If the practice erroneously treats a physician as an independent contractor . . . the IRS may seek to hold the practice responsible for the taxes that it should have withheld—plus interest and penalties.
We recently became aware of a non-ophthalmologist physician who had incurred many hundreds of thousands of dollars of federal employment tax liabilities, penalties, and interest and tax liens because he hired a number of physicians as independent contractors rather than as employees. Upon audit, the IRS claimed that those physicians should have been classified as employees. The IRS won that argument and, as a result, the physician was left with a large tax liability for unpaid employment taxes and many associated tax liens.

You don’t want to go there. Although less prevalent today than in the past, we still see ophthalmology practices hiring and classifying ophthalmologists as independent contractors rather than as employees. Some practices justify the independent contractor classification when the physician hired is working part time for multiple practices (although technically part-time status in and of itself does not determine a physician’s classification as an independent contractor or employee). In addition, many practices opt to classify new doctors as independent contractors solely to avoid paying high employment taxes and expensive benefit packages. Whatever the reason, it is important to understand how the difference between employee status and independent contractor status may factor into key areas of practice risk, revenues, and competitive activities.

Tax Rules
In ophthalmology practices the term “independent contractor” does not mean an employee who is obligated contractually to follow the dictates of the ophthalmology practice. Most ophthalmology practices are really seeking an associate employee. But based on erroneous or incomplete advice, the practice attempts to hire an associate physician as an independent contractor in name only—as a ruse. It’s an effort to dodge the practice’s legal responsibilities as an employer (i.e., to collect various taxes from the associate, to pay federal and state employment taxes on the associate’s compensation, and to provide employee benefits). The contract presented to the associate often states that the associate is to be called and classified as an independent contractor. However, in reality, the contract has most, if not all, of the characteristics of an employment agreement (and often reads exactly like an employment agreement that has the word “employee” changed to “contractor” and the word “employer” changed to something other than “employer”). As indicated by the case mentioned at the beginning of this article, the IRS is not taken in by such thinly disguised deception and imposes significant fines for those caught using this ruse.

Although in the past the IRS used a “20-factor test” to determine whether to classify a physician as an employee or independent contractor, the key factors in determining the difference are quite simple. First, if the hiring practice appears to be dictating the “manner and means” by which the associate performs his/her duties as a physician at the practice (e.g., hours, holidays, work days, methods of care, etc.), the IRS will consider the new doctor an employee. A second major factor is who “owns” the patients. If the contract states that the patients (and patients’ charts) remain the property of the practice, employment status is indicated. Third, if the associate is asked to sign a restrictive covenant (i.e., a non-compete clause), then the independent contractor classification is undermined.

To be honest, most independent contractor agreements we see are nothing more than a shallow attempt by the practice and/or the new doctor to hoodwink the IRS into thinking the agreement is something it is not. In my experience, with rare exception, almost all new associates hired by ophthalmology practices are in actuality being hired as employees, and therefore their contractual arrangements should be spelled out in an employment agreement and not in an independent contractor agreement.

Generally, it is best if all physicians rendering services for a medical practice corporation, professional limited liability company, or other practice entity are treated as W-2 employees rather than as independent contractors.

If the practice erroneously treats a physician as an independent contractor (and therefore does not withhold any employment taxes), and the contractor fails to pay his/her federal income or social security (FICA) taxes (and even if s/he does pay them), the IRS may seek to hold the practice responsible for the taxes that it should have withheld—plus interest and penalties.

Medicare Reassignment Rules
Basic Medicare reassignment rules specify that in a group practice billing Medicare for its physicians’ services, the physician must reassign his/her right to Medicare payments to the group. Both a W-2 physician employee and an independent contractor physician can properly assign his/her right to receive payment from Medicare to the group practice under the Medicare reassignment rules.

Medicare reassignment is generally done via a simple provision in the physician’s (employee’s or independent contractor’s) contract stating that all payments for the physician’s services are being assigned to

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the group and are the property of the group. The physician (employee or independent contractor) is enrolled as a member of the group via the appropriate CMS form.

**Stark Rules**
A W-2 physician employee of a group practice readily qualifies as a “physician in the group practice” for purposes of meeting the in-office ancillary services exception to Stark. However, it is now harder for an independent contractor physician to qualify as a “physician in the group practice” for purposes of meeting the in-office ancillary services exception to Stark.

An independent contractor physician will qualify as a “physician in the group practice” for purposes of meeting the in-office ancillary services exception to Stark only during the time the independent contractor physician is furnishing patient care services to the group practice’s patients in the group practice’s facilities. Thus, for example, if the independent contractor physician is going to order, furnish, or supervise designated health services to be billed by the group (e.g., drugs, A and B scans), then the independent contractor physician can only provide those designated health services in the practice’s facilities and not at other locations such as at a hospital, nursing home, or other out-of-office location. This regulation will prohibit an ophthalmology practice from billing for designated health services ordered by an independent contractor physician in such other locations.

In addition, under Stark, the group’s contract must be directly with the individual independent contractor physician and not with a separate legal entity such as another physician’s practice entity or a staffing company.

**Restrictive Covenant**
Yet another issue with independent contractor status is that it potentially weakens any non-compete provision in the physician’s contract with the practice. Judges are accustomed to seeing non-compete clauses in physician employment agreements and not in independent contractor agreements. It makes sense that an employer would require such a non-compete covenant by an employee physician before introducing the physician to the practice’s referrers and patients, and there is plenty of precedent for enforcing such covenants against physician employees. But judges will most certainly question a non-compete clause in an independent contractor agreement. This is because independent contractors typically render services to many clients in a geographic area and therefore it makes little sense that a bona fide independent contractor would knowingly agree to a clause that potentially restricts the contractor’s future provision of services in that area. Thus, use of the independent contractor format may raise questions in the judge’s mind as to whether the non-compete covenant is a reasonable, properly enforceable restriction.

**Careful Consideration**
Despite these issues with independent contractor status, the classification is still often used. While legally questionable in many instances, independent contractor status is convenient, particularly for part-time physicians. By treating the physician as an independent contractor, the practice avoids having to add the physician to its retirement plan and other benefit structures. The practice saves money because it does not have to pay the employer share of social security and other employment taxes because independent contractors pay 100% of the FICA taxes due on their services. And for some physicians, there is a psychological element of “independence” that is attractive (as opposed to being a “mere employee”).

Thus, practices considering independent contractor status for a physician should

- make an initial assessment, with the assistance of the practice’s attorney, whether independent contractor status is truly appropriate (remember, the tax consequences of being wrong are significant);
- assuming that independent contractor status is truly appropriate, make sure that the physician is only providing any designated health services for the practice while on the practice premises, so as to comply with Stark rules; and
- make sure that the independent contractor agreement contains a provision assigning the right to payment to the practice for all services rendered by the physician for the practice regardless of where the services are furnished. 

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