Although you hope none of these scenarios happen, if one of your group’s physicians is terminated or decides to work elsewhere, several physicians leave to form a separate practice, or the group crumbles completely, you’ll face complicated, emotionally charged matters to sort out.

The best time to decide how you’ll handle a potential split (e.g., who owns the accounts receivable [A/R], which staff will go where) is before problems arise—ideally when you form the group, says consultant Mary Witt.1

“It’s always easier to clarify what the rules are going to be [regarding a split] when everybody’s getting along,” she says. When people are already hurt or angry and want to separate quickly from the practice, it’s almost impossible to negotiate a reasonable strategy to dissolve the practice, she explains.

To prevent a difficult situation from becoming disastrous, address the following provisions in your employment and shareholders’ agreements when forming or reviewing your exit strategy.

Financial affairs

Even in a relatively clean departure, such as a nonpartner leaving to practice with a noncompeting group, some financial concerns are inescapable:

- **A/R complications.** Although there will likely be outstanding A/R for services that physicians provided before they left the practice, payers will continue to send reimbursement for those services to the practice. However, departing doctors could argue that they deserve some of the revenue they generated before leaving, Witt says. When you form the group, decide now how much, if any, A/R they will be entitled to and how you will handle payment.

In some cases, such as with Medicare, billing is done via the group number, says healthcare attorney and consultant Joan Roediger.2 Therefore, the physician would be required to submit a form to Medicare reassigning to the group his or her right to receive benefits, she says. However, some payers write checks to individual physicians. So even physicians who reassigned the right to payment to the practice need proper documentation to support whether they are required to turn over all or part of checks written in their own name, Roediger says. This is usually addressed in the physician’s employment agreement or other practice governing agreements.

- **Loan/financing obligations.** In a group practice with any sort of bank loan, line of credit, mortgage, or equipment-leasing obligation, chances are there are personal guarantees written in shareholders’ names, Roediger says. If one

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1 Contact Witt at the Camden Group at 310/320-3990 or via e-mail at mwitt@thecamdengroup.com.
2 Contact Roediger, a partner at the Philadelphia office of the law firm Obermayer, Rebmann, Maxwell, & Hippel, LLP, at 215/665-3216 or via e-mail at joan.roediger@obermayer.com.
Exit strategy

of the shareholders departs, the group needs that person’s name to be taken off of the loan as a personal guarantor. However, financing institutions may not easily agree to remove a guarantor’s name from a lease or loan.

Therefore, groups should learn their lenders’ policies up-front and, if necessary, draw up a legal agreement (between the group and departing doctor) regarding loans and financial guarantees well before the date of departure or termination, she says.

• Practice valuation methods. If you are selling your practice and plan to divide the money among all former members, determine the worth of the practice. And because several methodologies for practice valuation exist (see p. 8 for more about practice-valuation methods), agree up-front about what calculation method you’ll use, Witt says. If you valued the practice when it was first formed, be consistent and use the same method before a sale, she adds.

Legal concerns

The following legal concerns also arise when a doctor leaves the practice:

• Chart ownership. Doctors are not allowed to simply take their patients’ charts when they leave. “A departing employee cannot make unauthorized copies of confidential business records [including medical charts],” says consultant Randy Bauman.3 “Not only would this open them up to several potential causes for legal action, but it is possibly a HIPAA [Health Information Portability and Accountability Act of 1996] violation as well.”

Although the corporation (in this case, the group practice) is responsible to act as a custodian of its patients’ medical records, the patients truly “own” their records. Therefore, a patient can always, by signing a written release, have a copy of the records transferred to someone else, says healthcare attorney and consultant Vasilios “Bill” Kalogredis.4

The practice is allowed to charge for copying records, but HIPAA limits this fee to the actual cost of copying. Some state laws place additional limits. If the group decides to charge, the departing physicians must decide whether to front that cost or pass it off to the patients.

In most cases, groups don’t bother charging for copies because of the public relations risk in doing so, says Kalogredis. However, especially with a bitter breakup, it may be difficult to agree on an endpoint by which the copies must be furnished, he adds. HIPAA allows 30 days to copy records and some states (e.g., California) give only 15, but departing physicians and their patients will likely want the transfer made sooner.

With many splits, a group’s remaining staff have little incentive to move copying for a defected doc to the top of their to-do list. One solution is for the group and departing doctor to come up with a mutually agreeable time (e.g., a weekend) for the doctor’s new staff to copy the records, Bauman says. He recalls one situation in which a doctor actually brought his own copier and paper to his former office to perform the task.

• Patient lists. In most cases, patient lists legally belong to the practice, not individual physicians. “Unless you practice in a state that authorizes or mandates patient notification [of a physician’s move (e.g., Texas)], you really don’t have a right as a physician to your patient list,” Roediger says. Further, if you take your patient list and solicit those patients (without a written agreement to the contrary), you may breach your fiduciary responsibility to the group, she adds.

Therefore, set ground rules as a group regarding whether you will allow departing physicians access to their patient lists, whether they will be allowed to communicate with those patients, and in what manner. Consider preparing a joint statement to all patients informing them of the changes to your practice.

• Restrictive covenants. To avoid having physicians who leave your practice become your practice’s direct competition, have a restrictive covenant that complies with your state’s requirements and specifies how geographically close to your office former physicians may practice after they leave.

• Release of liability. With your attorney’s advice, decide whether you want departing doctors to sign a document releasing you from liability in any potential lawsuit resulting from their termination of employment, Roediger says.

Similarly, a departing physician may ask for a mutual release whereby you release him or her from liability related to the group’s past actions as well, she adds.
Environmental matters

The turmoil caused by a group split extends beyond just the physicians. Be aware that the upheaval can affect your staff and patients in the following ways:

• **Staff.** Much as children in a divorce, it’s common for staff to find themselves caught in the middle of an acrimonious group split. “Both sides start looking for allies in the beginning, thinking of which staff they want to take with them,” Witt says.

Not only is everyone involved under extreme stress, but the practice is still attempting to run as usual and see patients. “You don’t want to prolong that environment,” Witt says, recommending that groups sort out future plans as quickly as possible.

To expedite the process, with third-party help, draw up a list with two columns—one for each “new” practice—and list staff whom each side will be allowed to invite to join it going forward, Roediger suggests.

She has used this method in similar situations and says that as long as both sides agree not to solicit staff in the other side’s column, the process goes relatively smoothly. She suggests forming the lists based on personalities and skill sets that will work well together in a new setting.

Unfortunately, this sometimes means splitting up longtime coworkers. “There’s no perfect situation,” says Roediger.

• **Patients.** In a perfect world, the remaining and departing doctors would draft a joint letter announcing the change to patients, Roediger says. However, this level of cooperation may be too much to expect in a hostile situation.

Although the remaining practice isn’t required to make it easy for departing doctors, there are professional lines it shouldn’t cross.

For example, regardless of whether you send a letter to patients, they will eventually call the office looking for their doctor. Don’t lie and tell the patient you don’t know where the doctor is if you do know, Roediger says. Make sure your staff give out former physicians’ new practice information.

Nor should staff bad-mouth a former physician. “There may be hurt feelings or dislike, but you want to make sure your staff are being consistent and sticking to a script in terms of what they’re going to tell patients,” she says.

The unforeseen

Even with careful planning, you’re bound to run into the unforeseen. “Inevitably, you’re always going to run into some problem none of the parties ever saw coming,” Roediger says.

For example, you may have forgotten to spell out what method you’ll use to value the practice, or some members may no longer agree with the framework you set out. In these cases (and especially if you have no formal agreement), it’s usually necessary to recruit a third party.

“Nobody is going to end up totally happy,” Witt says. But a neutral party such as a consultant, attorney, or outside mediator can guide physicians to compromises that achieve the best possible outcomes, she says.

In such situations, Roediger typically attends several meetings in which the physicians go over each provision. She then confirms the final decisions in a letter to the physicians and has them sign the letter stating that they agree to those outcomes.
Customer service excellence is more than nice to have—it’s a must for physician practices that want to control their liability and improve their bottom line.

If patients believe they are important participants in their own healthcare—rather than nameless faces that you and your staff try to move through your office as quickly as possible—they’re less likely to sue you and more likely to work with you to find solutions.

The only way to ensure customer service excellence is to implement an organized, visible customer service program throughout your practice and keep it alive through consistent maintenance efforts.

**Five-star customer service basics**

Five-star service is the highest level of customer service that you can provide to your patients. It requires viewing your patients as customers, with the ultimate goal of providing high-quality healthcare. It focuses on quality at every phase of the patients’ experience and contact with you and your office.

True five-star service organizations include the Ritz-Carlton, the Disney Company, and the Four Seasons. Five-star quality is indicated by more than the surroundings, lobby, size of the rooms, or food portion size: It is indicated by how staff at these businesses greet customers, handle questions, and resolve complaints. This concept is at the core of these organizations, and every employee is expected to embrace it.

Five-star service in a healthcare setting is no different. In a five-star service physician practice, the group adopts service excellence as part of its culture.

Doing so requires that the group make the five-star concept part of hiring, orientation, reorientation, evaluations, inservices, education, incentives, and compensation or bonus structures.

The service excellence concept begins at the receptionist’s desk and includes the reception area, examination room, and quality of the actual visit with the provider.

It is reflected in how you and your staff speak to each other. An especially important aspect of service in the physician’s practice is how you handle complaints and concerns, which provide opportunities for you to improve your practice in the service area each year.

**Importance of five-star customer service**

Imagine that this level of service and patient satisfaction took place in your practice in a consistent manner. Hundreds of similar facilities nationwide are beginning to work up this service curve and are already reaping the benefits.

They quickly become providers and employers of choice, see improved patient outcomes, experience higher staff retention, attract higher quality candidates for staff positions, and win a bigger share of the market.

The five-star concept focuses the practice not only on service excellence but also on cooperative teamwork and enhanced communication.

As a result, five-star physician practices tend to be among the most productive.

**Customer service can reduce liability**

Data available regarding the thousands of malpractice cases and interviews with top plaintiffs’ attorneys reveal that communication errors and service lapses are usually what cause plaintiffs to speak with a lawyer in the first place. Lawyers look for service lapses when deciding whether to accept a case, and experts have an easier time finding fault. Ultimately, lapses can affect the way jurors evaluate a case.

Improved service and communication are at the core of a five-star service culture. They will help control malpractice exposure and will lessen the severity of every claim you may have.

Patients who believe that you care about them and treat them well are more likely to seek guidance from you than an attorney when a complication occurs.

On the other hand, if the relationship is already strained, such complications can cause a patient who had pent-up anger or frustration to head to a lawyer’s office with horror stories about how mismanaged your practice is and...
how that mismanagement led to a terrible outcome.

The five-step process
There are five steps to achieving a five-star service culture:

• **Step #1: Set the five-star goal and win support from leadership.** The process begins with setting the initial goal of striving for a five-star culture in a step-by-step fashion, and then securing the support of the practice’s leadership.

• **Step #2: Kick off the program.** Step two is the kick-off process. The goals must be accepted by all directors, owners, and leaders of the organization. Then introduce the five-star concept to your staff.

• **Step #3: Assess where you are on the five-star curve.** Obtain the perspectives of all staff, physicians, and patients at your practice to identify areas of service in which you can improve.

• **Step #4: Push the concept through the entire practice.** Identify and move through barriers that prevent your practice from progressing along the five-star service curve. Tools such as clear policies and procedures and staff training can help you get past these barriers and maintain the five-star service culture.

• **Step #5: Keep it alive.** Focus on keeping the program alive. This task is perhaps one of the most difficult. Medical practices are busy and will continue to have challenges that divert focus away from five-star service.

Editor’s note: The above article was adapted from HCPro’s new book, *Five-Star Customer Service: A Step-by-Step Guide for Physician Practices.* For more information or to order, call our Customer Service Department at 800/650-6787 or visit our online store at www.hcmarketplace.com.

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**Proposed rule includes nuclear medicine Stark prohibition**

The Centers for Medicare & Medicaid Services’ (CMS) *Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006: Proposed Rule* includes a proposal to make nuclear medicine (i.e., tests and therapy using radioactive substances) a designated health service (DHS).

That means nuclear medicine would be covered under the Stark self-referral law, which prohibits examining physicians from providing DHS to their patients.

The Stark rule already covers many radiology procedures. In 2001, nuclear medicine was excluded from the rule because CMS believed that most nuclear medicine was practiced in hospitals, which were already covered by Stark.

“We believe nuclear medicine services [both diagnostic and therapeutic services and supplies] pose the same risk of abuse that Congress intended to eliminate for other types of radiology, imaging, and radiation therapy services and supplies,” said CMS in the proposed rule.


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**Study: Convenience and access drive doctors’ use of e-CME**

More than 70% of primary care physicians (PCP) who use electronic continuing medical education (e-CME) say convenience and “anytime access” are the top usage drivers, according to a survey from CME provider Pri-Med.

More than 40% say they use e-CME Web sites to search for specific information about conditions their patients have, and another 40% say they use e-CME Web sites to follow up on information they received during a live presentation or class.

Nearly two out of three PCPs use the Internet every day to find clinical or professional information, while 17% say the Web is their preferred source for CME—a 70% increase from 2003.

Two-thirds of PCPs have participated in e-CME in the past year, and nearly half say they plan to increase their participation in the next year.

Other popular online destinations for PCPs are Web sites designed specifically for doctors and sites that provide links to clinical resources, says Pri-Med.

Physician compensation

Overcome overhead angst by choosing the best allocation method for your group practice

Rent, utilities, staff salary, marketing, and other items not related to compensation all generate expenses—known as overhead—necessary to run a medical practice. Most healthy practices collect enough revenue to pay the overhead and still pay the doctors.

However, groups often struggle with how to allocate overhead—which is deducted from physicians’ revenue—fairly.

Equal isn’t always fair

Groups employ a number of methods to meet this challenge. The simplest approach is to divide the overhead evenly among physicians. For example, in a four-doctor group, each physician would pay 25% of the overhead costs, regardless of how much overhead each physician actually incurs.

“It works fine in practices that are generally equally productive,” says Martin Brown,¹ a shareholder for consulting firm Pershing, Yoakley, & Associates. However, groups’ efficiency and productivity are rarely this in sync, he adds.

As a solution, groups may look to divide overhead commensurate with each physician’s productivity. Under this system, a physician who generates 60% of the group’s net revenue would pay 60% of the total overhead. But Brown says this method is also flawed because it doesn’t account for the difference between fixed (e.g., office rent) and variable costs (e.g., medical supplies).

Higher productivity alone doesn’t mean a doctor incurs higher costs, he says. For example, a physician who sees only 10 patients per day doesn’t use any less electricity (a fixed cost) than a colleague who sees 20, so this system unfairly penalizes the more productive doctor.

Variable costs, on the other hand, should be lower for less productive physicians. For example, the 10-patient-per-day doctor will use half of the tongue depressors, needles, and paper for patient bills as the 20-patient doctor, thus eliminating half of his or her overhead.

Therefore, Brown recommends groups allocate only fixed costs on a pro rata (equal) basis and divide the remaining variable costs based on productivity.

Pitfalls of cost accounting

Don’t scrutinize variable costs too closely, Brown warns. Not only can overzealous cost accounting harm the culture of your group (who wants to account for every paperclip?), but it can also inhibit achieving your strategic objectives. “Practices that are constantly worrying about managing their expenses are the ones that miss opportunities to invest in their practice and grow it,” he says.

For example, consider a multigenerational practice that is considering buying a large piece of equipment. Although the physicians in their early 40s may willingly enter a new 20-year lease for the sake of a business opportunity, those in their late 50s—who may also be group leaders or have significant influence—may balk at investing in an item that will only benefit them for three or four years (assuming they haven’t arranged to allocate costs as the equipment is used), Brown says.

To maintain a healthy perspective, focus on whether your practice spends in a way that gives you the greatest patient throughput (to maximize revenue), rather than expending too much energy on keeping costs down, says

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Geoffrey T. Anders, JD, CPA, CHBC, consultant with the Health Care Group in Pennsylvania.

**Classifying costs a challenge**

In theory, fixed costs won’t fluctuate if your practice treats slightly more or fewer patients, whereas variable costs will correspond with the number of patients doctors actually see. In reality, many costs don’t fit neatly into one category or the other, Anders says.

For example, take a two-doctor practice in which Dr. A spends most of his time seeing patients in the hospital, while Dr. B is always in the office. Should both doctors pay the same amount for office space?

Although Dr. A could not practice without an office and the rent is constant regardless of the number of patients he sees—or where he sees them—the fact is that he uses the exam rooms, office phones, etc., perhaps 20% of the time, yet pays only 50% of the cost.

Here’s another conundrum: Suppose a practice rents or finances an x-ray machine. The cost of the machine is fixed. But most equipment has a finite capacity (e.g., an x-ray machine may be good for 100,000 films). Should two partners each pay half if one doctor takes two-thirds of the pictures (thus using up two-thirds of x-ray’s capacity) and the other doctor only takes one-third?

The list of such “semivariable” or “semifixed” costs—those that flip from variable to fixed or vice versa depending on how they’re used—continues. And deciding how to classify these costs can be confusing, to say the least, Anders says.

**Overhead wrong focus**

Further, the idea of allocating overhead shouldn’t be your group’s focus, Anders says. He advises groups to concentrate on profits.

“The entire group needs to be concerned with controlling overhead—spending not the least amount possible, but the right amount on any particular overhead category—and maximizing profits,” he says.

In essence, Anders says the best way to allocate overhead is to not allocate it at all. Instead, simply take all the money that comes in the door of the practice, subtract all of the overhead (e.g., variable, fixed, semivariable, etc.), and then decide how you will distribute the remaining profits to the doctors, he says.

By using factors such as productivity to divide the profits, you will automatically divide the overhead proportionately without ever getting into complicated cost accounting for compensation purposes—although thorough accounting is still needed to ensure that overhead costs are appropriate.

This approach is particularly useful for groups that are looking to hire another physician—an endeavor that will generate significant startup costs until the new doctor develops a profitable patient base. Charging that doctor an equal or proportional share of overhead could easily overcome that doctor’s compensation until that doctor fully develops his or her practice.

Although many groups grant new doctors a grace period before they begin to charge overhead, it’s difficult to determine a fair arrangement because the time it takes to build a patient base varies widely in different specialties and locations, Anders says.

There are other factors that are easier to adjust for by dividing profits rather than overhead, he adds. Consider a physician with a large patient base whose colleagues treat the patients that the doctor doesn’t have time to see. Although other physicians actually see these overflow patients, the overbooked doctor is partly responsible for attracting them to the practice, Anders says.

Align whichever approach you take in handling overhead with your group’s values and keep the matter in perspective. If you find your group becoming too preoccupied with overhead and cost accounting, remember that a true business-partner relationship constitutes much more than just an overhead-sharing arrangement, Brown says.

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Consultant’s perspective

Don’t apply commercial valuation methods to groups

By Leif C. Beck,1 JD, CHBC

Despite the services group practices provide and the income they generate, physicians don’t always recognize what a valuable asset their practices represent. In fact, many groups have substantial capital value. How much value depends on a wide range of variables, including—often improperly—the reason someone wants to know the practice’s value in the first place.

For example, valuation of a practice comes into play in various situations, including:

• arranging for a new doctor to become a partner on buy-in terms that are fair to both sides
• setting a fair pay-out to a partner upon retirement, death, disability, or other departure
• merging with one or more groups that have disparate earnings, thus requiring a goodwill adjustment in planned physician share ownership or income distribution
• negotiating for a hospital to purchase a group practice or sell it back to its former owners
• buying a practice to augment or protect your market share in your service area
• determining a large group’s assets/capacity to finance the purchase of major equipment
• negotiating the allocation of assets between a partner and a nondoctor spouse in a divorce proceeding
• defending a lawsuit involving ex-partners

Capitalization-of-earnings caveat

In contentious circumstances (e.g., a divorce proceeding or partner-level dispute), lawyers for nondoctor spouses and other plaintiffs typically rely on a valuation approach known as capitalization of earnings. The method is commonly used in valuing commercial businesses and determining stock market values. However, it can put doctors into a terrible financial position when it is applied to valuing a private medical practice.

This method is particularly problematic with divorces of doctors who have unusually high incomes. Consider the case of a successful specialty surgeon in solo practice with a sterling reputation and a huge case load who worked inordinately long hours to garner a nearly seven-figure income. The doctor’s spouse’s lawyer asserted that the practice’s goodwill value was $5,000,000 due to its earnings.

In truth, however, the practice had almost no goodwill value because no buyer could have effectively stepped into the surgeon’s shoes. The goodwill was personal to the surgeon because of outstanding clinical and personal skills and the extensive time that he or she devoted to the practice. It was neither caused by nor part of the business, and it was not a quantifiable, transferable asset.

Reality of business value

Ex-partners make the capitalization-of-earnings argument against groups in much the same manner. If, for example, a five-partner cardiology group produces $3,500,000 of annual revenue, which provides the partners a total of $1,700,000 of income—$340,000 per partner—the group may appear extremely valuable.

An aggressive lawyer may retain a business-valuation expert who concludes that six times earnings is a fair value for the business, thus finding the practice to be worth $10,800,000. But most doctors working in the industry know that such a practice simply cannot sell for that sort of price.

That price is unrealistic because the business has to pay a fair wage to excellent cardiologists to generate the same or higher revenue. Subtracting $350,000 (which was at or below the median income for cardiologists in private practice three years ago) leaves zero earnings to capitalize.

Group documents rule

There’s another compelling reason capitalization of earnings falls short in group practice situations. Although those suing or divorcing may claim that the group is worth millions of dollars, they are up against the value to which the partners have already agreed in their shareholders’ or partnership agreements.

How can the group be worth more than that if no member is free to sell his or her ownership interest in it unless he or she sells it back to the group at the contracted price?

This is just another reason to be sure that your buy-out agreements, which establish a pay-out that relates to real life, are in place. Review your formula at least every three years to keep it current. Your agreement may call for some goodwill value, but having a properly thought-out formula agreed to and signed by all partners can help you avoid big trouble.

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