In a recent decision hailed by the insurance industry, the United States Court of Appeals for the Fifth Circuit rejected the arguments of many independent pharmacies and struck down Texas’ “any willing provider” pharmacy statute. The decision is both a setback for locally-owned pharmacies and a victory for managed care organizations. In Texas Pharmacy Association v. Prudential Insurance Co. of America, the Fifth Circuit held that health insurance plans and managed care plans cannot be required to allow a participant to use any pharmacist agreeing to accept the terms and conditions of the applicable plan. Although the ruling applies to all entities billing for physician services, the ER industry uniquely is disadvantaged by the ruling.

**Assignment of Medicare Claims**

The Medicare statute and regulations historically have provided that Medicare Part B benefits may be paid only to the beneficiary, or to the physician or other supplier (DME, physical therapy, etc.) who rendered the services, if that physician or supplier accepts “assignment” of the Medicare claim from the patient. The law prohibits the physician or supplier from reassigning that claim to a third party, however, except in limited circumstances.

The intent of the law is to prevent physicians and suppliers from factoring their claims to outside financing.

**"ANY WILLING PROVIDER" AMENDMENTS STRUCK DOWN**

In a recent decision hailed by the insurance industry, the United States Court of Appeals for the Fifth Circuit rejected the arguments of many independent pharmacies and struck down Texas’ “any willing provider” pharmacy statute. The decision is both a setback for locally-owned pharmacies and a victory for managed care organizations. In Texas Pharmacy Association v. Prudential Insurance Co. of America, the Fifth Circuit held that health insurance plans and managed care plans cannot be required to allow a participant to use any pharmacist agreeing to accept the terms and conditions of the applicable plan. The decision, which is based upon the Employee Retirement Income Security Act of 1974 ("ERISA"), is another example of the sweeping impact of federal law in the fast changing health care community.

The case involved a challenge to 1995 amendments to the “any willing provider” statute enacted to protect pharmacies in Texas. The Texas Pharmacy Association filed the lawsuit to force Prudential Insurance Company to comply with the statutory mandate. Specifically, the Association contended that Prudential’s practice of limiting payments under its managed care and insurance plans to participating providers violated the amended “any willing provider” statute. Prudential argued that the law was preempted by ERISA because the statute applied to employees of ER management companies or medical groups billing for services provided by physicians unless those physicians are bona fide employees of the medical group. While HCFA claims its interpretation is consistent with the statute and regulations and is merely a clarification of its existing policies, it actually represents a radical departure from past practice across the country. The ruling applies to all entities billing for physician services, the ER industry uniquely is disadvantaged by the ruling.

When a physician accepts assignment of a Medicare beneficiary’s claim, he may reassign that claim only under certain circumstances.

(please see “HCFA Tightens Restrictions” on pg. 6)
As the healthcare industry has consolidated and become increasingly sophisticated, the past decade has witnessed an increasingly competitive business environment for providers of all types, marked by the introduction of myriad new products and businesses into the marketplace. Hospitals form integrated delivery systems and offer insurance “products;” physicians form IPAs to attract managed care business. As a result, companies spend vast amounts of time and money promoting their goods and services to potential customers.

A critical element of companies’ promotional programs is to develop consumer recognition through the creation of “tag lines,” logos, and product and business names – otherwise known as trademarks and service marks. Due to the proliferation of such marks, it has become more important than ever for companies to be extremely vigilant and diligent about protecting their trademarks and service marks. To be sure, this intellectual property may become a company’s most valuable asset, worth more than the company’s real estate, plant, and equipment combined.

Generally, trademarks and service marks are any words, symbols, or devices that serve to identify the goods or services of one company and to distinguish them – in the minds of consumers and the general public – from goods or services provided by others. In addition to identifying the source of goods or services, trademarks provide quality assurance to potential purchasers. Almost anything capable of indicating source may serve as a trademark. For example, names, logos, letters, numbers, combinations of colors, and even sounds have been registered as trademarks.

To ensure that its various names and logos are adequately protected, a company should develop a game plan for identifying and protecting them. This plan should include the pursuit of state or federal registrations of the company’s various trademarks or service marks, as well as the protection of these marks from other companies’ uses of confusingly similar marks.

Before adopting and using a product name, logo, “tag line,” or even a new company name, a company should conduct trademark searches – as distinguished from corporate name searches with the various states’ secretaries of state – to help eliminate names, marks, or slogans that are not available for use because another company or person has obtained prior rights to such marks or to confusingly similar marks. Using such trademark searches during the selection process allows a company to verify the availability (or unavailability) of a mark at an early stage, often times saving the company from expending resources developing, marketing (or even defending) the use of a trademark that may be confusingly similar to one owned by another company.

Whether one is a specialty IPA that plans only to operate in one county, or a medical equipment manufacturer interested in a national market, a company interested in trademark registration has various options. Where a mark is used only within a particular state, a company may wish to consider applying for a state trademark registration. This route, less expensive and less time-consuming than the federal registration process, provides the registrant with statewide protection of its mark. A state registration constitutes prima facie evidence of the registrant’s exclusive right to use the mark in that state in connection with the goods or services identified in the registration certificate.

Companies engaged in or even contemplating business in more than one state, however, would benefit from the broader protection of federal registration. Federal registration is available both for marks that are already in use and for those which a company has a bona fide intent to use in the near future. There are significant advantages available to trademark owners who register a mark under federal law. The benefits of registration on the “Principal Register” of the United States Patent and Trademark Office include the following: (1) the registration confers prima facie evidence of the validity of the registered mark; (please see “An Ounce of Prevention” on pg. 4)
In a dramatic departure from existing law, the San Antonio Court of Appeals recently ruled that hospitals are now vicariously liable for the negligence of their emergency room physicians, greatly broadening the liability exposure of hospitals. In *Sampson v. Baptist Memorial Hosp. Sys.*, 940 SW2d 128 (Tex. App.—San Antonio 1996), the court of appeals disregarded the general rule in Texas that hospitals are not liable for the negligence of a physician who is an independent contractor. Instead, the court imposed a new nondelegable duty upon hospitals for the negligence of emergency room physicians. According to the court’s opinion, hospitals are now vicariously liable for the negligence of independent physicians, despite the fact that hospitals post signs in their emergency rooms and require patients to sign consent forms, both of which indicate the physician’s status as independent contractor as opposed to an employee.

In reaching its conclusion, the majority noted it was taking a great “leap” and realized its decision might lead to undesirable and unintended economic ramifications, including the closure of emergency rooms. Despite these serious concerns, the court concluded that:

At a time when hospitals are engaged in sophisticated managed care structuring and advertising in an effort to induce patients and insurance companies to use their services, we contend that hospitals must accept the responsibility that attaches to the services it undertakes (sic) to generate revenues. . . . [This result] is dictated by the simple fact that an injured party must rely on a hospital’s emergency room because there is no other place to go.

*Sampson* involved a patient who was taken to the emergency room at Southeast Baptist Hospital, an affiliate of the defendant Baptist Memorial Hospital System (“BMHS”), for treatment of an unidentified insect bite. Signs were displayed in the emergency room that stated that the physicians were independent contractors. Additionally, prior to receiving treatment, the patient signed a consent form that explained in elaborate detail the physician’s status as an independent contractor. After signing the consent form, the patient was treated and released. One to two days later, the patient returned to the hospital by ambulance and was treated by a second doctor and then released. Fourteen hours after her second visit, the patient was taken to a different hospital, was diagnosed as having been bitten by a toxic brown recluse spider, and was placed in intensive care for treatment of septic shock.

The plaintiff sued BMHS, claiming that BMHS was vicariously liable for the negligence of the second physician because he was an employee or, in the alternative, an ostensible agent of BMHS. The trial court granted summary judgment for BMHS on the vicarious liability and negligent treatment claims, and the plaintiff appealed. The San Antonio Court of Appeals reversed and remanded the case.

**Apparent Agency Doctrine**

Rather than applying the law of *ostensible agency* that has been the rule in Texas since 1986, the court utilized the concept of *apparent agency* in reaching its decision.

The court determined that the plaintiff had provided sufficient evidence to raise an issue of fact regarding the first element of apparent agency by providing an affidavit in which the plaintiff affirmatively stated that she went to the hospital for treatment and did not request a specific physician. After being treated and released, the patient went to a different hospital, was diagnosed as having been bitten by a brown recluse spider, and was placed in intensive care for treatment of septic shock.

The court concluded that the plaintiff was justified in relying upon the representation of authority by the hospital because she had a reasonable belief in the physician’s authority to provide treatment. The court further noted that the plaintiff was justified in relying upon the hospital’s reputation for providing quality care.

The court also noted that the plaintiff had provided evidence that the hospital’s emergency room was the only place where she could receive treatment for her injury. The court concluded that the plaintiff had provided sufficient evidence to raise an issue of fact regarding the second element of apparent agency, that the hospital “held out” the physician as its employee.

The court concluded that the plaintiff had provided sufficient evidence to raise an issue of fact regarding the second element of apparent agency, that the hospital “held out” the physician as its employee.

The court also noted that the plaintiff had provided evidence that the hospital’s emergency room was the only place where she could receive treatment for her injury. The court concluded that the plaintiff had provided sufficient evidence to raise an issue of fact regarding the second element of apparent agency, that the hospital “held out” the physician as its employee.

(please see “Texas Court Expands Liability” on pg. 8)
CORRECTION OF ERRORS IN TAX QUALIFIED RETIREMENT PLANS
NEW IRS RULES BRING COMMON SENSE TO THE TABLE

With each passing session of Congress and regulatory enactments, the rules for tax qualification of retirement plans grow more and more complex. Physician groups and other employers risk plan disqualification and related disastrous tax consequences for even the most minor of operational errors in tax-qualified retirement plans.

In a significant step in the direction of common sense and rationality, however, the Internal Revenue Service recently issued a field directive relating to the correction of errors in tax-qualified retirement plans. The field directive does not replace the current alphabet soup of correction programs (including VCR, CAP, APRS, and SVCR); however, the field directive will be effective to avoid the more complex correction procedures.

The field directive was issued in January 1997 as an advisory to IRS auditors who examine tax-qualified retirement plans. The directive, technically known as the Administrative Policy Regarding Self Correction (APRSC) (more alphabet soup), applies to all tax-qualified retirement plans, including defined benefit plans, profit sharing plans, money purchase pension plans, 401(k) plans, and 403(b) annuities.

In general, the APRSC allows plan sponsors to correct operational errors that occur in the administration of their retirement plans without risking disqualification of the plan and without involving the IRS in the correction process. An operational error occurs as a result of failure to follow the technical requirements of the governing plan documents. Issuance of the APRSC indicates a recognition on the part of the IRS that the tax-qualification laws and regulations are so complex that it is virtually impossible to maintain a retirement plan without inadvertently triggering some operational violations from time to time.

The APRSC categorizes operational violations into two types, referred to simply enough as significant and insignificant. The classification of a violation as significant or insignificant is to be determined based upon an evaluation of the specific facts and circumstances. A significant violation must be corrected by the end of the year following the year in which the error occurred. Insignificant error may be corrected at any time. In general, correction involves placing the plan into the same position that it would have held if the error had not occurred.

To be eligible for APRSC, a plan must have a current determination letter from the Internal Revenue Service (which should not be much of a challenge for most plans). In addition, the plan sponsor must have practices and procedures in place that are reasonably designed to promote and facilitate overall compliance with the tax qualification requirements. Although not technically required, it is advisable that the practices and procedures be contained in a plan compliance policy that is adopted and applied by plan sponsors.

Questions about plan errors and corrections can be directed to Eric Hulett or Jim Griffin in Dallas. While the risk of errors can’t be eliminated, the APRSC brings rationality to dealing with the correction of errors that are inevitable in this complex legal environment.

Wm. Eric Hulett

AN OUNCE OF PREVENTION (CONT’D FROM PG. 2)

(2) after five years of continuous use, the registration may become “incontestable,” thereby foreclosing most challenges to the validity of the mark; (3) the registration is constructive notice of the registrant’s ownership, dating back to the filing of the application, cutting off later claims of good faith use in territories remote from the registrant’s use; and (4) the registration will be cited as a bar to later applications filed by others to register similar marks. A federal registration also entitles the owner to use the official “®” notice of federal registration with the mark. While it is possible to register trademarks in each of the fifty states of the United States, it is generally unnecessary unless a company desires an additional level of protection in one or more states where the company’s principal activities are concentrated, or if litigation over a mark is imminent.

Please call Frank Vecella, Carl Butzer, or Cami Dawson Boyd in Dallas if you would like further information or assistance concerning the development of a strategy to protect trademarks or other intellectual property such as copyrights, patents, and trade secrets.

Cami Dawson Boyd
The Health Care Financing Administration (HCFA), seeking to be physician-friendly, nevertheless has once again muddied the waters of reimbursement for services provided by a physician’s leased employees. Contrary to the diagnosis of several writers, however, HCFA’s action may have little practical effect for the physician.

Last October, HCFA amended its “incident to” rule, which permits Medicare reimbursement for services rendered by an employee of a physician that are incident to the physician’s professional services. The rule prohibited reimbursement when services were performed by a physician’s “leased employee,” typically a worker who is an employee of a management service organization (MSO) or a PPM entity but who works under the supervision of a physician pursuant to a management agreement between the MSO or PPM and the physician. A leased employee is not the employee of the supervising physician who leases him, and thus, technically, his services were outside the scope of the “incident to” rule.

Some physicians simply ignored HCFA’s rule and submitted Medicare claims for leased employee services. Other physicians worried, however, that such a practice could produce, at a minimum, a liability to repay amounts received from HCFA on such claims. Moreover, the growing phenomenon of leased employees in the healthcare industry magnified the potential problem to one of immense proportions.

To address these concerns, HCFA amended its Carriers Manual to treat a person as an employee of a supervising physician if the person is a part-time, full-time, or leased employee of the physician. The rule prohibited reimbursement when services were performed by a physician’s “leased employee,” typically a worker who is an employee of a management service organization (MSO) or a PPM entity but who works under the supervision of a physician pursuant to a management agreement between the MSO or PPM and the physician. A leased employee is not the employee of the supervising physician who leases him, and thus, technically, his services were outside the scope of the “incident to” rule.

... an individual clearly cannot be both the common law employee and the leased employee of one person.

Some physicians simply ignored HCFA’s rule and submitted Medicare claims for leased employee services. Other physicians worried, however, that such a practice could produce, at a minimum, a liability to repay amounts received from HCFA on such claims. Moreover, the growing phenomenon of leased employees in the healthcare industry magnified the potential problem to one of immense proportions.

To address these concerns, HCFA amended its Carriers Manual to treat a person as an employee of a supervising physician if the person is a part-time, full-time, or leased employee of the physician. Had HCFA stopped there, no further question would exist. HCFA also defined “leased employee,” however, as a nonphysician working under a written employment agreement that ensures that the physician exercises control over all actions of the leased employee with regard to the rendering of medical services; the definition provided, further, that the nonphysician “must be considered an employee of the supervising physician ... under the common law test ... as specified in the Social Security Act.” (Emphasis added.)

The healthcare press immediately sounded an alarm, suggesting that the Carriers Manual revision had introduced an irreconcilable conflict into its definition of “leased employee.” By definition (at least for federal income and employment tax purposes), a leased employee is the common law employee of one person (the MSO) – the party that withholds and pays federal income and employment taxes – and the leased employee of another person (the physician). Under this approach, an individual clearly cannot be both the common law employee and the leased employee of one person. Yet, in its Carriers Manual revision, by defining “leased employee” as entailing a common law element, HCFA arguably has made it impossible for a leased employee to satisfy the “incident to” rule.

It is possible, however, to apply the manual in a manner that resolves this inconsistency. If one limits the common law employee test to the activities of the employee while he is rendering medical services, the employee may in fact possess the requisite relationship with the supervising physician. The common law test for an employer-employee relationship inquires whether an employer has the right to direct and control a worker’s performance of his duties. When an MSO leases an employee to a physician, the MSO has the right to direct and control the employee in general aspects of the employment, such as the particular physician to whom the employee is leased. The physician, on the other hand, has the right to direct and control the employee in the day-to-day performance of medical services. In that limited sense, therefore, the employee may be the “common law employee” of the physician.

Time may tell whether HCFA focuses upon the medical services aspect of a worker’s activities in determining leased employee status, as suggested above. HCFA representatives have indicated that a worker’s status for federal tax law purposes is not of primary importance to the agency, suggesting that one should not import the tax law distinction between common law and leased employees into the Carriers Manual.

From a practical standpoint, this issue should not trouble a physician who uses leased employees in his medical practice. HCFA’s expressed intent in adopting the manual change was to eliminate the concern about obtaining reimbursement for leased employees’ services. It seems unlikely, therefore, that HCFA would apply its amended rule in a manner that would deny reimbursement for such services merely because the worker is not a “common law employee” of the physician according to traditional tax law principles.

Ann E. Ward
Any Willing Provider (cont’d from pg. 1)

Employee benefit plans and was not saved from federal preemption under the guise of insurance regulation. In this regard, ERISA preempts all state laws that relate to employee benefit plans except state laws that regulate the business of insurance.

The Texas “any willing provider” statute, originally enacted in 1991, provided that health insurance policies must allow insureds to use any willing pharmaceutical provider. The 1995 amendments extended the statute to any managed care plan and declared void any plan provision in conflict with the law. The 1995 statutory amendments defined a “managed care plan” as a health maintenance organization, a preferred-provider organization, or another organization that, under a contract or other agreement entered into with a participant in the plan, provides health care benefits. Notably, the law specifically excluded self-insured employee benefit plans subject to the provisions of ERISA.

In reaching its preemption decision, the court analyzed ERISA’s broad preemptive effect and the narrow limitations that apply to ERISA preemption. The court determined that the 1995 amendments related to ERISA employee benefit plans and, therefore, the amendments were subject to preemption. The court then concluded that the 1995 amendments were not saved from ERISA preemption as a law regulating the business of insurance. In reaching that conclusion, the court found that the 1995 amendments did not apply solely to entities in the insurance industry. In a secondary ruling, the court upheld the pre-amendment “any willing provider” statute that regulated only insurance policies issued in Texas. Because the 1995 amendments are not enforceable, most insurance policies in Texas are no longer subject to “any willing provider” restrictions for pharmacy services.

As a result of the court’s decision and a previous decision rejecting Louisiana’s “any willing provider” statute, employee benefit plans subject to ERISA are relatively unencumbered in structuring preferred provider arrangements and similar provider agreements. In the future, the enforceability of “any willing provider” statutes will depend upon whether the statute in question regulates insurance policies specifically or whether the statute regulates employee benefit plans generally. The distinction is narrow but determinative. Based upon the court’s ruling, it appears that the former type of statute would likely survive judicial scrutiny while the latter would be invalidated. Providers of pharmacy and medical services must exercise caution in relying upon the enforceability of “any willing provider” statutes. The court’s decision likely will strengthen the bargaining position of managed care companies by nullifying protective state laws.

Wm. Eric Hulett

HCFA Tightens Restrictions (cont’d from pg. 1)

companies that would seek to be paid directly by Medicare. Medicare and Medicaid’s experience in the early years of those programs was that such factoring agreements often led to inflated and inaccurate claims for reimbursement by the financing entity. As the House Report containing the legislation at the time concluded:

Such reassignments have been a source of incorrect and inflated claims for services, and have created administrative problems with respect to determination of reasonable charges and recovery of overpayments. H. Rep. No. 92–231 at 104 (1971).

When a physician accepts assignment of a Medicare beneficiary’s claim, he may reassign that claim under only limited circumstances. For example: (1) the physician may reassign the claim to his employer, when required to do so as a condition of his employment, (2) payment may be made to the hospital, clinic or other facility where the services were rendered if there is a contractual arrangement between the physician and the facility under which the facility submits the bill for the services, (3) payments may be assigned to the primary physician under a locum tenens or reciprocal billing arrangement with a covering physician, or (4) payment may be made to an organized health care delivery system, if there is a contractual arrangement.
HCFA Tightens Restrictions (cont’d from pg. 6)

arrangement between the system and the physician under which the system bills for the physician’s services.

The current dispute involves the exception for the assignment of claims to an employer, as well as the exception for services furnished by a health care delivery system. Most medical groups typically employ their physicians, but they also frequently enter into independent contractor arrangements with certain physicians rendering services to the group. In the emergency room services industry, for example, an independent contractor relationship is the predominant arrangement. HCFA and its carriers historically have allowed such groups to bill Medicare directly for the services of the independent contractor physicians on behalf of the medical group with which those physicians were aligned. Payments were made in the group’s name and deposited into the group’s account, and the group compensated the contracting physician in accordance with the existing agreements of those parties.

The exception for payments made to a health care delivery system allows direct payments to a clinic or medical group as long as the services are furnished in a facility that the medical group owns or leases. Medicare Carriers Manual, § 3060.3C. Virtually all medical groups own or lease the premises in which they furnish services, but for some provider-based physicians such as emergency room physicians, radiologists, and anesthesiologists, the “own or lease” requirement normally cannot be met. Such provider-based medical groups must rely upon the employer test.

New Policy

Under its new strict interpretation of the law, HCFA requires a W-2 employment relationship for the group or management company to bill for the doctor’s services. The new policy would require medical groups and management companies billing on behalf of such provider-based physicians to chose one of two alternatives:

(a) The medical group could directly employ all of its physicians as bona fide W-2 employees, which would allow the group or the management company to bill directly in the name of the medical group for the services of all such physicians; or

(b) The group or management company could bill directly in the names of the independent contractor physicians who rendered the care, as long as the billing arrangement complied with Section 3060 of the Carriers Manual, which carefully regulates how such a billing agent may bill and collect on behalf of the physician.

Medical groups and management companies have many legitimate business reasons to wish to contract with physicians as independent contractors. Faced with a threat to their primary method of operations, the emergency room industry appealed the HCFA interpretation to the top levels in the agency. After months of meetings and exchanges of information, the industry recently received a letter from Administrator Bruce Vladek confirming HCFA’s interpretation and urging the ER management companies to come into compliance with the law.

... all medical groups who do not own or lease the premises in which they furnish patient care services (not just those in the emergency room industry), should be aware that for Medicare patients, they may bill only in the name of the group for the services of physicians who are bona fide W-2 employees of the medical group.

Provider-Based Medical Groups May Bill Only for Employees’ Services

As a result of the new interpretation, all medical groups who do not own or lease the premises in which they furnish patient care services (not just those in the emergency room industry), should be aware that for Medicare patients, they may bill only in the name of the group for the services of physicians who are bona fide W-2 employees of the medical group. For those physicians with whom the medical group has an independent contractor relationship, the group may not file such claims with Medicare under the group’s provider number but may bill on behalf of the physician and collect on behalf of the physician. Once the group collects the payments on behalf of the independent contractor physician, the group of course can distribute those funds as previously agreed between the physician and the medical group. For Medicare purposes, however, the payment may be made only to and in the name of the independent contractor physician actually rendering the services.

Jed Morrison
Regarding the second element, the court again concluded that the patient had provided sufficient evidence to raise an issue of fact regarding whether the hospital “held out” the physician as its employee. BMHS argued that by posting signs in the emergency room and having the patient sign the consent forms, any inference that the physician was being held out as BMHS’s employee would be unreasonable. The court, on the other hand, determined the plaintiff’s affidavit raised a question of fact regarding whether the signs were sufficient notice because the defendant presented no evidence pertaining to the number or conspicuousness of the signs. Additionally, because the plaintiff claimed she did not recall seeing the consent form or signing it, the court determined a question of fact existed regarding whether the plaintiff was in a position to understand the terms of the consent form.

In an even greater departure, the court then “felt compelled to take its analysis one step further.” Rather than applying the existing law of ostensible agency, the court determined that the written notice provided in consent forms and posted in emergency rooms is not sufficient to negate a hospital’s holding out of the emergency room physicians as employees, given the circumstances in which patients seek emergency medical treatment. Based upon public policy, therefore, the court determined that hospitals will now be liable for malpractice that occurs in their emergency rooms.

While the majority significantly departed from Texas law generally applicable in these situations, Justice Duncan strongly dissented. She argued that the court had no authority for applying the concept of apparent agency to the facts because (1) apparent agency was not pleaded, briefed, or argued by either party, (2) apparent agency does not reflect Texas law, and (3) the concept is inconsistent with Texas law regarding independent contractors. Justice Duncan further argued that BMHS took every step, short of closing its emergency room, not to hold out the physicians as its employees. On the basis of ostensible agency, and not public policy, Justice Duncan would have affirmed the grant of the defendant’s motion for summary judgment.

The hospital has filed a notice of intent to appeal to the Texas Supreme Court. In the meantime, while the San Antonio court’s decision is not binding throughout the state, it should serve as a warning to Texas hospitals. Should this decision become state-wide law, hospitals may no longer be able to escape liability for the negligence of their emergency room physicians by posting signs and having patients sign consent forms. A hospital may be able to insulate itself better from the potential effects of this decision by placing multiple and conspicuous signs in its emergency room and by explaining the independent contractor relationship in advertising materials so that potential emergency room patients may become aware of that relationship prior to any treatment.

Jennifer Shufelt

...[the dissent] argued that BMHS took every step, short of closing its emergency room, not to hold out the physicians as its employees.

© 1997 Jackson Walker L.L.P.