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# **AN APPLE A DAY KEEPS LIABILITY AWAY: THIRD PARTY PAYER LIABILITY AND THE CORPORATE PRACTICE OF MEDICINE DOCTRINE**

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## I. THE PROBLEM OF RURAL PUBLIC HOSPITAL INSOLVENCIES

### Introduction

Imagine that at one o'clock in the morning a young mother begins experiencing severe, acute abdominal pain, but is unaware of the cause. In obvious need of medical attention, she is taken directly to the emergency room where she is admitted, and it is determined that her appendix is inflamed and needs to be removed. Her attending physician moves forward with the laparoscopic appendectomy, a very run-of-the mill procedure, and will keep her in the hospital until morning. While her incision is small, over the next eight hours, it becomes inflamed, warm, and painful to the touch. It is clear that her surgical wound is infected, which ordinarily would not be considered a major concern, except that there has been an outbreak of methicillin-resistant staphylococcus aureus (commonly known as MRSA<sup>1</sup>) in the hospital in which she is being treated. Left untreated, this aggressive strain of bacteria can infiltrate the bloodstream and cause a life-threatening condition called sepsis, which can lead to septic shock and death. The young woman's physician, obviously concerned, informs her that he must contact her medical insurance agency before he can consider extending her hospital stay to determine whether the wound contains MRSA. She waits patiently, sure that her health insurance company will defer to the best judgment of her physician, only to be greeted a few hours later by a nurse with discharge papers. She is sure that the nurse has the wrong room and informs the nurse that her physician, concerned about her surgical area, decided to keep her a few more days. The nurse replies that the woman's insurance company rejected her physician's request because it does not believe that continued hospital observation is "medically necessary." The

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<sup>1</sup> See A. Pantosti & M. Venditti, *What is MRSA?*, 34 EUR. REPARATORY J. 1190, 1190-96 (2009) (MRSA is an evolved form of *S. aureus* that is capable of destroying both penicillin and methicillin, an antibiotic specifically developed to fight *S. aureus*. MRSA is extremely infectious and can cause problems even for healthy individuals such as children and healthy adults).

young woman is then sent home with a prescription for antibiotics and a well-wish.

Who decided that the young woman should not be kept in the hospital for further observation? Are they aware that she might be infected with MRSA and left untreated could die? Who gave them the authority to override her physician's best judgment? Does this nameless, faceless authority who has not examined her, cannot be reached by her, and who seems to have ultimate control over the care and treatment of her body have her best interests in mind? What does "medically necessary" even mean, anyway?

While the above scenario is imaginary, this type of situation is all too real for many people. Many insurance companies, as a cost-containment mechanism, use a system called concurrent or prospective utilization review to approve or deny treatments recommended for their policy holders by the policy holder's treating physicians.<sup>2</sup> If the insurance company does not believe that a requested treatment is medically necessary, the physician's recommendation will be denied and the insurance company will refuse to cover the cost of the suggested procedure.<sup>3</sup> Insurance companies derive the power to determine what is medically necessary from their insurance contract.<sup>4</sup> However, this contractual language can and often does violate the corporate practice of medicine doctrine (CPMD), a doctrine adopted by states to prohibit corporations from practicing medicine through licensed employees.<sup>5</sup> While the CPMD in most states make exceptions

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<sup>2</sup> See Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 26-27 (1993) (discussing cost containment mechanisms including prospective, concurrent, and retrospective review).

<sup>3</sup> See HENRY T. IREYS ET AL., *DEFINING MEDICAL NECESSITY: STRATEGIES FOR PROMOTING ACCESS TO QUALITY CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, MENTAL RETARDATION, AND OTHER SPECIAL HEALTH CARE NEEDS* 2 (1999).

<sup>4</sup> Linda A. Bergthold, *Medical Necessity: Do We Need It?*, 14 HEALTH AFF. 180, 182 (1995) (discussing the term "medically necessary").

<sup>5</sup> Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 447 (1987) (discussing the corporate practice of medicine doctrine).

for licensed hospitals,<sup>6</sup> there remains the opportunity to impose civil liability, such as negligence, on health insurance companies when the health insurance company wields power over physicians by withholding compensation for treatments and procedures that insurance companies do not deem “medically necessary.” To avoid liability under the CPMD, health insurance companies should avoid creating contracts between hospitals and the insurance company that provide the insurance companies with the power to rely on their own policies to decide whether a treatment or procedure is medically necessary.

This paper will discuss the background of the term “medically necessary,”<sup>7</sup> cost containment mechanisms including concurrent and prospective utilization review,<sup>8</sup> and the CPMD.<sup>9</sup> This paper will then analyze how prospective review by insurance companies and their ability to decide what is medically necessary breaches the CPMD.<sup>10</sup> Finally, this paper will conclude that the legal system should hold the responsible parties, including hospitals and insurance companies, liable for breach of the CPMD.<sup>11</sup>

## II. BACKGROUND

### A. Insurance Companies: Terms and Definitions

Insurance law is a vast topic that can be extremely confusing, especially for individuals who are unfamiliar with this area of law, and even for those who are. Listed below are several health insurance related terms and definitions that will be relevant to the discussion of

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<sup>6</sup> Berlin v. Sarah Bush Lincoln Health Ctr., 179 Ill. 2d 1 (1997).

<sup>7</sup> See *infra* Part II Section II.

<sup>8</sup> See *infra* Part II Section II.

<sup>9</sup> See *infra* Part II Section III.

<sup>10</sup> See *infra* Part III Sections I, II, III.

<sup>11</sup> See *infra* Part IV.

health insurance companies, utilization review, and the corporate practice of medicine.

### ***1. Third Party Payer***

Congress defines the term “third party payer” to mean “any health care insurer, including any hospital services corporation, health services corporation, medical expense indemnity corporation, mutual insurance company, or self-insured corporation, that provides coverage for health or health-related items or service.”<sup>12</sup> Essentially, any insurance company or plan that pays medical costs for a third party is referred to as a third party payer.<sup>13</sup> Third party payers include two groups, traditional indemnity insurance (a now declining form of insurance) and managed care organizations.<sup>14</sup>

### ***2. Traditional Indemnity Insurance***

Traditional indemnity insurance allows a patient to go see any physician at any time on a fee-for-service basis and requires the patient to pay a deductible or co-insurance.<sup>15</sup> They often require the patient to directly compensate the physician and bill the insurance company later for reimbursement.<sup>16</sup>

### ***3. Managed Care Plan***

Managed care organizations are the most common form of insurance today, and no two arrangements are exactly alike.<sup>17</sup> The term “managed care plan” can be defined as “an integrated system that manages health care services for an enrolled population rather than simply providing or paying for them. Services within managed care

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<sup>12</sup> Bipartisan Health Care Reform Act of 1994, H.R. 5228, 103rd Cong. (2nd Sess. 1994).

<sup>13</sup> *See id.*

<sup>14</sup> Neelam K. Sekhri, *Managed Care: the US Experience*, 78 BULL. OF THE WORLD HEALTH ORG. 831-33 (2000).

<sup>15</sup> *See id.* at 831.

<sup>16</sup> *See id.*

<sup>17</sup> *See id.*

plans are usually delivered by providers who are under contract to, or employed by the plan.”<sup>18</sup>

Types of managed care organizations include managed indemnity plans, preferred provider organizations (PPOs), consumer driven health plans (CDHPs), individual practice associations (IPAs)/network model HMOs, staff/group model HMOs, point of service (POS) plans, and physician hospital organizations (PHOs).<sup>19</sup> The “managing” part of managed care organizations is done in a variety of ways using a variety of different tools.<sup>20</sup> One of the tools managed care organizations use is utilization management, also referred to as utilization review, as a cost containment mechanism.<sup>21</sup>

## **B. Insurance Companies’ Use of the Term “Medically Necessary”**

### ***1. Defining the Term “Medically Necessary”***

Defining the term “medically necessary” is key to the understanding of utilization review and insurance contracts. According to the US Department of Health and Human Services, the term “medical necessity” refers to “the legal authority of a managed care organization (MCO), a Medicaid agency, or other purchaser of health care to determine whether a specific service will be covered in a specific situation.”<sup>22</sup> Ultimate decisions about what is medically necessary often lie with the MCO’s medical director who usually makes the decision based on what is common medical practice, or “standard protocol,” denying patients procedures that are considered out of the ordinary.<sup>23</sup> A MCO’s definition of medically necessary may differ from a practicing physician’s definition, and the medical

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<sup>18</sup> JONATHAN P. WEINER, THE US MANAGED CARE/HEALTH INSURANCE INDUSTRY: A FACT SHEET & GLOSSARY OF TERMS 1 (2007).

<sup>19</sup> *Id.* at 1-2.

<sup>20</sup> *Id.* at 2.

<sup>21</sup> *Id.*

<sup>22</sup> IREYS ET AL., *supra* note 3, at 1.

<sup>23</sup> *See id.*

director's decision that a procedure is not medically necessary may go against the physician's recommendation.<sup>24</sup>

Not only might a MCO's definition of medically necessary differ from a health care provider's, the definition of medically necessary will almost certainly differ from one third party payer to another.<sup>25</sup> Third party payers insert their own definitions of what is "medically necessary" into their insurance contracts and then refuse coverage of treatments or procedures that they deem not "medically necessary."<sup>26</sup> Each insurance company's definition of the term "medically necessary" is inconsistent and purposely kept extremely vague.<sup>27</sup> This aids the insurer by providing flexibility when making decisions about what treatments and procedures will be covered by the insurance policy.<sup>28</sup>

## ***2. Utilization Review: Retrospective, Concurrent, and Prospective Review as Cost Containment Mechanisms***

"Utilization management" is defined by the National Academy of Medicine, formerly the Institute of Medicine, as "a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision."<sup>29</sup> A form of utilization management is utilization review, which is the process by which a third party payer determines whether medical treatment was or is medically necessary.<sup>30</sup> MCOs generally perform cost containment functions through the use of utilization

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<sup>24</sup> *See id.*

<sup>25</sup> Bergthold, *supra* note 4, at 181 (discussing the meaning and use of the term "medically necessary").

<sup>26</sup> *See id.*

<sup>27</sup> *See id.* at 182.

<sup>28</sup> *See id.*

<sup>29</sup> COMM. ON UTILIZATION MGMT BY THIRD PARTIES, DIVISION OF HEALTH CARE SERVICES, INST. OF MED., CONTROLLING COSTS AND CHANGING PATIENT CARE?: THE ROLE OF UTILIZATION MANAGEMENT 2-3 (Bradford H. Gray & Marilyn J. Field eds., 1989).

<sup>30</sup> Randall, *supra* note 2, at 27.

review.<sup>31</sup> Utilization review analyzes on a case-by-case basis whether medical treatment being prescribed by a health care professional is appropriate and necessary.<sup>32</sup> The main purpose of utilization review is to attempt to control health care costs, an important public health interest, while continuing to ensure that patients receive necessary medical care in the form of hospital and medical services.<sup>33</sup>

Common types of utilization review include: prior review and approval of proposed procedures (prospective review); continued stay review (concurrent review); and denial of unapproved claims (retrospective review).<sup>34</sup> In these forms of utilization review, the third party payer evaluates whether the treatment or procedure is medically necessary and limits coverage based on this decision.<sup>35</sup>

Retrospective review is a process by which insurance companies, or third party payers, review services that were provided by a physician or health care entity and decide, after the fact, whether or not those services were necessary.<sup>36</sup> This is accomplished by analyzing the common practices of different health care providers<sup>37</sup> and then comparing the services that were approved and carried out by the health care provider under review to detect practices that are out of the ordinary.<sup>38</sup> If the extended stay is declined, then a physician employed by the third party payer reviews the decision and renders an ultimate decision as to whether an extended stay is necessary.<sup>39</sup>

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<sup>31</sup> Michelle R. King, *Restricting the Corporate Practice of Medicine: Subverting ERISA to Hold Managed Care Organizations Accountable for Health Care Treatment Decisions—The Texas Initiative*, 23 DEL. J. CORP. L. 1203, 1205 (1998).

<sup>32</sup> See *id.*

<sup>33</sup> *Id.*

<sup>34</sup> Randall, *supra* note 2, at 27.

<sup>35</sup> COMM. UTILIZATION MGMT. BY THIRD PARTIES, *supra* note 29, at 3.

<sup>36</sup> Randall, *supra* note 2, at 27 n.110.

<sup>37</sup> See Richard A. Hinden & Douglas L. Elden, *Liability Issues for Managed Care Entities*, 14 SETON HALL LEGIS. J. 1, 52 (1990) (discussing utilization review including retrospective, prospective, and concurrent utilization review and listing specific examples of retrospective review).

<sup>38</sup> See IREYS ET AL., *supra* note 3, at 1.

<sup>39</sup> Randall, *supra* note 2, at 27.

Concurrent review is often called “length of stay certification.”<sup>40</sup> Third party payers use concurrent review to determine what length of time is appropriate for a patient’s hospital stay or if certain procedures are appropriate.<sup>41</sup> An example of concurrent review is when a patient’s treating physician fills out a form requesting an extension of the patient’s pre-approved hospital stay and sends it to the third party payer.<sup>42</sup> A nurse working for the third party payer then reviews the relevant medical information and makes a decision as to whether an extended stay is necessary.<sup>43</sup> Decisions that decline the extended stay are reviewed by a physician employed by the third party payer who then makes the ultimate decision as to whether an extended stay is necessary.<sup>44</sup>

Prospective review is conducted in non-emergency situations.<sup>45</sup> Third party payers require application and preapproval for non-emergency hospital stays or procedures.<sup>46</sup> They often pre-approve the length of the hospital stay as well.<sup>47</sup> If a hospital stay or procedure is not deemed medically necessary by the third party payer, the third party will not approve the treatment and will refuse to compensate the health care facility, denying the patient the ability to receive medical care.<sup>48</sup>

Denial of treatment payment by MCOs that use utilization review is usually accompanied by a disclaimer. The included statement informs the patient that the denial is only in regard to payment for the treatment or procedure, not a denial of the treatment or procedure itself, and that only a consultation with the physician can determine

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<sup>40</sup> *Id.* at 27 n.111.

<sup>41</sup> *Id.*

<sup>42</sup> *See id.* at 27 n.114.

<sup>43</sup> *Id.* at 27 n.111.

<sup>44</sup> *See id.*

<sup>45</sup> *Id.* at 27 n.112.

<sup>46</sup> *See id.* at 27 n.113.

<sup>47</sup> *See id.*

<sup>48</sup> *See id.*

the treatment plan.<sup>49</sup> Similar language is often included in contracts between MCOs and health care providers.<sup>50</sup> Although the MCO may proclaim that the physician is in charge of the medical decisions and can defy the utilization review and continue with the treatment despite lack of payment, this is not the reality of the situation.<sup>51</sup> Due to the high cost of health care, a denial of payment for treatment is, in effect, a denial of treatment altogether.<sup>52</sup>

### C. The Corporate Practice of Medicine Doctrine

Many states subscribe to what is generally referred to as the “corporate practice of medicine doctrine” (CPMD). The CPMD prohibits a corporation from directly employing a physician and thereby indirectly practicing medicine without a license.<sup>53</sup> While each state has its own version of the doctrine, in general, corporate practice of medicine doctrine prohibitions “do not allow a business corporation to practice medicine or employ a physician to provide professional medical services.”<sup>54</sup> Many states have statutes that directly prohibit the corporate practice of medicine, some states’ doctrines are found in common law, while others have no CPMD at all.<sup>55</sup> States that do employ a CPMD often have exceptions to their doctrines for licensed hospitals or professional service corporations where each shareholder of the corporation is a licensed physician.<sup>56</sup>

The ultimate goal of the CPMD is to guard the sanctity of the doctor-patient relationship.<sup>57</sup> Allowing a corporation controlled by lay

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<sup>49</sup> Hinden & Elden, *supra* note 37, at 54.

<sup>50</sup> *See id.*

<sup>51</sup> *See id.*

<sup>52</sup> *Id.*

<sup>53</sup> *See* MARY H. MICHAL ET AL., CORPORATE PRACTICE OF MEDICINE DOCTRINE 50 STATE SURVEY 2-3 (2006).

<sup>54</sup> *Id.*

<sup>55</sup> *See id.*

<sup>56</sup> *Id.*

<sup>57</sup> *See* Garcia v. Tex. State Bd. of Med. Exam’rs, 384 F. Supp. 434 (W.D. Tex. 1974).

people to directly employ physicians jeopardizes the sanctity of the doctor-patient relationship by subjecting it to possible abuses.<sup>58</sup> These abuses occur when the lay people who employ physicians place budget concerns over patient needs or are allowed to supervise medical decisions and procedures.<sup>59</sup> In essence, the corporate practice of medicine doctrine supports the principle that only a licensed physician should have authority over the “complex, esoteric” discipline that is the practice of medicine.<sup>60</sup> Fundamentally, the purpose of the doctrine is to “ensure physicians’ independent medical judgment.”<sup>61</sup>

### ***1. How the Corporate Practice of Medicine Doctrine is Used Today***

Although most states’ CPMDs still exist in statute or common law, in recent years, many have come to view the doctrine as obsolete.<sup>62</sup> Only five states continue to have a vibrant corporate practice of medicine doctrine, the most prominent of which are Texas and California.<sup>63</sup> Among the states that continue to use the CPMD, though the doctrines differ, there is enough consistency between them that some general rules can be inferred.<sup>64</sup>

The overarching purpose of the CPMD is to “assure that medical decisions are made by licensed medical professionals and to prevent interference by lay persons in medical judgments or the provisions of

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<sup>58</sup> See *id.*

<sup>59</sup> See *id.*

<sup>60</sup> See Chase-Lubitz, *supra* note 5, at 471.

<sup>61</sup> CRAIG A. CONWAY, LEGISLATIVE UPDATE: TEXAS’ CORPORATE PRACTICE OF MEDICINE DOCTRINE 1 (2009).

<sup>62</sup> State Bar of Texas Health Law Section, Denise M. Webb, *The Impact of the Corporate Practice of Medicine Doctrine on the Formation of Integrated Delivery Systems in Texas*, STATE BAR SECTION REPORT 2 (1997).

<sup>63</sup> *Id.*

<sup>64</sup> See Michael F. Schaff & Glenn P. Prives, *The Corporate Practice Of Medicine Doctrine: Is it Applicable to Your Client?*, 3 BUS. L. & GOVERNANCE, May 2010, at 1-7 (discussing generally the corporate practice of medicine and how it is applied from state to state).

medical care.”<sup>65</sup> Generally, the doctrine holds that some decisions are inherently medical and require a licensed physician’s expertise.<sup>66</sup> The doctrine dictates that a physician should be able to make these medical decisions independent from any outside influence or control by a lay person, a corporation, or a lesser licensed professional.<sup>67</sup> The doctrine generally prohibits a physician from entering into a relationship that would cause a non-physician to direct or control the medical practice of the licensed physician, or fee-split with the physician.<sup>68</sup> The ability to interfere with a licensed physician’s practice would, in essence, allow the non-physician to practice medicine without a license.<sup>69</sup>

## II. ANALYSIS

### A. How Insurance Companies’ Contractual Ability to Decide What is Medically Necessary Breaches the Corporate Practice of Medicine Doctrine

#### 1. *Control of Medical Decisions by Non-Physicians*

Physicians are controlled by insurance companies when they are forced to alter their decisions based on whether they will be compensated for treatments or procedures. Such an arrangement would be a violation of the CPMD. This can occur directly via an actual employment contract or indirectly when a third party payer influences the physician’s medical decisions through contractual obligations.<sup>70</sup> Even when the insurance company does not directly employ a physician, the power to use utilization review to determine what is medically necessary for a patient produces the same practical effect as

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<sup>65</sup> Webb, *supra* note 62, at 1.

<sup>66</sup> See Schaff & Prives, *supra* note 64, at 2.

<sup>67</sup> See *id.*

<sup>68</sup> See *id.*

<sup>69</sup> See generally Chase-Lubitz, *supra* note 5, at 367.

<sup>70</sup> See *infra* note 74 and accompanying text.

having an employment agreement with the physician. It gives the insurance company control over the physician similar to that which an employer has over its employee.<sup>71</sup>

At least one type of MCO, staff model HMOs, directly employ physicians to provide care for HMO patients.<sup>72</sup> In other types of managed care organizations, including IPA model HMOs and PPOs, a physician's fees are contractually determined and the physician is bound to comply with organizational regulations.<sup>73</sup>

In managed care organizations, [t]he physician is legally and professionally obligated to act in the patient's best interest. The third-party payer is contractually obligated to pay for services rendered by the physician. The physician is contractually obligated to provide services under the guidelines set by the third-party payer if the physician wishes to be paid for the medical services. Thus, the physician manages the patient's health care for the third-party payer.<sup>74</sup>

Whether physicians are employed directly by a MCO or merely have contractually determined fees and are contractually obligated to comply with guidelines set by the third party payer, they are being controlled by the MCO. Therefore, they are in a relationship with the organization, and this relationship violates the CPMD.

## ***2. Insurance Companies' Use of the Term "Medical Necessity"***

One of the main powers that a managed care organization holds over a physician is its power to determine what is medically necessary. This power is derived contractually (as described *supra* in the section on the term "medically necessary").<sup>75</sup> Third party payers insert their

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<sup>71</sup> See *Flynn Bros., Inc. v. First Med. Assocs.*, 715 S.W.2d 782, 785 (Tex. App. 1986) (describing a relationship between a physician and his lay person-controlled management services company that breached the corporate practice of medicine doctrine because the contractual control that the management company had over the physician, while the physician was not an "employee" of the company, "under their agreement, the practical effect was the same.").

<sup>72</sup> See *Hinden & Elden*, *supra* note 37, at 8.

<sup>73</sup> *Id.*

<sup>74</sup> *Randall*, *supra* note 2, at 19.

<sup>75</sup> See *supra* text accompanying notes 25-28.

own definitions of what is medically necessary into their insurance contracts, and the physician is required to defer to those definitions or risk providing treatments and procedures to patients without compensation.<sup>76</sup> The vagueness of the contractual definition favors the third party payers because it allows them to deny any procedure as that they see fit, and the physician is obligated to accept their decision.<sup>77</sup>

Some years ago, it was much easier to hold managed care organizations liable for prospective review than it is today. Before statutory reform, if the third party payer, even arbitrarily, refused to approve a nonemergent procedure, other than contesting the denial directly to the insurance company, the physician had no recourse against the insurance company other than to urge the patient to seek a remedy in the justice system.<sup>78</sup> Contesting the denial to the insurance company was likely to have little effect as the insurance company could again choose to arbitrarily deny the claim.<sup>79</sup> A patient seeking to have a life-saving experimental procedure could be denied coverage by an insurance company because the procedure was not considered common medical practice, even though the patient's treating physician considered this procedure to be medically necessary.<sup>80</sup> This control by insurance companies exerted pressure on physicians and did not allow physicians to have independent control over their medical practice.

Today, at least in Texas, recent amendments to the Insurance Code have improved conditions for policy holders because they include added safeguards against insurance companies' use of improper

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<sup>76</sup> Bergthold, *supra* note 4, at 182.

<sup>77</sup> *See id.*

<sup>78</sup> *See Wickline v. Cal.*, 192 Cal. App. 3d 1630, 1640 (1986) (describing a situation where a woman, Mrs. Wickline, was denied care by her insurance company, Medi-Cal, and her attending physician did not contest the decision because he felt that the insurance company "had the State's interest more in mind than the patient's welfare and that the belief influenced his decision not to request a second extension of Wickline's hospital stay. In addition, he felt that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital.").

<sup>79</sup> *Id.*

<sup>80</sup> *See IREYS ET AL.*, *supra* note 3, at 1.

utilization review.<sup>81</sup> Previously, when a patient's claim was denied, the only option was to appeal the decision directly to the insurance company. Currently, however, rather than ineffective appeals directly to insurance companies, policy holders have the ability to appeal to a third party review board after exhausting the insurance company's internal appeals process.<sup>82</sup>

However, an ongoing problem is that insurance appeals drain patients and their family members of valuable time and energy. "In circumstances involving an enrollee's life-threatening condition," policy holders are not required to comply with the insurance company's internal review process and may appeal directly to an independent review board.<sup>83</sup> Alternatively, they may request an expedited appeal.<sup>84</sup> However, if the patient is not considered to be in a "life-threatening" circumstance, the insurance company's internal appeals process could take up to 48 business days, equivalent to approximately 66 calendar days including weekends.<sup>85</sup> This includes three business days to review the original denial decision,<sup>86</sup> 30 business days for a regular appeal after the appeal information is received by the utilization review agent,<sup>87</sup> and 15 business days for a specialist appeal, which may only be completed upon the health care provider's timely request and within ten business days of the appeal being denied.<sup>88</sup>

After exhausting the insurance company's internal appeals process, the policy holder may finally appeal the decision to an

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<sup>81</sup> Carey Olney, *How do I appeal a Health Insurance Claim Denial?*, OFF. OF THE PUB. INS. COUNS., <http://www.opic.texas.gov/health/health-insurance-articles/item/753-how-do-i-appeal-a-health-insurance-claim-denial> (last accessed Sep 15, 2017).

<sup>82</sup> *Id.*

<sup>83</sup> Tex. Ins. Code § 4201.360 (2005).

<sup>84</sup> Tex. Ins. Code § 4201.357 (2005).

<sup>85</sup> Tex. Ins. Code § 4201.304-359 (2005).

<sup>86</sup> Tex. Ins. Code § 4201.304 (2005).

<sup>87</sup> Tex. Ins. Code § 4201.359 (2005).

<sup>88</sup> Tex. Ins. Code § 4201.356 (2005).

independent review organization.<sup>89</sup> While the insurance company's utilization review agent has only three business days to provide the independent review organization with the appropriate appeal information,<sup>90</sup> the Insurance Code has no maximum required timeframe within which an independent review organization must make its decision.

A person, even in a life-threatening condition, who is already struggling with an illness is likely to feel overwhelmed by denial of payment and, lacking expert knowledge of the insurance code, might be unlikely to pursue an appeals process. The appeals process could take months, and the policy holder might still end up with a negative result. Even for a person with a life-threatening condition, as a lay person with no legal knowledge, he might be unaware that he has the ability to appeal directly to an independent review board to circumvent the insurance company's denials. To discover this information would require, time, legal research, and the ability to interpret insurance statutes. For patients who are already ill and stressed, this seems an impossible task.

### ***3. How Managed Care Organizations Breach the Corporate Practice of Medicine Doctrine***

Utilization review, including prospective and concurrent review that allows third party payers who lack a medical license to override a physician's medical judgment about what is medically necessary for the patient, breaches the CPMD. The Insurance Code now requires utilization review agents to conduct utilization review under the direction of a licensed physician.<sup>91</sup> However, this does not alleviate patients' concerns because the physician would still be employed by the insurance company, similar to the facts in *Wickline v. California*,

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<sup>89</sup> Tex. Ins. Code § 4201.401 (2005).

<sup>90</sup> Tex. Ins. Code § 4201.402 (2005).

<sup>91</sup> Tex. Ins. Code § 4201.152 (2005).

discussed *infra*.<sup>92</sup> This means that the physician's loyalty is not to the patient, but to the insurance company, an entity without a license to practice medicine, yet one which still controls the physician via an employment contract.

Amendments to the Insurance Code sought to improve the utilization review process and prevent insurance companies from performing arbitrary utilization review by providing patients with the option of appealing to an independent review organization after exhausting the insurance company's internal appeals process. However, patients who are ill and lack advanced legal knowledge are unlikely to pursue the months-long appeals process to make second and third appeals, after which they may appeal to the independent review organization. This daunting, arduous process after which a patient may contact the independent review organization, is prohibitive and in effect prevents patients from properly exercising their right to have an independent review. Due to the fact that few patients will pursue appeals process until they are permitted to utilize the independent review process, there is still a strong argument that insurance companies maintain control over the utilization review process, including decisions about what is medically necessary for a patient, and that they continue to use this process to control physicians.

The main problem with insurance companies retaining control over utilization review and making determinations as to what is medically necessary for patients is that third party payers are almost always a corporate entity and therefore are not licensed entities.<sup>93</sup> In MCOs, third party payers contract with various horizontally-integrated hospitals and individual physician practices.<sup>94</sup> The most common way for a MCO to work is using an "independent practice association," or IPA. This entails physicians forming an association to contract with a third party payer and continuing to practice

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<sup>92</sup> See Wickline, 192 Cal. App. 3d at 1637.

<sup>93</sup> Garcia, 384 F. Supp. at 438 ("No corporation can meet the requirements of the statute essential to the issuance of license.").

<sup>94</sup> Sekhri, *supra* note 14, at 4.

individually but also receiving payment through the association's structure.<sup>95</sup> The physicians and health care facilities that have contracted with the third party payer to be a part of the MCO are not paid based on the services that they provide to patients but instead at a set annual rate per subscriber to the organization.<sup>96</sup> The third party payer, via the managed care organization model, either directly employs or contractually controls the physician's fees and cannot obtain any sort of license to practice medicine.<sup>97</sup> Consequently, the third party payer is practicing medicine without a license by controlling a physician's medical decisions via a contractual obligations to comply with the third party payer's definition of medically necessary. By doing so, the third party payer breaches the CPMD.

In *Garcia v. Texas State Board of Medical Examiners*, the court held against the corporate practice of medicine because it believed that a corporation controlled by lay people should not be given the power to influence a licensed physician's medical decisions.<sup>98</sup> The court listed three possible abuses that could likely result from a company controlled by lay-persons employing licensed physicians.<sup>99</sup> First, the court was concerned about lay persons' interference with the doctor-patient relationship.<sup>100</sup> Second, the court noted the possibility of an emphasis being placed on budget considerations rather than patient care.<sup>101</sup> Finally, the court suggested that employment of licensed

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<sup>95</sup> *Id.*

<sup>96</sup> See Chase-Lubitz, *supra* note 5, at 479.

<sup>97</sup> *Dr. Allison, Dentist, Inc. v. Allison*, 360 Ill. 638, 640 (1935) ("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 . . . No corporation can qualify.").

<sup>98</sup> *Garcia*, 384 F. Supp. at 434.

<sup>99</sup> Chase-Lubitz, *supra* note 5, at 472.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

physicians by companies controlled by lay people could promote lay supervision over medical procedures.<sup>102</sup>

### **B. Exception to the CPMD: How and Why it is Acceptable for a Hospital to Employ a Physician**

As stated above, the corporate practice of medicine doctrine makes an exception for hospitals in that licensed hospitals are permitted to employ physicians.<sup>103</sup> Although not as explicitly as hospitals, HMOs, which are a subclass of managed care organizations, are often considered an exception to the CPMD as well.<sup>104</sup>

One law referenced by jurisdictions that consider HMOs exempt from the CPMD is the Federal Health Maintenance Organization (HMO) Act of 1973. This act does not expressly preempt the CPMD but does inhibit it.<sup>105</sup> A second statute that attempts to preempt the CPMD by allowing corporations to hire physicians is the Employee Retirement Income Security Act of 1974 (ERISA).<sup>106</sup> Although many jurisdictions use ERISA to avoid applying the CPMD, some jurisdictions attempt to legislate around ERISA in order to avoid preemption of the CPMD.<sup>107</sup>

Certain aspects of the unique relationship between hospitals, physicians, and patients give hospitals a reasonable right to be exempt from the CPMD. In *Berlin v. Sarah Bush Lincoln Health Center*, the court held that the CPMD does not apply to licensed hospitals.<sup>108</sup> The court defined the doctrine as a prohibition against corporations providing professional medical services and cited the rationale of the doctrine to conclude that “the employment of physicians by corporations is illegal because the acts of the physicians are attributable to the corporate

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<sup>102</sup> *Id.*

<sup>103</sup> MICHAL ET AL., *supra* note 53, at 2-3.

<sup>104</sup> ALLEGRA KIM, THE CORPORATE PRACTICE OF MEDICINE DOCTRINE 15-16 (2007).

<sup>105</sup> *Id.* at 15-16.

<sup>106</sup> See King, *supra* note 31, at 1205-07.

<sup>107</sup> *Id.*

<sup>108</sup> See Berlin, 688 N.E.2d 106 at 112.

employer, which cannot obtain a medical license.”<sup>109</sup> The court also listed several policy arguments espousing the “dangers of lay control over professional judgment,” including “the divisions of the physician’s loyalty between his patient and his profitmaking employer, and the commercialization of the profession.”<sup>110</sup>

The court in *Berlin* used two different rationales to support the exclusion of hospitals from the prohibition of the corporate practice of medicine. First, the court agreed with other jurisdictions in that the CPMD should not be applied to nonprofit hospitals and health associations because the public policies that support the doctrine do not apply to physicians employed by charitable situations. The court cited an opinion which stated that the “actions of nonprofit association which contracts with licensed physicians to provide medical treatment to its members in no way commercializes medicine and is not the practice of medicine.”<sup>111</sup> Second, the court in *Berlin* agreed with other jurisdictions in that the CPMD should not apply to hospitals, preventing them from hiring physicians, because hospitals are authorized by other laws to provide medical treatment to patients. Moreover, hospitals are given an independent duty by law (e.g., hospital licensing statutes) to provide health care and medical treatment to patients.<sup>112</sup>

The *Berlin* court ultimately ruled that the public policy concerns, which support the CPMD, do not apply to a licensed hospital.<sup>113</sup> The court also held that the concern regarding lay control over professional judgment does not exist in a licensed hospital because in a hospital setting, there is a separate, self-governing, professional medical staff that oversees the quality of medical care provided by the hospital.<sup>114</sup> Also, the employment agreement in this case expressly provided that the hospital would not attempt to direct or control the physician’s

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<sup>109</sup> *Id.* at 110.

<sup>110</sup> *Id.*

<sup>111</sup> *Group Health Ass’n v. Moor*, 24 F. Supp. 445, 446 (D.D.C. 1938).

<sup>112</sup> *Berlin*, 688 N.E.2d at 112-13.

<sup>113</sup> *See id.* at 113.

<sup>114</sup> *Id.* at 113-14.

medical judgment or practice other than the control that is typically required and given to professional medical staff.<sup>115</sup>

#### **D. How Employment of Physicians by Managed Care Organizations Violates the Underlying Reasons for the Corporate Practice of Medicine Doctrine**

While there is a reasonable purpose to allow hospitals to be exempt from the CPMD and be given the ability to employ physicians, there is no such exemption justification for insurance companies. Allowing third party payers to employ physicians or control their medical decisions using utilization review defeats the rationale of the CPMD. A third party payer cannot obtain a license as a hospital can,<sup>116</sup> and the third party payer is not in the business of caring for patients, like a hospital.<sup>117</sup> In a hospital, even though the physicians are separately licensed, they are still not governed by the hospital's board of directors. They are governed by professional medical staff,<sup>118</sup> as referred to in *Berlin v. Sarah Bush Lincoln Health Center*, discussed *supra*,<sup>119</sup> via a peer review process.<sup>120</sup> This avoids the issue of lay control over medical decisions, while simultaneously ensuring quality of care.

Unlike when a hospital employs a physician, if a managed care organization is given the right to employ physicians or even influence

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<sup>115</sup> See *id.* at 114 n.5.

<sup>116</sup> Garcia, 384 F. Supp. at 438.

<sup>117</sup> Berlin, 688 N.E.2d at 112-13.

<sup>118</sup> 1 HEALTH L. PRAC. GUIDE § 2:10 (2013) ("A 'professional review body' is: a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.").

<sup>119</sup> Berlin, 688 N.E.2d at 113-14.

<sup>120</sup> HEALTH L. PRAC. GUIDE, *supra* note 118 ("A professional review action is: an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.").

their medical decisions via utilization review, there will be concern over whether the physician's loyalty is to his patient or to his profitmaking employer. Where a hospital is legally accountable for the health and well-being of the physician's patients,<sup>121</sup> a managed care organization is not. Therefore, the managed care organization's primary concern is cost management, not patient care. Also, unlike a physician employed by a hospital, one employed by an insurance company is contractually obligated to comply with the wishes of the third party payer. If he does not, he will be working without compensation.<sup>122</sup> This effectively coerces the physician into doing the bidding of the insurance company.

A managed care organization's contractual ability to influence a licensed physician's medical decisions violates every rationale supporting the CPMD noted by the court in *Garcia v. Tex. State Bd. of Med. Exam'rs*.<sup>123</sup> A lay person-controlled managed care organization can create its own definition of what is medically necessary and insert it into its insurance contract with physicians and hospitals. A physician is obligated to practice within the confines of this definition, or else risk not being compensated for his work.<sup>124</sup> This would constitute interference with the doctor-patient relationship and would likely be considered lay supervision over medical procedures. A managed care organization's use of utilization review and denial of treatments that are not considered medically necessary could be considered evidence that it is placing more emphasis on budget considerations than on patient care.

While the managed care organization could hire consultant physicians, those physicians would still be considered as employed by the organization. A consulting physician's livelihood is based on performing cost-controlling mechanisms for the managed care organization, including prospective, concurrent, and retrospective

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<sup>121</sup> See Berlin, 688 N.E.2d 106 at 112-13.

<sup>122</sup> See Hinden & Elden, *supra* note 37, at 8.

<sup>123</sup> Garcia, 384 F. Supp. at 434.

<sup>124</sup> Bergthold, *supra* note 4, at 181.

review.<sup>125</sup> Third party payers, through their contracts with health care providers, induce compliance with utilization review through financial incentives and penalties.<sup>126</sup> This is not analogous to a peer-review committee made up of professional medical staff members who are employed by a hospital to ensure a high quality of care for patients. Such inducement by third party payers is a direct violation of the CPMD.

### **E. Liability for Third Party Payers for the Use of Utilization Review**

While it is unfortunate for the health care provider and patient when a third party payer denies coverage for a treatment or procedure because it deemed them not medically necessary upon retrospective review, it is unlikely that an insurance company could face liability for this decision.<sup>127</sup> An insurance company's liability usually arises when a patient is injured because the third party payer denied him or her treatment based on prospective or concurrent review.<sup>128</sup>

The landmark case discussing liability for third party payers when performing utilization management functions is *Wickline v. California*.<sup>129</sup> In this case, Mrs. Wickline was hospitalized for peripheral vascular issues and was determined to have an occlusion of the abdominal aorta due to arteriosclerosis.<sup>130</sup> She was initially sent home to wait for pre-approval from her third party payer, Medi-Cal, for the

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<sup>125</sup> Sekhri, *supra* note 14, at 837.

<sup>126</sup> Randall, *supra* note 2, at 4.

<sup>127</sup> Hinden & Elden, *supra* note 37, at 52.

<sup>128</sup> *See id.*

<sup>129</sup> *Id.*

<sup>130</sup> *See Wickline v. Cal.*, 192 Cal. App. 3d at 1640 (1986) (describing a situation where a woman, Mrs. Wickline, was denied care by her insurance company, Medi-Cal, and her attending physician did not contest the decision because he felt that the insurance company "had the State's interest more in mind than the patient's welfare and that the belief influenced his decision not to request a second extension of Wickline's hospital stay. In addition, he felt that Medi-Cal had the power to tell him, as a treating doctor, when a patient must be discharged from the hospital.").

necessary surgical procedure to insert a graft into her artery.<sup>131</sup> Medi-Cal pre-approved Mrs. Wickline for the surgical procedure and a ten-day stay in the hospital.<sup>132</sup> After her surgery and during her ten-day stay, Mrs. Wickline encountered several complications and required two additional surgeries.<sup>133</sup> On her ninth day in the hospital, the treating physician at the hospital, Dr. Polonsky, determined that “it was medically necessary” for Mrs. Wickline’s hospital stay to be extended for eight more days. Dr. Polonsky cited several reasons, including danger of infection of the surgical site, clotting, and his belief in his ability to save both of Mrs. Wickline’s legs. Dr. Polonsky filled out a Medi-Cal request form and submitted it to Medi-Cal’s on-site nurse.<sup>134</sup> The on-site nurse believed that she was unable to approve the extended stay, so she called a Medi-Cal consultant, a physician who was employed by Medi-Cal and located at Medi-Cal’s Los Angeles office.<sup>135</sup> The Medi-Cal consultant did not approve the requested eight-day extension, but instead, based on his consideration of medical factors unrelated to Mrs. Wickline’s condition, he approved her for a four-day extension.<sup>136</sup> When Mrs. Wickline was discharged at the end of her extended stay, she returned home and developed an infection and clotting in her leg. This obstructed circulation and made it necessary for her to return to the hospital nine days after her initial discharge.<sup>137</sup> Because of her infection, Dr. Polonsky believed that it would be life-threatening to perform another surgical procedure to remove the clotting. Unfortunately, when alternative treatment failed, Dr. Polonsky was forced to amputate Mrs. Wickline’s leg.<sup>138</sup>

*Wickline* involves both prospective and concurrent review by a third party payer. The pre-approval required by Medi-Cal for Mrs.

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<sup>131</sup> *Id.* at 1635.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *See id.* at 1636.

<sup>135</sup> *Id.* at 1637.

<sup>136</sup> *Id.* at 1638.

<sup>137</sup> *Id.* at 1640-41.

<sup>138</sup> *Id.* at 1641.

Wickline's elective surgical procedure is an example of prospective review,<sup>139</sup> and the necessary review by the third party payer of an application for an extended hospital stay is an example of concurrent review.<sup>140</sup> In *Wickline*, the court refused to impose liability on the third party payer. The court's decision was based on the fact that Mrs. Wickline's treating physicians did not protest the disapproval of her extended stay, not on whether the third party payer had any responsibility.<sup>141</sup> In fact, the court in *Wickline* ruled that "[t]hird party payors of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost-containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden."<sup>142</sup>

Applying the situation of the young mother discussed in the introduction of this paper *supra*,<sup>143</sup> the language in *Wickline* suggests that liability could be extended to third party payers and managed care organizations who refused to extend the mother's stay in the hospital if this use of concurrent review caused an injury.<sup>144</sup> In the introductory story, the young woman's physician could have refused to follow the mandate of the MCO and recommended that she stay three extra days in the hospital. The MCO would have refused to pay for the extended stay, and the young woman would most likely not have been able to afford the treatment and would have elected to leave.<sup>145</sup> If the young woman was infected with MRSA, her infection would most likely spread and require her re-admission to the hospital for necessary treatment up to and including amputation of her leg, or even death, due to sepsis.<sup>146</sup> The physician would not have been liable to the young

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<sup>139</sup> Randall, *supra* note 2, at 27.

<sup>140</sup> *Id.*

<sup>141</sup> *Wickline*, 192 Cal. App. 3d at 1645-46 (1986).

<sup>142</sup> *Id.* at 1645.

<sup>143</sup> See discussion *supra* Part I.

<sup>144</sup> See Hinden & Elden, *supra* note 37, at 55.

<sup>145</sup> See *id.*

<sup>146</sup> See Pantosti & Venditti, *supra* note 1.

woman for malpractice because he recommended that she continue her stay in the hospital. If she had done so, her injury would most likely have been prevented.<sup>147</sup> However, the MCO could be found liable for medical malpractice and be required to compensate for the injuries sustained.<sup>148</sup>

If, however, as in *Wickline*, the young mother's physician is influenced by the MCO to change or renounce his medical opinion or recommendation and decides to send her home against his best medical judgment due to his contractual obligation to comply with utilization review, this would violate the CPMD. The MCO is controlling the physician and not allowing him to practice medicine independently. This lay control over medical decisions should be considered a direct violation of the CPMD, and the MCO should be held liable for the young mother's injuries caused by their negligent breach of the doctrine.<sup>149</sup>

## **F. How Insurance Companies Can Be Affected by Breach of the Corporate Practice of Medicine Doctrine**

### ***1. Liability Resulting from a Void Contract***

As noted earlier, many states consider their CPMDs to be an obsolete device.<sup>150</sup> However, the doctrines still exist, lurking in the background of health law, capable of being used against the unsuspecting.<sup>151</sup> One chief use of the doctrine now is to render contracts that breach the doctrine void.<sup>152</sup> The doctrine is usually

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<sup>147</sup> See *Hinden & Elden*, *supra* note 37, at 55.

<sup>148</sup> See *id.*

<sup>149</sup> See discussion *supra* Background Section III.

<sup>150</sup> See *Chase-Lubitz*, *supra* note 5, at 448.

<sup>151</sup> See *id.*

<sup>152</sup> See *Berlin*, 688 N.E.2d 106 at 116 (holding that a physician attempting to use the corporate practice of medicine doctrine to make void the employment contract he had with the hospital at which he was previously employed which contained a non-compete clause so that he could retain his employment with a competing hospital only a few blocks away from his previous employer). See generally *Flynn Bros., Inc.*, 715 S.W.2d at 782 (Tex. App. 1986) (explaining that

enforced when the contract between a physician and a third party is breached. As a result, the parties come before the court, and the breaching party usually contends that the contract violated the CPMD and was therefore void.<sup>153</sup>

An example of this type of case is *Flynn Brothers, Inc. v. First Medical Associates*.<sup>154</sup> In this case, the Flynn brothers, who were not physicians, learned that St. Paul Hospital was searching for an outside party to contract with to staff its emergency department.<sup>155</sup> The Flynn brothers formed a partnership with a physician, Dr. Adcock, in which Dr. Adcock agreed to staff and run the emergency department, the Flynn brothers agreed to provide management services, and the profits would be split—80% to the Flynn brothers and 20% to Dr. Adcock.<sup>156</sup> The hospital awarded the contract to the Flynn brothers and Dr. Adcock, but the parties later learned that the contract was invalid under the Texas Medical Practices Act, from which the CPMD is derived in Texas. Dr. Adcock then formed the professional corporation First Medical Associates (FMA), which became the contracting party with the hospital, and the Flynn brothers formed the corporation Flynn Brothers, Inc. (FBI), which obtained an exclusive management agreement with FMA.<sup>157</sup> The parties agreed that Dr. Adcock could not sell his interest in FMA to the detriment of FBI or contract with any party other than FBI for the management of FMA. FBI would receive 66.67% of FMA's net profits in exchange for management services.<sup>158</sup>

Dr. Adcock became unhappy with the agreement and wanted to sell his interest in FMA, but the Flynn brothers refused to allow him to

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a physician disgruntled with his employment situation in which he contracted with a management services company who retained a large portion of his earnings and attempting to make void the contract, arguing that the contract violated the corporate practice of medicine doctrine).

<sup>153</sup> *Id.*

<sup>154</sup> *Flynn Bros., Inc.*, 715 S.W.2d at 782.

<sup>155</sup> *Id.* at 783.

<sup>156</sup> *See id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

do so.<sup>159</sup> The conflict was ultimately brought to court, where the court found that their agreement was illegal because it breached the CPMD.<sup>160</sup> The court stated that under the Medical Practices Act, a corporation comprised of lay persons could not employ a physician, and although Dr. Adcock was not technically an employee of FBI, under the contract language, the practical effect was the same.<sup>161</sup> The court held that the design, effect, and purpose of the contract contravened the Medical Practices Act, and that the contract was void.<sup>162</sup>

While insurance companies will not incur liability from a determination that a contract is void, they can be adversely affected in different ways. For example, by entering into contracts that are void because they breach the CPMD, insurance companies risk losing business associates as well as policy holders.

## 2. *Negligence Per Se*

Insurance companies that breach the CPMD can be held legally liable for the breach through the doctrine of negligence per se. Most courts recognize that certain elements must be present to prove that a defendant has been negligent per se.<sup>163</sup> These elements include:(1) “that the defendant violated a certain statute or regulation; (2)that the plaintiff is of the class which the statute or regulation was intended to protect; (3) that the plaintiff suffered injury of the type the statute or regulation was designed to prevent; and (4)

that the violation of the statute or regulation was the proximate cause of the injury.”<sup>164</sup>

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<sup>159</sup> *Id.* at 784.

<sup>160</sup> *Id.*

<sup>161</sup> *Id.* at 785.

<sup>162</sup> *Id.*

<sup>163</sup> J. Richard Caldwell Jr. & Joseph A. Regalado, *Negligence Per Se*, 64 FDCC Q. 465, 467 (2015) (discussing uses and elements of negligence per se).

<sup>164</sup> *Id.*

A patient who is injured by an insurance company's use of utilization review that breaches the CPMD would have a claim that satisfies all elements of negligence per se. First, the CPMD is a regulation and also found in statute in some states.<sup>165</sup> Second, a patient injured by the corporate control of physicians is exactly the class of plaintiffs that the CPMD is intended to protect.<sup>166</sup> Third, the CPMD intends to prevent corporations or any other entity from controlling physicians and, in effect, practicing medicine without a license<sup>167</sup> because this could ultimately lead to patient injury. Finally, a patient injured by an insurance company's breach of the CPMD would not have been injured "but for" the insurance company's use of contractual language to control physicians' practice of medicine. Therefore, the insurance company's violation of the CPMD would be the proximate cause of the patient's injury.

## CONCLUSION

The legal system should no longer ignore the contractual language between hospitals and insurance companies that breaches the CPMD and should hold them liable for their actions. Prospective and concurrent utilization review by insurance companies and their contractually-determined ability to decide what is medically necessary breaches the CPMD. While utilization review serves an important function of cost containment, the risks that concurrent and prospective utilization review pose to the doctor-patient relationship and to the sanctity of the physician-controlled medical practice is too great. Licensed physicians should be the only individuals with the ability to determine what is medically necessary for a patient, and this determination should be made independent of insurance company interference. To avoid lay person interference with the doctor-patient relationship, overemphasis on budget considerations rather than on patient care, and lay supervision over medical procedures, managed

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<sup>165</sup> See MICHAL ET AL., *supra* note 53.

<sup>166</sup> Garcia, 384 F. Supp. at 434.

<sup>167</sup> See *Chase-Lubitz*, *supra* note 5, at 465.

care organizations should not be given the ability to create their own definition for what is medically necessary in their contracts with health care providers. As discussed, allowing the insurance company to determine what is medically necessary forces the health care provider to accept this definition via utilization review with which the health care provider is contractually obligated to comply. Insurance companies should consider using a different mechanism to address their cost containment concerns, one that is more analogous to the hospital's professional peer review committee and operated by professional medical staff<sup>168</sup> rather than by a single on-site nurse and a remote physician employed by the insurance company.<sup>169</sup>

Although the CPMD is largely ignored and is considered by many to be obsolete, the doctrine still exists in statute and in common law and continues to thrive in a few states today.<sup>170</sup> Courts should hold parties liable for negligence when they create contracts that allow insurance companies to breach the CPMD and potentially harm patients through utilization review. The sanctity of the doctor-patient relationship and a physician's ability to practice medicine independent from lay person control are important concepts in our health care system. The legal system should not allow insurance companies to interfere with this relationship by breaching the CPMD.

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<sup>168</sup> 42 U.S.C.A. § 11151.

<sup>169</sup> Wickline, 192 Cal. App. 3d at 1637-38 (1986).

<sup>170</sup> WEBB *supra* note 62; Schaff & Prives *supra* note 64.