



After Madoff: What Should Charities and their Stakeholders Be Doing in a New World of IRS Transparency?

by Michael J. Kline

One of the most perplexing and disquieting group of investors/victims of the infamous Ponzi scheme of Bernard L Madoff is the long list of charitable organizations, many of them large and well-respected, that have reportedly lost many millions of dollars through investing with him. A number of the charitable entities that are tax-exempt under Section 501(c)(3) of the Internal Revenue Code have even been forced to abruptly cease their operations.

This article will examine some of the unique aspects of 501(c)(3) tax-exempt charities that made them attractive targets for Madoff, some of the mistakes that were made by those with responsibility for charitable assets, and opportunities for all charities and their stakeholders to better protect themselves in the future.

These matters coincide with the new and far more comprehensive and transparent annual reporting obligations of 501(c)(3) organizations on Form 990 with the Internal Revenue Service. While many charities will view the new Form 990 as a burden and extra work, the Form 990 can be a useful vehicle to repair charitable images damaged by Madoff or other events and to bolster charitable governance and compliance practices and reputations. Filed Forms 990 are universally available for review and copying from the internet. Later in this article information will be provided about how the new Form 990 can be used advantageously by charities and how anyone can obtain copies of them.

Who are the Stakeholders that were affected by Madoff?

A charity has many stakeholders. For example, a non-profit hospital's stakeholders may include donors, patients, physicians, employees, vendors, the governing board, the community, government, among others. The primary stakeholders that will be a focus of this article are its donors, the intended beneficiaries under its mission and the governing board or other management that is charged with the fiduciary duty of enabling it to achieve its stated mission. The presence of a mission, such as the provision of charity care by a tax-exempt hospital, distinguishes a 501(c)(3) organization from a profit-oriented business entity.

Why Were Charities Such Attractive Targets for Madoff?

In order to identify mistakes that charities made and suggest proactive responses, it is important to understand some of the reasons why they were primary objectives for Madoff to assist him in lengthening the life span of his Ponzi scheme. They include the following:

- For 50 years Madoff enjoyed the status and reputation of being a leader and innovator in the investment industry and had served as Chairman of the NASDAQ Stock Market.
- Madoff created an aura of trust by appearing to be the epitome of the "Three W's" that are most desirable attributes sought by charities in their

board members and supporters: generosity from Wealth, sharing of Wisdom and performance of Work.

- Madoff's reporting of consistently high, stable "returns" over years would encourage charities to limit distributions in favor of rolling over their purported returns to augment revenues and balance sheet assets; if endowment funds were needed, they would use other funds first.
- Charities with large endowments have consistently adhered to policies that have limited their spending to a small percentage of their endowment funds in a given year.
- Tax-exempt charities did not need to take any distributions from the Madoff investments to pay income taxes on their returns.
- The fact that respected charities appeared to have been making high returns with Madoff over a long period led to a desire by other charities to share in the "profits".
- Madoff operated in a cunning fashion to convince investors that his acceptance of their money made them members of a special select group.
- Boards of charities in recent years feel under enormous pressure to generate investment returns that exceed those of recognized benchmarks and are not less favorable than their peers.

What Mistakes Did the Charities Make in Investing with Madoff?

The actions of boards, investment committees and advisers of charities in

investing with Madoff were questionable in a number of aspects. Volunteer members of boards of charitable organizations with a mission are fiduciaries that should generally discharge their duties in good faith; in compliance with law and prevailing business ethics; with the degree of diligence, care and skill that an ordinary, prudent person would exercise under similar circumstances; and without undue conflict of interest.

In one or more respects the boards of charities that invested with Madoff fell short on these standards, including the following examples:

- It has been published that Madoff's purported investment vehicles were characterized by him as "split-strike conversion products using both index options and individual stock options, both with and without index puts." It would appear that such obscure and exotic investments are not traditional types that are suitable for tax-exempt organizations with a mission other than making money and maximizing revenues. The volunteer board members of non-profits, who are generally earning only "psychic income" often lack the time, background, experience or inclination to be capable of evaluating such investments. Additionally, most states have granted higher levels of protection from personal liability for board actions to uncompensated board members of charities than to directors of profit-oriented business entities.
- One or more charities had actual conflicts of interest in that Madoff was a board member at the same time that the organization was investing funds with him for a generous fee. In other cases there may be "perceptual" conflicts of interest, e.g., where Madoff was not a board member of charities that invested with him, but was a contributor or had board members who were otherwise investors with him or social or business relationships.
- A charity has a mission, which transcends merely generating money, that was the basis of its receiving tax-exempt status. Donors are not providing contributions as seed money for the board to take substantial and unquantifiable risks to increase endowments. They are giving to a cause

that has meaning that they wish to support financially.

- The improvident investment policies of a charity in investing with Madoff has subjected it not only to actual losses of investment value, but also the potential for "clawback" by the trustee for Madoff assets if the entity did take monetary distributions and received substantial and disproportionate payments as compared to the average cash return for all other investors.

What should charitable governing boards do to rehabilitate relationships with donors and beneficiaries?

The unfortunate experiences with Madoff of many charitable organizations should be poignant object lessons for all charitable organizations and their fiduciaries, whether or not victims of Madoff. It has become critical that all 501(c)(3) entities review, analyze and reform their operating policies and procedures in areas such as governance, investment policies, education of board members about financial and operational matters, avoidance of conflicts of interest, etc. Only by demonstrating their commitment to best practices in governance and operations can they succeed in the increasingly competitive environment for shrinking donor dollars in an adverse economic climate.

What is the Form 990 and how can it assist 501(c)(3) entities in achieving governance reforms and demonstrating these reforms to stakeholders?

For many years Form 990 was viewed as an annual financial report by a 501(c)(3) entity to the IRS for the prior fiscal year. The financial statements are an important part of the Form 990 and track very closely the annual audited financial reports of the organization. The Forms 990 for 2008 can be expected to be generally dismal because of declining contributions due to an adverse economy and significant losses in market values of charitable endowment funds during 2008, whether or not there were Madoff investments. Most 501(c)(3) organizations will have a need to explain clearly and carefully in their 2008 filings why losses were incurred and the steps to be taken to avoid or reduce a repetition of such losses. The IRS changes in the

disclosure requirements of Form 990 for 2008 encourage that approach.

Form 990 is required to be filed with the IRS by the 15th day of the month following the end of a charity's fiscal year, e.g., May 15, 2009 for a fiscal year ended on December 31, 2008. It must be understood that, unlike federal tax returns filed by business corporations, Forms 990 can be accessed anonymously by anyone in the world at any time. Websites, perhaps the most well known of which is www.guidestar.org, archive Forms 990 on line, ordinarily within two months after they are filed with the IRS. Potential donors, competitors, governmental agencies, beneficiaries and many others easily and routinely can access Forms 990.

A charity can have up to two extensions for filing a Form 990 that could delay its filing until November 15, 2009. It can be anticipated that many 501(c)(3) entities will try to extend their filing dates as long as they can in order to see what others are doing with the new Form, to delay disclosing adverse results in 2008 or to complete changes in governance and operating policies and procedures prior to filing. There are potential penalties for a 501(c)(3) entity that fails to file a complete and correct Form 990 with the IRS on a timely basis.

It is advisable for charities to file Form 990 for 2008 as soon as practicable, so that the initiative for building bridges to stakeholders can be maximized. An early filing of the 2008 Form 990 with positive answers to the new schedules and questions can disclose a strong commitment to a defined mission, appropriate governance and investment policies, involvement of the board in preparing the Form 990, a whistleblower policy, a modern and responsible conflicts of interest provision, appropriate policies for setting executive compensation, etc. The new changes to Form 990 will allow a charity to use the IRS items as a checklist of "best practices" and tell its story in its own words. Additionally, charities should post their Forms 990 on their own websites, together with principal governance documents that demonstrate their commitment to best practices.

Conclusion

The unfortunate Madoff scandal, an adverse economy and other events have combined to create challenging times for charities and their stakeholders. A properly prepared Form 990 that reflects recent proactive

changes in governance and operations under the leadership of the governing board will go far in repairing the damage to the images of those that invested with Madoff and to enhance the reputations of those that avoided the Madoff morass.

For more information about this topic, contact Michael Kline at 609.895.6635 or mkline@foxrothscild.com.

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Ownership Realignment: Time to Sell A Piece of The Pie?

By Albert R. Riviezzo

If you plan to sell a portion of your ownership interest to a hospital, a management company or other physicians, consider what each group will bring to the table and how it will affect the way your ASC is managed.

The Local Hospital

Faced with the prospect of losing lucrative surgical cases, many hospitals have realized that holding minority interests in surgery centers is better than having no interest at all. From the physicians' perspective, having a hospital involved in ownership may be attractive for the following reasons:

- Deep pockets. Besides sharing the cost of developing and operating a surgery center, hospitals are attractive to lenders, who may be willing to lend more money to a surgery center with a hospital as a guarantor.
- Management experience. Many physicians believe (sometimes mistakenly) that hospitals have greater expertise than they do when it comes to operating healthcare facilities.
- Freedom from economic credentialing. Inviting the local hospital to be part owner in your center may ameliorate the political fall-out that physicians often fear when they threaten to take cases from the hospital to your ASC.

If you become involved with a hospital, don't cede too much control of the management and operation of your center. Keep in mind that non-profit hospitals are tax-exempt entities and as such may be required to control certain management policies related to the care of patients who are uninsured. For this reason, non-profit hospital investors may demand a majority ownership interest in your ASC to ensure the center operates in a manner consistent with the hospital's charitable purpose.

When a hospital becomes involved in the daily management of your surgery center, you may find yourself in an arm-wrestling match. The hospital, for example, may be eager to handle the billing and collections. However, billing for services in an ASC is very different from billing for hospital services. As a result, you may be better off hiring and training your own billing staff or engaging a third-party ASC billing company.

Letting a hospital have a say in your day-to-day operations, such as OR scheduling, could undermine the very purpose of establishing the freestanding ASC in the first place. Hospitals, especially nonprofits, may be less interested in maximizing the profitability of your ASC than they are in appeasing physicians who are on staff at both facilities.

Management Companies

If you're considering partnering with a management company, you'll need to evaluate whether, in fact, the management

company brings sufficient value to the bargaining table to warrant the management fees and the equity and stock purchase rights the company seeks.

Many regional and national ASC management companies, some of them publicly traded, are interested in owning or acquiring interest in existing physician-owned surgery centers. Whether it's a majority or minority interest depends on the management company's business model.

These companies offer full menus of services, from generating initial feasibility studies to development, licensure and accreditation, and day-to-day management. They usually provide these services based on long-term management contracts that give them control over the day-to-day operations of centers in exchange for management fees that are usually based on net collections.

Some management companies are interested in maximizing profits before selling ASCs at a multiple of earnings. This may conflict with your objective of long-term ownership. Beware that management companies may require physician-investors to agree to "bring along" stock purchase rights. That may require you to sell some or all of your interest in the center if the management company finds a willing buyer and wants to sell its part. At the same time, management companies may not agree to grant physicians "tag along" rights to sell under the same circumstances because a buyer may not

be interested in purchasing an interest in the ASC if the physicians don't continue as owners.

Besides their expertise, for-profit management companies don't have the "charitable mission" issues that non-profit hospitals have. However, their management fees can cut sharply into physician-investor returns. When it comes to day-to-day management issues, physicians may find that they have only traded one master (the local hospital) for another, without gaining any more control over the ORs than they had when they took their cases to the hospital.

You may also find that management companies dictate the structure of acquisition transactions. If you run into this, consult your tax adviser to determine whether there will be capital gain treatment (currently taxed at a maximum of 15 percent of the gain realized) or ordinary income treatment, or some combination of the two, given to the proceeds of the sale. Usually sellers seek capital gain treatment while buyers try to allocate a portion of the

purchase price in a way that could result in the sellers having to recognize ordinary income, which for those in the highest income tax bracket would be taxed, currently, at 35 percent.

Physician-Investors

You may wish to forgo the corporate partner or hospital joint venture options by admitting additional surgeons to your ownership group. Be aware that there are requirements outlined in the federal anti-kickback regulations that must be met if the physician-owners of your center wish to enjoy the protection of an applicable safe harbor. You also must follow local securities laws, which vary in each state. Your physician-owners will be considered "promoters" for purposes of these laws.

The chemistry in physician-ownership groups can be likened to the chemistry of a football or baseball team. Where the chemistry is good, the ASC can be very efficient and extremely profitable. Yet as in sports, when the chemistry is bad, the ASC will falter. Adding new surgeons can

change the chemistry — for better or for worse. You also need to carefully consider the specialty of each physician-owner candidate, and factor that into your overall case mix to ensure your center runs at maximum efficiency and profitability.

Protect Your Investment

If you plan on realigning the ownership of your surgery center, consult with a lawyer who can assist in preparing the appropriate documentation. Choosing the wrong partner or failing to incorporate adequate protections in your center's governing documents can result in you losing control of the way your center is run and counteract the economic benefits of being a part-owner.

For more information about this topic, contact Albert Riviezzo at 610.458.4949 or ariviezzo@foxrothshcild.com.

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MEDICARE'S RECOVERY AUDIT CONTRACTOR PROGRAM

by *Michael G. Wiethorn*

In 2003, Congress enacted the Medicare Prescription Drug Improvement Modernization Program Act of 2003. Pursuant to this Act, the Department of Health and Human Services was directed to conduct a three-year demonstration program using Recovery Audit Contractors (RACs) to find out if the use of RACs would be a cost effective method to detect and correct improper payments in the Medicare Fee for Service Program. The RACs were charged with finding overpayments as well as underpayments. The initial demonstration operated in New York, Florida and California and then was expanded to Massachusetts and South Carolina. As detailed in the Medicare Recovery Audit Contractor Program, Evaluation of the Three-Year Demonstration published in June 2008, RACs have corrected \$980,000,000 in overpayments and \$37,800,000 in underpayments. The RACs returned \$693,600,000 to the Medicare Trust Funds even after subtracting the amounts repaid to providers for underpayments, the amount overturned on appeal and the cost of operating the RAC Demonstration Program.

Even before these results were published in June 2008, Congress acted again under the Tax Relief and Health care Act of 2006. This legislation required a permanent and national RAC program to be in place by January 1, 2010. The original intention was to have the permanent program implemented in the summer of 2008. Because of protests filed

by companies bidding on the contracts to act as recovery audit contractors, the implementation of the national program has been delayed. On February 4, 2009, these protests were resolved and the program will be going forward this summer.

Diversified Collection Services of Livermore, California (Diversified), has received the contract to act as the RAC for Pennsylvania. Diversified is expected to begin their review of Medicare billing records no later than August 1, 2009. Diversified as well as the other RACs will use their own proprietary software and systems as well as their knowledge of Medicare rules and regulations to determine what areas to review.

The RACs can make a determination that an overpayment or underpayment exists pursuant to two means. Automated reviews utilize the proprietary techniques of the RACs to identify claims that clearly contained errors resulting in improper payments. Automated reviews, where medical records are not requested, must have a clear policy that serves as a basis for the overpayment. A statute, regulation, National Coverage Determination, coverage provision in an interpretive manual or Local Coverage Determination that specifies the circumstances under which a service will always be considered an overpayment suffice as clear policies. When improper payments were clearly identified, providers were contacted by the RAC to collect any overpayment amounts or pay any

underpayment amounts. For example, a RAC can make a finding that an overpayment exists pursuant to an automated review based on medically unbelievable service such as claims for two or more identical surgical procedures for the same patient on the same day at the same facility.

Medical records of the providers were requested by the RACs in the case of claims that likely contained errors. The review of the medical records by the RAC to make a determination of whether a wrong payment was made is called a complex review. In implementing the permanent program, CMS limited the number of medical records that can be requested of a physician or physician practice by a RAC. The following limitations will apply: solo practitioner – 10 medical records per 45 days, a group of 2-5 individuals – 20 medical records per 45 days, a group of 6-15 individuals – 30 medical records per 45 days and a group exceeding 16 individuals up to 50 medical records per 45 days can be requested. It is important to note that if a physician does not timely respond to a medical record request, then there will be a deemed overpayment.

Which health care entities to be reviewed for overpayment and underpayments will be determined by the RACs using their own software and systems to determine what areas to review. The most common reasons for improper payments on claims occurred for the following reasons:

- payments are made for services that do not meet Medicare's medical necessity criteria
- payments are made for services that are incorrectly coded
- providers fail to submit documentation when requested or fail to submit enough documentation to support the claim
- provider is paid twice because duplicate claims were submitted

The vast majority of the improperly paid claims resulted in overpayments to providers; however, there were circumstances when there were underpayments as well. If a RAC identifies underpayments as well as overpayments to the same provider, then the overpayments are to be offset by the underpayments. In the event a RAC identifies an underpayment for which there is no overpayment, the appropriate carrier or intermediary is to be informed by the RAC with a claim adjustment and payment to the provider for the underpayment.

All RACs are paid on a contingency basis. Diversified will be highly motivated in Pennsylvania to identify the overpayments since their compensation will be 12.45 percent of those overpayments that they are able to recover for the Medicare Trust

Fund. However, providers are not without recourse in that the Medicare appeals process will remain the same for physicians under the RAC program. A provider has 120 days from the date of the receipt of the initial claim determination to file an appeal under the appeal process for a re-determination by a Medicare contractor. A re-determination must be requested in writing and should be accompanied with any supporting documentation that is the basis of the appeal. Second-level appeals (reconsideration by a qualified independent contractor) through fifth-level appeals (review in Federal District Court) are available to providers to challenge the RAC determination.

As a result of the demonstration program, some changes were made for the benefit of providers as well. The look-back period under the permanent program is now limited to three years as opposed to four that were available under the demonstration program. Further, each RAC is required by CMS to hire a physician medical director to oversee the medical review process and inform provider associations about the program. CMS is also requiring each RAC in each state to conduct town hall type meetings with health care providers prior to initiating

the program. Having spoken with a representative of Diversified, it is anticipated that such meetings will occur in Pennsylvania in June or July 2009. The dates and times as well as locations of the town hall meetings will be posted on the CMS website.

Additionally, each RAC is required to establish a website that will identify vulnerabilities; that is to say what the RAC will likely be auditing as well as improper payments that have been consistently subject to review by the RAC. This information will be valuable to providers once posted so that they can begin to identify issues within their own practice.

As August 1, 2009, draws closer there will be additional information posted on the websites of both CMS and Diversified to help providers prepare to deal with the new program. Once announced, each provider should make it a priority to attend the town hall meeting to be conducted by Diversified.

For more information about this topic, contact Michael Wiethorn at 412.394.5537 or mwiethorn@foxrothshchild.com.

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All A-Twitter Over On-Line Physician Ratings: The Protection and Risks Related to Patient Waivers

By Justin D. Ackerman

The topic of “mutual privacy agreements” offered by companies such as Medical Justice has found its way back into the news recently. In his article, “Doctors Respond to Internet Ratings by Patients” on March 15, 2009, Steve Twedt of the Pittsburgh Post-Gazette outlined the war being waged between Internet sites that promote the rating of physicians by their patients and certain physicians who feel that they are at a systematic disadvantage because they have no ability to defend themselves without running into patient privacy and ethical considerations.

As Twedt explains, some physicians now request that their patients sign a document promising, in part, that he or she will not post negative comments about the physician on any Internet site without the physician's consent. Proponents state that these waivers represent the one weapon available to physicians in leveling the playing field in the ever-expanding battle against frivolous on-line assaults on physicians' hard-earned reputations. Detractors state that these waivers are nothing but glorified gag orders stifling patients' First Amendment rights.

The controversy surrounding these waivers gives many physicians pause in implementing such a requirement. Refusal to execute a waiver does not justify terminating a pre-existing relationship with a patient. Ethics considerations, however, would not prohibit a physician from refusing to enter into a patient relationship with an individual who refuses to sign.

Those physicians who choose to adopt such a practice would be well advised to further consider all of the consequences that may arise with the waivers when weighed against the potential benefits.

In order to adequately analyze the protection that a waiver provides to a physician, one must first distinguish between true and false comments. No patient may defame a physician on-line or otherwise. Defamation is a term often used to include all types of negative speech; however, it really only applies if the speech (written or verbal) is both untrue and harms another's reputation. Therefore, in cases where an identified individual defames a physician, a waiver likely offers no additional protection.

Although First Amendment rights are not necessarily implicated in connection with the waivers, courts have recognized and protected an individual's right to anonymous speech under the First Amendment. While only a few courts have dealt with the issue of disclosing the identity of authors of anonymous on-line comments, those cases have required the plaintiffs to offer evidence of defamation, including damages. The plaintiff may also have to show that the damage sustained outweighs the poster's First Amendment right to anonymous speech.

Before even reaching the issue of the poster's identity, the physician will likely have to make a significant investment of time and money, in the form of legal fees.

Even if a physician obtains signed waivers from each of his or her patients, those waivers will likely be of little assistance in the case of an anonymous poster.

Additionally, waivers typically cover only the individuals who sign them. These waivers offer the physician no protection from a family member of a disgruntled patient posting negative (but non-defamatory) comments. This loophole may quickly eviscerate the time, energy and capital expended toward initiating the waiver policy. After taking together all of these considerations, it appears that a conventional waiver only offers the physician additional protection from a patient posting true (i.e. non-defamatory) comments on an Internet site under the patient's own identity.

Proponents of these waivers have taken an unconventional approach to offer some additional protections. They propose that the patient assigns to the physician his or her intellectual property rights (i.e. copyrights) associated with comments posted on the Internet. Using this approach, which has not yet been tried in court, physicians have persuaded website hosts to remove the questionable comments to avoid a copyright infringement suit.

If courts ultimately recognize that physicians requiring waivers receive a property right from the patient in connection with the waiver, the question then becomes whether assignment of

copyrights may be viewed as something of value that the physician receives from a patient that rises to the level of “balance billing.” Balance billing is the act of billing Medicare and in-network patients in excess of the reimbursed rate and is prohibited in Pennsylvania and many other states. With respect to Medicare, a physician who violates this prohibition may be excluded from participation for two years.

To be sure, physicians find themselves in a somewhat unique position with patients

vis-à-vis other businesses and their customers. In some respects, a physician is at the mercy of a disgruntled patient. Waivers of the type described in this article may be a valid mechanism to begin to balance the playing field. The monetary investment is relatively slight and, even if they accrue no additional legal rights, the institution of such a policy may have a chilling effect on patients making negative comments via the Internet.

Nevertheless, before proceeding with such a policy, physicians should consider all of

the possible ramifications, some of which may not be immediately apparent. In many circumstances, it may be true that the public relations backlash and potential reimbursement issues make the battle one not worth winning.

For more information about this topic, contact Justin Ackerman at 412.394.5593 or jackerman@foxrothshchild.com.

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A newsletter on the current legal issues facing today's health care industry

May 2009



INSURING AGAINST EMPLOYEE THEFT

By *William L. Weiner*
and *Carl Anthony Maio*



Often times we read or hear media reports involving theft of funds entrusted to the care of volunteers or employees.

Frequently, not-for-profits such as fire and rescue companies, little league, soccer and other sport associations have tens of thousands of dollars stolen by one or more individuals unable to resist the temptation to divert funds when no one is looking. However, it is not just nonprofits that are the objects of such thefts. Physician practices also find themselves being victimized.

For example, "*Woman Pleads Guilty to Stealing \$783,000*," was the headline of a recent newspaper article detailing the theft from a local ophthalmology practice by its business manager over a 10-year period. This theft might have continued, except that the bank at which the practice maintained its account discovered certain irregularities and notified the practice. The employee was fired, subsequently pleaded guilty to charges of fraud and, according to the article, will likely receive a three-year prison term. The physicians' in the victimized practice say they have learned their lesson, and have changed their policies and procedures as a result of the loss they suffered.

While strong internal controls, including such things as an employee code of conduct and separation of duties among employees responsible for a practice's finances, are important, the lack or failure of such controls need not result in a severe financial loss for a practice. Although perhaps not as well known as other kinds of coverage, there is a type of insurance

that is available to practices that can protect them against the sort of fraud described above. Specifically, such insurance, known as "Employee Dishonesty Coverage," enables a practice to insure itself against and recoup financial losses it suffers as a result of employee theft. However, based upon our experience, many practices are unaware of the existence of Employee Dishonesty Coverage, and are also unaware that such coverage may be purchased at reasonable rates.

Physicians and their practices are often more concerned with Professional Liability Coverage (a/k/a Medical Malpractice Insurance) rather than General Liability (GL) Coverage. But, Professional Liability Coverage does not provide any relief when an employee steals funds from a practice. Rather, Employee Dishonesty Coverage can be added to a GL Policy.

In addition to such things as the building, fixtures, and portable equipment, additional coverage can be purchased when there is a risk of employee dishonesty. Employee Dishonesty Coverage insures against employee theft of money, securities, or property, written with a per loss limit, a per employee limit, or a per position limit. Employee Dishonesty Coverage can be one of the key coverages provided in a Commercial Crime Policy, but for purposes of this article, more frequently found in a GL Policy. Working with a team of risk management professionals and your insurance agent, a practice is likely to have a Business Owner's Package Policy (BOP). Within the

BOP, coverage can be added either by scheduling a specific employee position or having blanket coverage with a list of employees, including those having access to the practice's finances.

When Employee Dishonesty Coverage is purchased, the insurer will often recommend loss control techniques. Loss control is a risk management technique, seeking to minimize the possibility that a loss will occur or reduce the severity of those that do occur. Therefore, the insurer may be able to assist in developing stronger internal controls by defining checks and balances, oversight, and separation of duties, as opposed to having all of the bookkeeping functions rest with one employee of the practice. In short, multiple sets of eyes and ears are better than one.

Employee Dishonesty Coverage will also contain a cooperation clause, requiring an insured to assist its insurer in providing information about a claim necessary to validate a loss, and may also involve cooperation with law enforcement. Further, as an alternative to Employee Dishonesty Coverage, some practices may find it appropriate to purchase a Fidelity Bond – an insurance product similar to Employee Dishonesty Coverage that also acts to indemnify an insured against losses caused by theft by an employee or third party, such as an independent contractor providing billing, management or accounting services to a practice.

Working together, the practice's attorney, accountant, and insurance agent can assist in determining the type of coverage

and amount of per loss limit that is reasonable for the practice in light of its income; and while fraud may not be prevented, a practice's physicians can take comfort in knowing they have better and

tighter controls and appropriate insurance coverage in the event of a loss due to theft.

For further information, please contact Carl Anthony Maio at 215.918.3616 or camaio@foxrothschild.com, or

William L. Weiner at 215.918.3635 or wweiner@foxrothschild.com. Visit us on the web at www.foxrothschild.com.

This article also appeared in Physicians Practice.



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For more information about any of the articles in *Staying Well within the Law*, please contact any member of the Fox Rothschild Health Law Practice. Visit us on the web at www.foxrothschild.com.

Practice Co-Chair
David S. Sokolow
215.299.2712 or 609.895.3308
dsokolow@foxrothschild.com

Practice Co-Chair
Todd A. Rodriguez
610.458.4978
trodriguez@foxrothschild.com

Newsletter Editor
William H. Maruca
412.394.5575
wmaruca@foxrothschild.com

Offices

Atlantic City

Midtown Building, Suite 400
1301 Atlantic Avenue
Atlantic City, NJ 08401-7212
609.348.4515

Blue Bell, Montgomery County

10 Sentry Parkway, Suite 200
P.O. Box 3001
Blue Bell, PA 19422-3001
610.397.6500

Exton, Chester County

747 Constitution Drive, Suite 100
P.O. Box 673
Exton, PA 19341-0673
610.458.7500

Las Vegas

Wells Fargo Tower, Suite 500
3800 Howard Hughes Parkway
Las Vegas, NV 89169
702.262.6899

Los Angeles

1800 Century Park East
Suite 300
Los Angeles, CA 90067-1506
310.598.4150

New York City

100 Park Avenue, Suite 1500
New York, NY 10017
212.878.7900

Philadelphia

2000 Market St., 10th Floor
Philadelphia, PA 19103-3291
215.299.2000

Pittsburgh

625 Liberty Avenue, 29th Floor
Pittsburgh, PA 15222-3115
412.391.1334

Princeton

Princeton Pike Corporate Center
997 Lenox Drive, Building 3
Lawrenceville, NJ 08648-2311
609.896.3600

Roseland

75 Eisenhower Parkway, Suite 201
Roseland, NJ 07068
973.992.4800

San Francisco

235 Pine Street, Suite 1500
San Francisco, CA 94104-2734
415.364.5540

Stamford

One Landmark Square, 21st Floor
Stamford, CT 06901
203.425.9500

Warrington, Bucks County

2700 Kelly Road, Suite 300
Warrington, PA 18976-3624
215.345.7500

West Palm Beach

222 Lakeview Avenue, Suite 700
West Palm Beach, FL 33410
561.835.9600

Wilmington

Citizens Bank Center, Suite 1300
919 North Market Street
Wilmington, DE 19801
302.654.7444



Fox Rothschild LLP
ATTORNEYS AT LAW

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