Honigman Miller Schwartz and Cohn's *April 2002*

HEALTH LAW FOCUS

A Periodic Newsletter Published by The Health Care Department of Honigman Miller Schwartz and Cohn LLP

TAX RISKS OF PHYSICIANS PROFITING FROM WORK OF OTHERS

By Gerald M. Griffith

Most IRS compensation issues that arise in health care today have involved arrangements with tax-exempt hospitals. Both for-profit and nonprofit providers, however, should take note of a decision last year by the Tax Court disallowing part of a Section 162 business expense deduction taken by a PC for compensation paid to its shareholders/officers. The standards for deductible compensation have been applied by the IRS and the courts to compensation decisions in the nonprofit sector as well.

In *Pediatric Surgical Associates, P.C. v. Commissioner*, the PC's compensation system treated shareholder and nonshareholder surgeons differently. The four shareholders were paid a fixed monthly salary plus monthly bonuses. Although the employment agreements left the bonus calculation to the board's discretion, the bonuses were calculated by starting with the available cash of the PC and subtracting a reserve for short term expenses (including nonshareholder surgeon salaries). Any remainder was paid out in shareholder bonuses, pro rated for shareholders who are part-time employees. The two nonshareholders were paid only a fixed monthly salary with no bonus. The PC deducted the entire payments to shareholders as officers' compensation (the nonshareholders had no significant administrative duties). The IRS disallowed the deduction for a portion of those payments and assessed a 20% accuracy related penalty against the PC under Section 6662 of the Tax Code.

There is a two-part test for deducting payments as compensation - such payments must be both (1) reasonable in amount, and (2) paid purely for services rendered. The disallowance was based on the conclusion that a portion of the monthly bonuses paid to the shareholder surgeons represented a disguised dividend rather than payment for services. There was no dispute that the remainder, after that "profit," was reasonable compensation and reasonableness of the total payments were not at issue, only whether the payments were exclusively for the provision of services. The IRS' position was that a portion of the payments to the shareholders "is profit attributable to services performed by the nonshareholder surgeons, which should be treated as a nondeductible, disguised dividend rather than as deductible compensation."

There was no dispute that the PC could deduct as purely for services the portion of the shareholder compensation equal to collections from their services less their share of the PC's expenses. The PC argued that all payments to shareholders were per se reasonable "because they did not exceed [the PC's] profits" (*i.e.*, gross receipts from professional services of the PC less expenses of the PC). In addition, the PC argued that because the compensation paid was less than the shareholders' gross collections it was reasonable. The court rejected the PC's arguments as going more to the reasonableness and noted that the issue in dispute was whether the payments were purely for the shareholder surgeons' services. The court also rejected the PC's argument that compensation should be deemed payable for services so long as it does not exceed the profit on all of the surgeons' services. In its opinion, the court distinguished prior cases where it looked to historical practice profits to determine reasonableness. In those cases, the court looked to practice profits in sole proprietorships, where the profits were derived entirely from the services of the sole proprietor. The profits of Pediatric Surgical Associates were not necessarily

HMSC ATTORNEYS WIN LANDMARK MEDICARE LOSS ON SALE CASE

In a landmark decision, a Federal district court upheld a hospital's right to receive Medicare loss on sale reimbursement for a sale between two non-profit providers. The plaintiff was represented by Chris Rossman and Robert Jackson of Honigman Miller Schwartz and Cohn. The United States District Court for the Central District of Iowa ruled that the provider, a Mason City, Iowa hospital, was entitled to $3.2 million, which represents Medicare's share of the difference between the net book value of the assets sold and the sale price. The Court ruled that the transaction was a bona fide sale between unrelated parties, at fair market value, thereby meeting Medicare requirements for recognition. The Secretary of Health and Human Services has been attempting to argue in recent years that a sale between two non-profit corporations can rarely or never be arm's length, because non-profits are not motivated to maximize the purchase price. This case is a major precedent for many other providers that have appeals pending on this issue.

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derived entirely from the value of the services of the shareholders because its professional services were also provided by nonshareholder physicians, "whose contribution to [the PC's] profit we cannot assume to be zero." For example, the court noted that in one year the collections attributable to a nonshareholder surgeon were only slightly less ($460,000) than the collections attributable to a shareholder ($491,000).

The court was also not persuaded by the PC's principal argument, that reporting the payments as compensation on Forms W-2 and on its Form 1120 established an intent to treat the payments as compensation and should be dispositive. Instead, the court noted that "the board was not necessarily concerned that shareholder surgeon compensation not be overstated." The shareholder surgeons comprised the board and had approved their own compensation. Differences in compensation for the part-time physicians and paying him proportionately less based on time worked also was not determinative, because in the court's view it may have been nothing more than a redistribution of profits based on a shareholder's decision to partially retire and change to part-time status. Similarly, in upholding the 20% accuracy related penalty based on negligence (lack of reasonable cause and good faith belief that there was no underpayment), the court noted the contradictory testimony of one of the shareholders. When asked why the PC never paid a dividend he testified that the PC was not a very large organization, all of its income came from its services and it treated everything as salary. Yet later he testified that within a short time after they arrived the nonshareholders "made money" for the PC. Accordingly, the court concluded that the shareholders must have been aware that at least part of the PC's profits were attributable to the value of the services of the nonshareholders and their treatment of all profits as compensation to the shareholders was not in good faith.

In essence, the court found that the PC failed to properly account for the net collections of nonshareholder employed surgeons in valuing the shareholders' compensation. Moreover, the IRS disagreed with how the PC allocated collections and expenses to the nonshareholder surgeons. The Tax Court largely agreed with the IRS' approach with two exceptions: (1) because neither party had adequate support for its position on how collections should be allocated, the court used the upper end of the range given by the taxpayer's witness; and (2) the court allocated a per capita share of additional expenses to the nonshareholder surgeons. The amount of collections allocable to the nonshareholder surgeons net of their allocated expenses (both direct costs and allocable overhead) was recharacterized as profit to the PC and that portion of the shareholder compensation was treated as a nondeductible dividend.

The expense allocation in particular is potentially significant for physician recruitment scenarios where a physician joins an existing group. One area of concern is whether and to what extent the existing overhead of the practice should not be allocated to the new physicians instead of simply allocating the incremental costs of adding that new physician. Although the opinion in *Pediatric Surgical Associates* does not list all of the expenses that were allocated to the nonshareholder surgeons, the additional expenses allocated by the court (above and beyond the IRS allocation) included rent, repair and maintenance expense, depreciation of office equipment (excluding shareholder automobiles), telephone expenses, and equipment lease expenses. Those are expenses that arguably would have been incurred by the practice whether or not the nonshareholder surgeons joined the practice, yet the court found it reasonable to allocate those expenses to the nonshareholder surgeons thus reducing the net taxable income of the group and to allocate them on a per capita basis. The IRS had argued that the nonshareholder surgeons may have utilized the office space and staff to a lesser degree than the shareholder physicians, but there was no supporting evidence for that allegation. Moreover, the employment contracts obligated the PC to provide an office, support staff, supplies, equipment and other facilities and services necessary for the surgeons to carry out their duties. By analogy, in a recruitment scenario one could argue that those same expenses are fairly allocable among old and new physicians and do not represent part a profit factor for the existing practice.

Although reasonableness of compensation was not directly at issue, the court did make reference to it for one of the two audit years in a footnote [4]. The court noted that the amount disallowed for the second year was only $19,450 or 1.29% of the total deduction. "We hesitate to conclude that respondent would ask us to find that compensation was unreasonable based on such a small variance."

In addition to the favorable implications for recruiting scenarios and de minimis differences on reasonableness of compensation, the opinion in *Pediatric Surgical Associates* has a number of other implications for compensation in both the for-profit and nonprofit settings. For example, for purposes of the Stark Law exceptions applicable to group practices, per capita distribution of profits is one example of a permitted allocation methodology that CMS included in the preamble to the Stark II proposed regulations. Following that approach only for shareholders, however, may have negative tax consequences. Those tax consequences may be mitigated if the payments are also tied to the required performance of substantive administrative duties that nonshareholders do not perform.

In the nonprofit sector, pooling physician collections and distributing them per capita to less than all of the physicians generating the revenue may be treated as a disguised distribution of profits which likely would be inurement and may be a taxable excess benefit as well. There are, however, certain steps that can be taken to reduce these risks. Changing shareholder bonuses to a productivity or seniority basis and including nonshareholders in the pool, or applying per capita distributions to both shareholders and nonshareholders may eliminate the adverse tax consequences for PCs; however, absent an appropriate adjustment in base compensation the economic impact may be too great on the shareholders as a business matter. For nonprofits, it would also be helpful to assure that there is an independent determination of physician compensation (*i.e.*, that the group compensation is not determined by any of the physicians themselves) so that the IRS and the courts may place more weight on the organization's intent to treat payments as compensation for services.

THE MCLAREN CASE: FAILURE TO ESTABLISH LEASE AS NON-FMV RESULTS IN DISMISSAL OF GOVERNMENT'S CASE

By: Carey Kalmowitz

In a recent decision, the U.S. District Court for the Eastern District of Michigan held that the Government failed to establish that lease payments

paid by a hospital to individual physicians were above fair market value or that the lease rate was determined in a manner that took into account the value of any patient referrals. With the trial bifurcated to determine solely these issues, the finding by the Court that the lease arrangement was a fair market value transaction led the Court to hold that no violations of either Stark II or the Anti-Kickback Statute occurred. *United States ex. rel. Goodstein v. McLaren Reg'l Med. Ctr. et al*.

In the case, the Government alleged that the physician members of Family Orthopedic Associates L.L.C., a Flint-based orthopedic group ("FOA"), and an affiliate of FOA, Family Orthopedic Realty L.L.C. ("FOR"), participated in a "scheme" with McLaren Regional Medical Center ("McLaren") involving the maintenance by the FOA physicians of an improper financial and referral relationship with McLaren. Under the Government's theory, McLaren paid the individual FOA physicians, indirectly through FOR, remuneration disguised as lease payment, while, in return, the physicians referred Medicare patients to McLaren. The Government argued that, because the lease payments from McLaren to FOR and the individual FOA physicians exceeded fair market value, the financial relationship between the parties violated 42 U.S.C. § 1395nn(a)(1), commonly known as "Stark II," and 42 U.S.C. § 1320a-7b, commonly known as the "Anti-Kickback Statute."

On September 12, 2001, McLaren and the individual Defendants filed a motion to bifurcate the trial pursuant to Rule 42(b) of the Federal Rules of Civil Procedure, arguing that a separate bench trial should be conducted solely on the issue of whether the lease payments paid by McLaren were in excess of fair market value. The parties agreed that if the lease rate were determined to be fair market value, such a determination would effectively eliminate the Government's claims against all of the Defendants.

Although both the Government and the Defendants each called expert witnesses to support their respective claims regarding the fair market value nature of the lease payments, the Court explicitly stated that it found the Defendants' expert witnesses to be more persuasive and credible, in a number of respects, than the experts relied on by the Government. In addition, the Government failed to produce any evidence to establish that the lease rate was determined in a manner that took into account the value of patient referrals.

For these reasons, this Court concluded that the lease agreement was an arms length transaction, and the lease rate was consistent with fair market value and not determined in a manner that took into account the value of potential patient referrals. On this basis (*i.e.*, the absence of any finding of non-fair market value payments), the Court dismissed the action against the Defendants in its entirety.

Because of the bifurcated trial, it is not possible to ascertain whether, had the lease payments been found to be in excess of fair market value and the trial proceeded, the Government would have been able to successfully prosecute the Stark II and Anti-Kickback claims. The case does, however, support the proposition that the mere potential of a lessee or lessor to direct referrals to the other party, by itself, may not suffice for the Government to demonstrate that a lease is not commercially reasonable without introducing evidence to support the claim that referrals were, in fact, taken into account, in some manner, in establishing the lease rate.

CMS AND MDCIS INCREASE HOSPITAL SURVEY ACTIVITIES IN MICHIGAN

By: Stuart M. Lockman

The Michigan Department of Consumer and Industry Services ("CIS"), on behalf of the Centers for Medicare and Medicaid Services ("CMS"), has been conducting an increased number of validation surveys of Michigan hospitals for purposes of Medicare certification. It is vital for a hospital that is notified that a validation survey is to be conducted to take all necessary and appropriate actions to assure the best possible survey results. The results of several recent hospital validation surveys have been not only the loss of "deemed" Medicare certification based on the hospital's accreditation status, but also a notice of Medicare termination. While it may be possible to retain Medicare participation status by filing a plan of correction and making credible allegations of compliance, preventive actions to minimize or avoid adverse findings are preferable and can avoid a termination notice.

Upon arrival at the hospital, surveyors usually meet with the administrator or other appropriate hospital staff to outline how the survey will be conducted. The surveyor will address elements of each condition of compliance that may require discussion with the administrator and other staff members relative to specific standards and requirements. The surveyors must verify all facts by reviewing source documents and interviews. Thus, for example, individual staff members may be asked how he or she would handle an emergency, such as a fire or a code blue. Surveyors also may request documentation of quality assurance activities, and such evidence that any identified quality problems have been addressed and corrected by appropriate follow-up.

Because of the increased number of validation surveys being undertaken, even hospitals with "deemed status" based on their accreditation by JCAHO or AOA should implement a plan of review to assure favorable

HIPAA MODEL COMPLIANCE EXTENSION FORM NOW AVAILABLE:

The Centers for Medicare and Medicaid Services has published the HIPAA Model Compliance Extension Form. The Form can be used by covered entities to request an extension to the October 16, 2002 compliance date for standard transactions and code sets. An extension would make the compliance date October 16, 2003. The Model Compliance Extension Form can be accessed at **http://www.cms.gov/hipaa**. An electronic version of the Extension Form also will be available at that site soon.

NOTICE OF PROPOSED RULE MAKING REGARDING THE HIPAA PRIVACY REGULATIONS:

HMSC has prepared an analysis of the Notice of Proposed Rule making issued with respect to the HIPAA privacy regulations on March 21, 2002 and published in the Federal Register on March 27, 2002. That analysis will be distributed as a special edition of HMSC's "HIPAA Law Focus."

A copy of the NPRM as published in the Federal Register is available at **http://www.hhs.gov/ocr/hipaa/**

results if a survey is conducted by CIS. At a minimum, hospital administration should review the Medicare survey forms and identify any areas of hospital operation requiring attention prior to a survey being scheduled.

If a survey is scheduled, the hospital should contact legal counsel to clearly understand the role of the surveyors and rights of the hospital. For example, a facility may not legally refuse authorized officials from making unannounced visits. Refusal to allow the visit may result in Medicare termination. Surveyors may allow or refuse to allow facility staff to accompany them during the survey of the facility. At the conclusion of the survey, an exit conference will be held to informally communicate preliminary findings, and to provide an opportunity to exchange information. An attorney may be present at the exit conference but the surveyors may terminate the exit conference if the attorney tries to turn it into an evidentiary hearing. It is also permissible to tape record the exit conference provided that the surveyors are given a copy of the tape at the conclusion of the exit conference. At the discretion of the surveyors, the exit conference may be videotaped. If any documentation is requested by the surveyors, every effort should be made to deliver it before the end of the exit conference. If submission of certain documentation is permitted after the exit conference, the hospital should verify that it has a complete list of the requested documentation and the outside date for its submission.

Even before receipt of the written survey findings, the hospital may be able to begin developing a plan of correction for any differences identified during the exit conference. The time frame for submitting plans of correction is very short. Thus, when the hospital receives the written survey findings, it is imperative to take immediate action to develop an acceptable plan of correction to address each cited deficiency. The plan of correction must identify who is responsible for taking the corrective action, when the corrective action will be completed and how on-going compliance will be monitored. An unacceptable plan of correction can result in sanctions, including notice of termination from the Medicare program.

Providers sometimes are tempted to minimize the importance of these surveys, or to challenge the authority of the surveyors or the validity of their findings. Generally, these efforts are misplaced, and result in nothing more than antagonism and confrontation. CMS has the authority to institute a validation survey and the state agency has the responsibility to conduct the survey. Providers will be better served by responding to the deficiencies noted in a timely manner with a detailed action plan of resolving the deficiency in question. While an appeal may ultimately be successful, no provider can afford termination from the Medicare program while pursuing such an appeal.

PHYSICIAN SUPERVISION OF MEDICAL RESIDENTS - IS YOUR SUPERVISION ADEQUATE?

By Ann T. Hollenbeck

In February of this year, the Supreme Court of Ohio published an important decision finding that a physician who has assumed the obligation to supervise residents may be held liable for medical malpractice despite the fact the physician may never have seen or treated the patient alleging malpractice. *Lownsbury v. VanBuren*, Ohio, No. 00-1655, February 20, 2002.

The case involved a physician ("Physician") who was sued for malpractice for allegedly failing to adequately supervise obstetric residents. According to the lawsuit, the obstetric residents allegedly failed to properly care for a pregnant woman whose child was subsequently born with severe and permanent brain damage. Because Physician never saw or treated the pregnant woman, Physician argued that he owed no duty of care to the patient. The trial court accepted this argument, but upon appeal the Ohio Supreme Court rejected this argument finding that: "Physicians who practice in the institutional environment may be found to have voluntarily assumed a duty of supervisory care pursuant to their contractual and employment arrangements with the hospital."

The facts indicate that a colleague of Physician ordered the obstetric residents to induce labor in the mother; instead, the residents administered a contraction stress test. The fetal distress revealed by the contraction stress test was not noticed by the residents, and the mother was subsequently sent home. The mother gave birth to the brain damaged infant several days later.

Because Akron City Hospital and Physician had entered into a contract whereby Physician agreed to supervise the obstetric residents, the Ohio Supreme Court found Physician's duty of care to the patients treated by the residents to be established by virtue of his contractual agreement to supervise the residents. The court stated: "The basic underlying concept in [this case] is that a physician-patient relationship, and thus a duty of care, may arise from whatever circumstances evince the physician's consent to act for the patient's medical benefit." The court acknowledged that hospitals often delegate their responsibilities to supervise residents and that patients who enter into the hospital setting "have every right to expect that the hospital and adjunct physicians will exercise reasonable care in fulfilling their respective assignments." The Ohio Supreme Court remanded the case back to the trial court for a determination of the duties required by a supervising physician.

In support of its position, the Ohio Supreme Court cited a 1979 Michigan Court of Appeals case, *McCullough v. Hutzel*. 276 N.W. 2d 569. In *McCullough*, the plaintiff underwent a tubal litigation surgery that was performed by a resident at a teaching hospital. The plaintiff subsequently alleged malpractice and the case proceeded to trial. The jury returned a verdict against certain defendant-specialists in obstetrics and gynecology who undertook to supervise the resident finding that even though the surgery was performed by a resident, the supervising physicians had a duty to see that it was performed properly. The supervising-physicians' "failure to take reasonable care in ascertaining that the surgery was competently performed renders them liable for the resulting damages."

There are two lessons to be learned from the above-cited judicial decisions: first, the agreement to supervise medical residents may give rise to a physician-patient relationship between the supervising physician and the patients treated by the residents regardless of whether the supervising physician sees or treats such patients; and second, because of the creation of the physician-patient relationship, the supervising physician must consider whether he/she is providing appropriate and adequate supervision over medical residents.

TERMINATION OF PATHOLOGIST'S CONTRACT PURSUANT TO EXPRESS TERMINATION PROVISION DOES NOT IMPLICATE CONTRACT'S "DISPUTES" CLAUSE NOR GIVE RISE TO A RIGHT TO A HEARING

By: Zachary A. Fryer

In *Clark v. West Shore Hospital (2001 WL 897447)* the Sixth Circuit Court of Appeals held that a hospital did not breach its contract with a pathologist when the contract was terminated without providing a hearing to the pathologist, even though the contract provided a right to a hearing for disputes "arising under" the contract.

The plaintiff, Dr. Clark, is a licensed physician and a pathologist. The defendant, West Shore Hospital, is a public hospital in Michigan. In April 1991 Dr. Clark entered into a pathologist agreement with the hospital for a period of two years, which was renewed in 1993, 1995, and 1997. The agreement provided that "the Hospital or Pathologist shall have the privilege of canceling and terminating this Agreement in the sole discretion of either party upon one hundred twenty (120) days written notice by either party to the other." The agreement also provided that "all disputes arising under" the contract were to be "determined by the Joint Conference Committee of the hospital," subject to review by the hospital's Board of Trustees.

In October 1998 the hospital's administrator sent a letter to Dr. Clark stating that the hospital was terminating his contract in 122 days. Almost three months later Dr. Clark sent a letter to members of the Board of Trustees requesting a hearing to explain his side and hopefully reverse the termination. No hearing was granted.

Dr. Clark subsequently filed suit in federal court in September 1999, alleging a violation of 42 U.S.C. §1983 (which allows a person to sue for a violation of his rights under the U.S. Constitution or federal law), alleging that the termination was arbitrary and capricious in violation of his right to substantive due process, and also alleging three state law contract claims: breach of contract, breach of the duty of good faith and fair dealing and tortious interference with business relations. Dr. Clark sought money damages exceeding one million dollars, costs and attorney's fees and punitive damages.

The hospital's primary defense was that Dr. Clark had no right to a hearing, therefore no contract was breached, and absent a breach of contract, none of Dr. Clark's claims had merit. The hospital filed motions for dismissal (arguing that Dr. Clark had not alleged any legal claim) and judgment on the pleadings (arguing that only the hospital could prevail at trial based on the statements in the pleadings). The trial court dismissed the case. Dr. Clark then appealed to the Court of Appeals.

The Court of Appeals, applying Michigan law, ruled that the hospital had complied with the termination provision of the contract by providing written notice of termination to Dr. Clark within the required number of days prior to the effective date. The court ruled that the "disputes" provision of the contract, which would require a hearing, only applied to a dispute arising under the contract. Since the hospital's decision to terminate had not arisen under the contract but rather was in the hospital's discretion as specified in the contract, the "disputes" provision never came into effect. In the court's view, Dr. Clark disputed the wisdom of the hospital's decision to terminate but did not dispute the hospital's contractual right to do so. Therefore, the hospital had not breached the contract by refusing to provide a hearing.

The court then rejected each of the remaining claims. In his federal claim, Dr. Clark alleged that the termination violated both his procedural due process rights (*i.e.*, the right to be accorded due process before being deprived of any property or liberty interest) and his substantive due process rights (by depriving him of a particular constitutional guarantee or by committing a state action that so shocks the conscience as to violate his federal civil rights). The court ruled that Dr. Clark had not been deprived of a property interest because after the termination of his contract (which was not improper), he was an employee at will and therefore had no property interest. The court also noted that his staff privileges were not cancelled, and declined to adopt a theory of "effective termination" (that the value of staff privileges was eliminated by the termination, and therefore the privileges were effectively terminated by the contract termination). Finally, there was no violation of substantive due process because the contract termination was proper and therefore did not violate a constitutional guarantee or shock the conscience.

Dr. Clark's claim for a breach of good faith and fair dealing under Michigan law was held to have been properly dismissed because no duty of good faith and fair dealing exists in the employment context in Michigan (including the services contract involved here). The hospital could not breach an implied covenant which did not exist.

Finally, the tortious interference with business relations claim was held to have been properly dismissed. In Michigan, this cause of action requires the existence of a valid business relation or expectancy, knowledge of the relationship or expectancy by the defendant, intentional interference which induces or causes a breach or termination, and damage to the party whose relationship or expectancy was disrupted. The third element, intentional interference, requires either a *per se* wrongful act or performing a lawful act with malice and without legal justification. The termination was not a *per se* wrongful act to satisfy this third element, and Dr. Clark failed to allege the necessary malicious intent and any affirmative acts by the hospital which would show an unlawful purpose. Thus, this claim was dismissed because the plaintiff failed to make allegations that would support the claim.

In summary, the hospital did not act improperly when it terminated the contract pursuant to the termination clause, so the breach of contract claim and the other claims (which depended on a breach of contract) were defeated.

Hospitals may read *Clark* as a welcome affirmation that provisions allowing a party to terminate a contract without cause and without a hearing will be enforced as written, and a proper termination under such a provision does not create a right to a hearing, absent evidence of illegal motive or malice. Physicians who contract with hospitals should be aware that if they desire a right to appeal any termination of their contract pursuant to its terms, that right must be written into the contract, because it does not exist otherwise (absent egregious behavior, which was not alleged in *Clark*.)

It should be noted that *Clark* involved a contract for services and not staff privileges per se; Dr. Clark retained his staff privileges. Not addressed in this case is whether Dr. Clark's staff privileges could also have been terminated with the contract if it provided for automatic termination of staff privileges upon contract termination. It seems likely though that staff privileges could have been terminated in such a case, provided that the contract termination was proper. Also worth noting is that the Section 1983 claim which allowed Dr. Clark to sue in federal court was only available because the defendant was a public hospital. Section 1983 applies to actions of state or local government; a publicly owned hospital is considered an arm of government. Had the defendant hospital been privately owned, Section 1983 would not have applied and Dr. Clark would have been limited to his state law claims.

ERRONEOUS IRS DETERMINATION OF EMPLOYEE STATUS RESULTS IN TAX REFUND TO HOSPITAL

By: Michael J. Philbrick

A federal district court in Louisiana recently awarded a hospital a tax refund from the Internal Revenue Service ("IRS") based on the IRS's erroneous determination of the employee status of physicians providing medical director type services. *(North Louisiana Rehabilitation Center Inc. v. United States*, 88 AFTR2d Par. 2001-5589).

The plaintiff, North Louisiana Rehabilitation Center Inc. (the "Hospital"), is one of several majority owned subsidiaries of Continental Medical Systems, Inc., ("CMS") which operates freestanding for-profit rehabilitation hospitals. The Hospital contracted with various physicians to serve as medical directors and program directors. These physicians were hired to provide guidance on medical issues and the establishment of rehabilitation programs, as well as to assure the availability of medical staffing, and were treated as independent contractors by the Hospital for employment tax purposes. As such, the Hospital did not pay the employer's share of the physicians' federal employment or unemployment taxes, nor did the Hospital withhold federal income tax from their compensation.

The IRS conducted an employment tax audit on the Hospital for the tax years 1990 through 1995. Following the audit, the IRS determined that the physicians should have been treated as employees rather than independent contractors. The IRS assessed employment and unemployment taxes against the Hospital in excess of $217,000.

In response, the Hospital filed amended employment and unemployment tax returns, paid a portion of the tax that the IRS claimed was due, and filed a claim for a refund and a request for an abatement for each of the amended returns. The IRS failed to act on the Hospital's refund and abatement claim within the statutory period. As a result, the Hospital filed suit seeking a refund of the partial payment made to the IRS.

At issue is Section 530 of the Revenue Act of 1978 ("Section 530"), which shields a taxpayer who pays others for services from employment tax liability if that taxpayer has consistently treated them as other-than-employees (*e.g.*, independent contractors) unless the taxpayer had no reasonable basis for doing so. In order to avail itself of Section 530 in this matter, the Hospital must have consistently treated all similarly situated persons in the same manner (the "substantive consistency requirement"), consistently filed returns on the basis of treating the medical and program directors as independent contractors (the "reporting consistency requirement"), and must have had a reasonable basis to do so (the "reasonable basis" requirement).

Substantive Consistency Requirement

In order to qualify for protection under Section 530, an employer must establish that it has never treated any individual holding a substantially similar position as an employee for employment tax purposes. During the proceedings, the IRS acknowledged that all the medical and program directors retained by the Hospital were treated as independent contractors. Initially, however, the IRS argued that if the substantive consistency requirements were applied at the parent corporation level, the Hospital could not satisfy the requirement of substantive consistency because some of its sister corporations treated medical and program directors as employees. The IRS eventually conceded and agreed with the Hospital that the substantive consistency requirement should be applied separately for each subsidiary and not across separate, although related, entities.

The IRS next argued that a factual question existed as to whether a particular doctor, a staff physician employed by the Hospital in 1983 (the "Staff Physician"), held a substantially similar position to that of a medical director. If the Staff Physician held a position similar to that of a medical director, the Hospital could not demonstrate that it never treated any individual holding a substantially similar position as an employee.

The IRS contended that the employment of the Staff Physician created a factual question as to whether Plaintiff met the substantial consistency requirement of Section 530. According to the IRS, a medical director is responsible for the administrative and consultant oversight of rehabilitation programs and for ensuring that the programs are of high quality. These responsibilities include: (i) developing programs for patient care; (ii) ensuring that the staff doctors, nurses and therapists meet their job standards; (iii) sitting on various committees; (iv) ensuring that the hospital maintains its accreditations; (v) presenting educational programs to the staff; (vi) marketing the hospital's services to the community; (vii) developing hospital rules and by-laws; (viii) resolving disputes; and (ix) selecting new or replacement equipment. Medical directors, according to the IRS, generally spend between 35 and 40 hours per week on the specific duties of being a medical director. The IRS contended that in 1983 the Staff Physician was required to spend 40 hours per week on administrative duties which included serving on committees, assisting with patient care policies, protocols, and quality assurance programs, and consulting with administrative and medical staff on program development and quality of care.

The Hospital argued that the Staff Physician's position was not substantially similar to that of a medical or program director. The Staff Physician was retained as full-time attending physician. The Staff Physician was required to devote at least 130 hours per month to direct

clinical care and at least 40 hours per month to administrative duties. Further, the Staff Physician's schedule was determined by the Hospital and the Staff Physician could not be employed elsewhere or maintain a private practice. In contrast, the medical directors and program directors that the Hospital retains as independent contractors devote far less time to the Hospital, their role is primarily consultive and not clinical, they have their own private medical practices, and the Hospital does not dictate the means or manner of their work.

The court found that there was no genuine issue of material fact whether the Staff Physician position was substantially similar to that of a medical director. The court also found that the IRS had misstated the Staff Physician's administrative time requirements in that the Staff Physician was required to devote 40 hours per month, not per week, to administrative duties. Although the Staff Physician was required to devote a certain amount of time to various administrative duties, some of which overlapped with the duties of a medical or program director, the Staff Physician spent an average of ten hours per week on such duties as compared to the average 35 to 40 hours spent by the medical and program directors. Further, the nature of the Hospital's control over the Staff Physician's schedule and duties was wholly different from that which the Hospital exercised over the medical and program directors. The duties of a medical or program director could not be performed adequately by someone required to primarily perform clinical functions and only devote 10 hours per week to administrative duties. The nature of these differences precluded any finding that the Staff Physician held a substantially similar position to that of the current program or medical director.

Reporting Consistency Requirement

The Hospital had to establish that it filed all required tax returns on a basis consistent with its treatment of the physicians as independent contractors in order to avail itself of Section 530 protection. The IRS admitted that all such returns had been consistently filed.

The Reasonable Basis Requirement

Finally, in order to meet the requirements of Section 530, the Hospital had to establish that it had a reasonable basis for treating the physicians filling the roles of medical and program directors as independent contractors. Section 530 provides three non-exclusive statutory methods by which the taxpayer may establish a reasonable basis. Section 530 provides that a taxpayer shall be treated as having a reasonable basis for not treating an individual as an employee if the taxpayer's treatment of such individual was in reasonable reliance on (i) judicial precedent, published rulings, technical advice or a letter ruling with respect to the taxpayer from the IRS; (ii) a past IRS audit of the taxpayer in which there was no assessment attributable to the employment tax treatment of the individuals holding the same or substantially similar positions held by the instant individual; or (iii) a long-standing recognized practice of a significant segment of the industry in which the individual was engaged. The taxpayer need only show that it has one reasonable basis for treating the individual as an independent contractor in order to qualify for relief under Section 530.

Here, the Hospital asserted several reasonable bases for treating the physicians as independent contractors including: (i) that they reasonably relied on the for-profit rehabilitation industry's treatment of medical and program directors as independent contractors; (ii) that they reasonably relied on the advice of lawyers and accountants; (iii) the Hospital's reasonable treatment of the physicians as independent contractors under the traditional common law rules for classifying workers; and (iv) the Hospital's strict compliance with the prohibition on the corporate practice of medicine. The IRS, in turn, argued that the Hospital could not establish a reasonable basis for treating the physicians as independent contractors because: (i) the Hospital could not rely on generalized statements and its own practices in order to establish reliance on the for-profit rehabilitation industry's general practice; (ii) the Hospital's asserted reliance on the industry practice was not reasonable; (iii) the Hospital could not establish that it reasonably relied on the advice of lawyers and accountants; and (iv) the common law rules for classifying workers and the corporate practice of medicine doctrine do not provide a reasonable basis for treating the physicians as independent contractors.

The court, however, found that Hospital could satisfy the reasonable basis requirement by demonstrating that it had relied on the advice of legal counsel in making the decision to treat the physicians as independent contractors. Evidence presented by the Hospital demonstrated that all the contracts in question were reviewed and approved by legal counsel and personnel affiliated with CMS (the Hospital's corporate parent). CMS's management relied on the advice of both in-house and outside counsel in determining the Hospital's treatment of medical and program directors as independent contractors. According to the testimony of the CMS executives who signed the contracts on behalf of the Hospital, the CMS legal department would also consult with local counsel in order to ensure that the contracts were consistent with state law. Every contract presented had been reviewed by both in-house and outside counsel, and the signing executive completely relied on legal counsel's views and recommendations. Finally, the Hospital presented evidence that CMS's legal counsel frequently consulted with outside counsel in drafting and approving contracts between CMS's subsidiaries and their physicians. Specifically, CMS legal counsel testified that she and outside counsel discussed various IRS rulings and reviewed various common law tests in concluding that the medical and program directors clearly fell into the independent contractor category.

The court stated that the proper inquiry under Section 530 is simply whether a taxpayer's beliefs and decisions regarding his treatment of individuals as employees or independent contractors were reasonable and made in good faith. In answering that question, the court found that there were no genuine issues of material fact that the Hospital and CMS reasonably and in good faith relied on the advice of in-house and outside legal counsel in making the decision to treat the physicians as independent contractors. On that basis, the court found that the Hospital was protected by Section 530 and it granted the Hospital's motion for summary judgment and awarded the Hospital a refund of the monies it had paid to the IRS in partial payment of the taxes allegedly due.

SPEAKING ENGAGEMENTS

HMS&C Attorneys frequently are asked to speak at conferences and seminars. A calendar of upcoming speaking engagements is provided below.

Topic	***Date(s)***	***Location***	***Speaker(s)***
American Health Lawyers Association Medicare and Medicaid Institute: "Continuing Cost Based Reimbursement Issues"	April 3-5, 2002	Baltimore, MD	Chris Rossman
The Hospital and Healthsystem Association of Pennsylvania - Audio Conference on Act 13: The Medical Care Availability and Reduction of Error Act: "Insurance Options in Today's Market"	April 25, 2002	Teleconference	Julie Robertson
Marsh Healthcare Captive Forum- Hardening Healthcare Liabilities in a Softening Economy: "Captive Basics"	May 5-7, 2002	Colorado Springs, CO	Julie Robertson
American Health Lawyers Association Annual Meeting: "Federal Tax Law Update"	July 1-3, 2002	San Francisco, CA	Gerald M. Griffith

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William M. Cassetta
Zachary A. Fryer
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Ann T. Hollenbeck
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Valerie S. Rup
Julie M. Schuetze***
Margaret A. Shannon

* Licensed to practice law in Michigan and Florida, Florida board certified health law specialist.
** Licensed to practice law in Michigan and Ohio.
*** Licensed to practice law in Michigan, Washington, DC and Massachusetts.
**** Licensed to practice law in Michigan and Washington, DC.

For further information regarding any of the matters discussed in this newsletter, or a brochure that more specifically describes our practice in health care law, please feel free to contact any of the attorneys listed above at our Detroit office by calling (313) 465-7000.

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