical Law Compliance. A great many physicians are annihilated financially when Medicare and/or private insurance carriers request hundreds of thousands of dollars in refunds because the physician has used inappropriate billing practices or financial arrangements with third parties. In many cases these problems are reported to the government by employees who can earn a 15% "whistle-blower fee."

Many physician clients simply do not realize that they use improper coding, do not maintain sufficient patient file back-up, or bill for items that are inappropriately unbundled or altogether un-billable.

Several years ago, the concept of a "medical practice compliance audit" was in vogue, and many professionals, in the opinion of the author, significantly over-charged physician groups for "practice audits." Such audits extended far beyond a reasonable review of billing, patient file documentation, and third-party financial arrangement review.

Reasonable and periodic practice maintenance, reviewed by trusted medical consultant advisors, eliminates the need for such a costly venture. In the author's experience, most medical practices benefit from hiring an independent consultant to come into the practice, perhaps annually, to spend a day randomly reviewing patient charts and the billing and collection processes associated therewith.

Quite often a good consultant can spot billing opportunities where the practice is undercharging or not charging for certain services. An independent consultant can also be a tactful go-between to let certain members of a medical practice know that their file documentation is not sufficient. Such corrections are best conveyed by a neutral third party.

Consultants should be hired by a lawyer on behalf of the medical practice so that any problems they may uncover can stay confidential under the attorney-client privilege to the extent possible.

If and when the government criticizes a medical practice's coding, file documentation or other billing procedures, it is very helpful to be able to show that the practice conscientiously hired and followed the advice of a reputable billing and coding consultant on a periodic basis.

Many physician groups also are not familiar with or intentionally disregard rules relating to arms-length leases, compensation arrangements, and also the ability to refer tests within a group medical practice only if certain rules are followed. The author has had law-abiding and well-meaning physician clients arrested in their lobbies by the FBI as a result of being in business with the wrong people at the wrong time. Doctors can rest assured that any "scoundrel" that they have legitimate or questionable business relationships with will turn them in to get amnesty if and whenever approached by law enforcement, even if the doctor did nothing wrong. When law enforcement comes knocking the doctor should immediately have appropriate sub-specialty lawyers contact law enforcement on his or her behalf. Neither the doctor nor his or her staff should directly speak with any law enforcement officers at any time on any topic.

3. Failure to Theft-Proof the Practice's Monies and Accounts Receivable. The author regularly receives at least one phone call per year from a very upset physician who has had tens of thousands of practice dollars stolen by an employee. This employee has often been with the practice many years, and most of the time is the most trusted person in the practice other than the physicians themselves. As such, the employee is able to obtain physical possession of checks made payable to the practice by one or more payor sources and/or has written checks on the practice accounts for bogus expenses.

Over the years the author has seen medical practices unwillingly and unwittingly pay credit card expenses, electric company expenses, car payments, and even home mortgage payments for a medical practice employee. When the circumstances are reviewed, they reveal that most of these situations would have been avoidable with proper supervision and use of appropriate safeguards.

Additionally, money is often stolen from practice accounts when large projects such as buildings, construction, or similar matters are administered by a person who signs the checks and/or administers the checks and invoices for a busy physician.

Most of the time the theft is carried out by the most-trusted office manager without any assistance from another employee.

It is a very basic accounting system principle that the person or people who physically open the envelopes containing checks payable to the practice record the checks onto a log and ensure that the checks are properly deposited. These deposits are then reported to a separate employee who has the ability to record the payments in the practice's computer system.

It is a fatal error to allow one individual to have physical possession of checks and also the ability to enter payments or write-offs onto the practice's billing computer system. Even spouses have been known to steal from medical practices, especially when there are multiple partners.

Many practices use a post office box for checks to eliminate the risk of someone being able to "snatch a few checks from the mail" before they can be posted.

Many banks offer check-depositing services and addresses that can be used as well. These are often known as "lock box" arrangements.

Larger practices can have someone from their CPA firm visit the practice on an annual basis without advance notice to the practice personnel. This demonstrates to employees that there is some degree of monitoring going on and can discourage practice theft.

4. Using Greedy Investment Advisors. The number of different investments and life insurance and annuity arrangements that can be sold to doctors and their practices in the financial world is nothing short of astounding. The quality of each particular investment vehicle can vary dramatically in terms of actual financial safety, conservative versus aggressive orientation, likelihood of being acceptable to the IRS in the event of an audit, and as to the amount of commissions paid to advisors who may suggest such arrangements.

Expecting a physician to read a prospectus or to understand a complicated tax maneuver is like expecting a lawyer or a CPA to read an EKG- it is easy to be fooled! Anything that looks or smells like a tax shelter is susceptible to having an en masse IRS audit of all participants. Offshore captive carrier malpractice insurance arrangements often ring of the same tone. Life insurance purchased for buy-sell arrangements and otherwise may be subject to significant charges by the carrier based upon the commission being paid to a salesperson.

If the advisors are earning a significant portion of the amounts invested as compensation, a degree of manipulation, non-disclosure, exaggeration or outright lying can take place.

In the pension world actuaries and many CPA firms who practice extensively in the retirement plan arena yield the best results for clients. Pension and profit-sharing plans are well-protected under applicable creditor laws and well-accepted under the tax law in conventional form.

There is rarely a good reason for a pension or profit-sharing plan to own a life insurance or annuity product, except to compensate anyone who may be licensed in life insurance and annuities who has involvement in the pension or profit-sharing plan.

On the other hand, more aggressive plans such as 419A Welfare Benefit plans and 412i plans should be examined carefully by independent advisors before investing.

The author urges clients to use independent accountants who are not compensated directly or indirectly for the sale of financial products. The author has seen entire fortunes lost to tax shelter deals in the 1970s, leveraged real estate deals in the 1980s, land development deals in the 1990s, and now Madoff and related Ponzi and margined-securities deals in the present decade. Crime often pays, and the victim is the doctor who gets involved in these types of arrangements.

5. Failure to Have Anyone in the Practice Pay Attention to Contracts with Third Parties. Quite often medical practices get into disputes or find themselves stuck in agreements as a result of a trusting nature or lack of attention to details associated with contracts they enter into with third parties. Say, for example, somebody delivers a copier to the medical practice that the office manager has requested on a trial basis. Upon delivery, that person gets the receptionist to sign a contract accepting copier and binding the practice to 48 months of payments. Another example is when a medical practice has a lease that gives the doctors the right to extend after a certain date, but they forget to give notice of extension by the deadline. The practice gets held up by the landlord for a larger rent payment or has to vacate and find new property. A third example is when a lease for a large piece of equipment also requires the practice to maintain the equipment with one company only. The company may provide poor service or may not permit the practice to pre-pay the lease or re-finance it from a high rate of interest without paying tens of thousands of dollars in penalties.

Another trap some practices fall into is using an office manager or non-CPA accountant to draft legal documents that employ physicians or to set up companies for the practice, not realizing that the contracts have inappropriate provisions or do not cover essential items that a lawyer or appropriately qualified advisor would have pointed out.

F. Lee Bailey said that "anyone who acts as his own lawyer has a fool for a client." Most successful lawyers hire other lawyers to do work for them personally when it is outside of their area of specialty, or sometimes even when it is within their area of specialty because of this phenomenon. If lawyers are smart enough not to do legal work for themselves why aren't doctors and their other advisors?

6. Failure of Multiple Physician-Owned Practices to Have Appropriate Buy-Sell and/or Shareholder Agreements in Place. Many successful medical practices are run on a handshake or a long-forgotten and now archaic agreement, but when problems or changes in circumstances arise the results can be catastrophic - and quite lucrative for the legal profession.

For the sake of example, assume that Doctor A and Doctor B are lifelong friends who have practiced together 25 years and share 50% each ownership of a medical practice without current legal agreements. Their spouses have also been best friends.

They have always worked approximately the same and have always been paid the same. A couple of years ago they were offered $3,000,000 for the practice, which involved signing 5 year non-competes and 5-year employment agreements. They also own the practice real estate together in a separate company under which they have signed a $2,000,000 mortgage on real estate now worth only $1,500,000.

If Doctor A becomes disabled, they may not be able to agree on how much Doctor B should be paid to administer the practice. Disagreements may also arise regarding the hiring of a replacement doctor or doctors.

They may also not be able to agree on a price or terms for Doctor B to buy out Doctor A.

Often disabled physicians believe they will be returning to work. Meanwhile, their partners see the writing on the wall and take a more skeptical view of their capacity for recovery. The practice can be significantly damaged during this period of time until the disabled physician's status on returning to work is absolutely confirmed.

What if Doctor A becomes a drug addict or begins having illicit affairs with medical practice personnel that could cause obliteration of the practice? How can Doctor B force Doctor A to leave, or to even behave? How can Doctor B protect the practice and himself from responsibility for Doctor A's misconduct?

What if Doctor A dies? Doctor A's widow may believe that the practice is worth $3,000,000 and will be voting Doctor A's stock unless or until she is bought out. How can Doctor B convince Doctor A and her lawyers and valuation experts that the practice has lost significant value because of Doctor A's death? How can Doctor B run the practice if Doctor A's widow will not agree to any significant changes in situations where such changes become necessary?

How can Doctor B attract a new doctor to the practice if he has to disclose that he is not getting along with the 50% widow owner of the practice?

The list of examples goes on and on. It does take time and money to put together an appropriate Buy-Sell/ Employment/ Shareholder document package. Almost no two are the same as circumstances change. However, it is a valuable investment that every practice should make.

In addition, applicable state law and/or Medicare law often requires that compensation be based upon methods determined in advance that do not take into account the referral of patient services. As mentioned under number 2 above, the