KAMENSKY RUBINSTEIN HOCHMAN & DELOTT, LLP

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TAX: NEW TAX BURDEN ON PARTNERSHIPS

Proposed regulations issued by the IRS place new burdens on partnerships and entities that are taxed as partnerships (such as limited liability companies) that grant interests to their employees or contractors.

Under current tax law, when a partnership interest is granted as compensation for services, its treatment for tax purposes depends upon whether the partnership interest is characterized as a "profits interest" or a "capital interest". A "profits interest" is an interest which allows the partner to receive a share of the future profits of the company, but no interest in any of the assets of the company. Under current law, a partnership may grant a "profits" interest to an employee or a contractor as compensation for services, without income tax consequence to the partnership, employee or contractor if:

a) The employee or contractor does not sell the interest within two years;
b) The interest does not relate to a substantially certain and predictable stream of income from the company's assets; and
c) The profits interest is not a limited partnership in a publicly treated partnership.

If an employee or contractor receives a "capital interest" as compensation for services, the employee or contractor is treated as having received compensation equal to the value of that interest, less the amount, if any, paid for the interest. A "capital interest" is commonly understood to mean an interest that would allow the owner of the interest to receive a share of the partnership's assets if the partnership was liquidated immediately after the receipt of the interest.

Under the proposed IRS regulations, the receipt of a profits interest would be treated in the same manner as the receipt of a capital interest. This means that the receipt of a profits interest by an employer or contractor will be considered the receipt of compensation equal to the excess of the fair market value of the interest over the amount paid for it. This approach would require a profits interest to be valued and taken into account as income as of the date it is granted or, if later, the date the interest becomes substantially vested. If an interest is not substantially vested for any reason, the employee or contractor may elect to value the interest as of the date of receipt and take it into account as income at that time. This might occur if an employee or contractor believes the interest is going to increase in value by the time it becomes substantially vested.

Employers who grant a profits interest under the proposed regulations will have to make sure that: (a) the profits interest is properly valued; (b) the proper amounts are withheld from the wages of the recipients to cover income tax withholding and payroll taxes for the appropriate year; and (c) the grant of interest is timely reported to the IRS.

To ease the burden of valuing an interest, the proposed regulations do allow for a partnership to make a "Special Valuation Election." If this election is made, the fair market value of an interest is deemed to be the amount of cash a contractor would receive if, immediately after the transfer of the partnership interest, the partnership sold all of its assets solely for cash for fair market value and then liquidated. This approach offers certainty to the parties involved that the grant of a profits interest will have zero value. If no election is made, the parties need to prove the profits interest had no value. Unfortunately, not all interests qualify for the Special Valuation Election, which applies only to compensatory grants of so-called "Safe Harbor Partnership Interests." In many circumstances, the "Safe Harbor Partnership Interest" election may not be available or the best choice. In addition, partners who have a written Buy-Sell Agreement are not able to take advantage of the safe harbor election. This may be either positive or negative for the partners.

Partnerships that contemplate granting interests to employees or contractors need to carefully consider the impact the proposed regulations will have on both parties and whether the making of a Special Valuation Election is in their best interest. If you have any questions regarding this proposed regulation, please contact John Waters of our office.

INFORMATION & ARTICLES IN THIS ISSUE SUBMITTED BY:
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NEWSLETTER COORDINATORS:
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KRHD NOTES

Congratulations to the firm's Super Lawyers elected in 2006: Michael Erens, Marvin Kamensky, Sherwin Rubinstein and Miles Zaremski.

Michael Erens gave a lecture on June 13, 2006 for the Illinois Association of Healthcare Attorneys on the topic of "Managing Problem Physicians."

Philip L. Pomerance has been elected for a second 3 year term as a Director of the American Health Lawyers Association. Mr. Pomerance lectured at the University of Texas School of Law in Austin, TX on July 20, 2006 on the topic of "Multijurisditional Practice: Crossing Borders Without Breaking Eithical Boundaries."

Sherwin Rubinstein will be speaking at the Illinois Association of Healthcare Attorneys' Annual Symposium on October 4, 2006 on the topic of "Tax Issues in Healthcare Transactions"; Mr. Rubinstein has been designated as a "Leading Lawyer" for 2006.

Miles Zaremski has been appointed an Adjunct Professor of Law at the Case School of Law; Mr. Zaremski has been invited by the Scientific Committee of the World Association on Medical Law ("WAML") to chair and speak at a workshop on medical confidentiality at this Summer's meeting of the WAML in Toulouse, France in August, 2006.

***EMPLOYEE BENEFITS*: INCREASE IN FDIC COVERAGE FOR RETIREMENT ACCOUNTS**

Effective April 1, 2006, the FDIC insurance limits increased from $100,000 to $250,000 for certain retirement accounts maintained at banks and savings associations insured by the FDIC and at credit unions insured by the National Credit Union Administration. These higher insurance limits applies to traditional and Roth IRAs, "457 plan" accounts for state government employees and defined contribution pension and profit-sharing plans which permit participants to direct the investment of their accounts. The insurance coverage for non-retirement accounts, which remains unchanged at $100,000 is separate from the insurance coverage provided for retirement accounts.

Depositors do not have to take any action to be covered by the higher limit on retirement accounts. However, the retirement account must be invested in a deposit account, such as a certificate of deposit. The FDIC insurance does not cover mutual funds, securities, or annuities which are purchased through a bank.

There are a number of rules which make it possible to increase the amount of FDIC coverage for multiple accounts at the same institution. An individual's portion of an account owned jointly with someone else, such as a spouse, is separately insured up to $100,000. A participant's share of his employer's pension/profit-sharing plan (which does not qualify for coverage up to the $250,000 limit as a retirement account because self-directed investments are not permitted) is also separately insured for $100,000 so long as the details of the participant's beneficial interest in the account are ascertainable from the institution's records or from the records of the plan. Applying these rules, a husband and wife could have the following FDIC insurance coverage for multiple accounts at the same institution:

- Each could have an IRA insured for up to $250,000;
- Each could have an individual account insured for up to $100,000;
- They could have a joint account insured for up to $200,000; and
- Each could have an account under their employer's profit-sharing plan (for which they are not permitted to direct the investment) insured for up to $100,000.

Under the assumptions in this example, the total FDIC insurance coverage available for these account is $1,100,000.

If you are interested in more information about FDIC insurance coverage, visit the FDIC website at *www.fdic.gov*.

***HEALTHCARE*: ARE YOU READY FOR AN UNANNOUNCED JCAHO REVIEW?**

The Joint Commission on Accreditation of Health Care Organizations ("JCAHO") has announced that it is implementing a new policy of unannounced on-site accreditation surveys and certification reviews. The intent of this new policy is to require organizations to be in compliance at all times. Making on-site evaluations less predictable and more focused on potential performance issues is intended to satisfy both the public demand for greater organization accountability and organizations' demands for greater value from undergoing outside evaluations by an accrediting body such as JCAHO.

Between 2006 and 2008, an unannounced survey will be done on every organization in the year in which the organization is due for its next survey. Thereafter, surveys will take place 18 to 39 months following the organization's previous unannounced visit.

***HEALTHCARE*: CMS PROJECTS 4.6% REDUCTION IN MEDICARE PHYSICIAN PAYMENT RATES FOR 2007**

Providers should be aware that a 4.6% decrease in the Physician Fee Schedule for 2007 is anticipated. This reduction is apparently driven by the increase in Medicare spending for physician services, which grew by 8.5% during 2005 due to the growth, volume and intensity of physician services. Data for 2005 shows the largest growth is attributable to evaluation and management (E&M) services (31%); procedures such as physical therapy, podiatry and dermatology (29%); imaging services (27%); and laboratory and other tests (15%).

The AMA has indicated that the 2007 Medicare payment cut of 4.6% is just the tip of the iceberg, with CMS projecting cuts totaling 34% over the next 9 years. With practice costs on the rise, the AMA has predicted that physicians will have no choice but to cut back on Medicare patients they see.

For ideas on what your practice can do to increase its income and offset looming Medicare reimbursement reductions, please contact the Firm's Health Law Department.

HEALTHCARE: NEW CMS REGULATIONS FOR FILING 855 FORMS

On June 20, 2006, the new CMS enrollment policy for health care providers and suppliers will go into effect. The policy will involve new enrollment requirements as well as procedures for updating and revalidating enrollment information. All providers and suppliers, including those who have never completed a CMS-855 form, will be required to revalidate their information in the coming years. CMS believes that its new policies will ensure that the Medicare program has adequate information on providers and suppliers who bill the program. Existing providers are not required to take any action until requested to do so by CMS.

The new policy provisions include the following:

- All those who have never submitted a CMS-855 form are required to do so. For example, providers who have participated in Medicare prior to 1996 will not have an 855 on file. CMS will notify providers who are required to make this initial filing;
- Once enrollment is complete, revalidations must be submitted every 5 years. Medicare contractors will notify providers when their 5-year cycle starts, beginning with those who have never submitted a completed 855 form. Once contacted, a provider has 60 days to submit the completed form with supporting documentation. CMS will require a limited number of revalidations in FY 2006 and 2007, with increasing numbers after these dates. Providers must comply with the new policies when submitting these forms in order to obtain and maintain Medicare billing privileges;
- If there are no changes at time of revalidation, the provider may simply sign, date and return the form;
- Providers MUST report any changes in previously submitted information (such as ownership, practice location and billing service changes) and provide supporting documentation within 90 calendar days after the change. Failure to do so may result in revocation of billing privileges or deactivation. Because revalidation is required every 5 years, it will be easy for CMS to determine when there has been a failure to update information;
- When a provider relocates and the carrier changes, the entire 855 must be re-submitted;
- If a provider does not submit complete documentation within 60 days after submission of an application or a request from CMS for missing information, rejection may occur. This decision may not be appealed. A new application must be submitted to re-apply;
- Enrollment may be denied for noncompliance with enrollment requirements;
- CMS may revoke a currently enrolled provider's billing privileges for the same reasons that may justify denial of enrollment;
- Billing privileges may be deactivated if the provider does not submit claims for 12 consecutive months; and
- During a change of ownership, both the current owner and the new owner must complete and submit an enrollment application within 30 days after the transaction. If the current owner fails to do so, it may be penalized, even after the date of ownership change.
- If the prospective new owner fails to submit a new application containing information on the new owner within 30 days after the transaction, CMS may inactivate the billing number.

Online filing will not be in place until sometime in 2007, and for the present applications must be mailed to the carrier. It is estimated that applications will take 60 days to process. If you have any questions regarding new policy provisions or about completing the required enrollment forms, please contact one of KRHD's health care attorneys.

LITIGATION: HOW TO RESPOND TO A COURT ORDER OR SUBPOENA FOR PATIENT MEDICAL RECORDS

Under the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule, providers and lawyers must be cautious when responding to requests for protected health information ("PHI").

In general, covered entities are prohibited from using or disclosing PHI without written authorization from the patient except for treatment, payment or health care operations. Even when disclosure is allow under HIPAA, only the "minimum necessary" information to accomplish the purpose of the use, disclosure or request is permitted. The exception to this general rule is the disclosure permitted by a covered entity in response to: (a) a subpoena, discovery request or court order; or (b) an order of a court or administrative tribunal. Compliance with these two requests, however, is very different.

HIPAA allows a covered entity to disclose PHI in the course of any traditional or administrative proceeding in response to an order of the court or administrative tribunal provided that only the PHI expressly authorized by such order is disclosed. This means a court order signed by a judge who directs a provider to release an individual's medical information specified in a court order signed by a judge even without patient authorization. However, the covered entity can disclose only the PHI expressly authorized in the court order and no more.

When a request for PHI comes in the form of a subpoena or discovery request, the covered entity can legally release the PHI only if:

1. It receives satisfactory assurances from the party seeking the information that reasonable efforts have been made to ensure the patient has been given notice of the request; or
2. It receives satisfactory assurances from the party seeking the information that reasonable efforts have been made to secure a qualified protective order.

In the event a covered entity does not receive satisfactory assurances from the party seeking the information, the covered entity can make reasonable efforts to provide written notice to the patient itself or seek a qualified protective order from the court.

Any covered entity that receives a subpoena, discovery request or other lawful process requesting PHI must evaluate whether the legal standards described above have been satisfied. Please contact us if you receive any subpoena, discovery request or other demand for PHI so that we can properly advise you and your practice on how to proceed.

HEALTHCARE: ATTENTION: ALL PROVIDERS WHO OWN OR LEASE THE USE OF AN IMAGING FACILITY

We have recently learned that the office of the Attorney General of Illinois has commenced an investigation into business relationships between physicians and medical imaging centers by issuing a number of subpoenas to certain imaging centers and physician groups with lease agreements with imaging groups. These subpoenas have been issued pursuant to investigative powers provided under the Illinois Consumer Fraud and Deceptive Business Practices Act.

At this time, the subpoenas are for records and testimony and generally request information relating to relationships between the imaging facilities and physician groups that have lease arrangements with the imaging facilities. Although this investigation has just begun it seems clear to us that the Attorney General believes that there may be improper inducements either requested by or offered to physicians to refer patients to certain facilities.

What To Do If You Receive A Subpoena:

It is our suggestion that if you receive one of these subpoenas or a related inquiry, you immediately contact us for legal advice. Under no circumstance should you voluntarily discuss lease arrangements or other financial arrangements with any investigator. In no event should you hide or destroy any records that may be subject to such a subpoena. Please do not hesitate to contact us if you have any questions.

HEALTHCARE: OIG PROMOTES PROVIDER SELF-DISCLOSURE PROTOCOL INITIATIVE

The head of the Office of the Inspector General ("OIG") recently announced a new initiative to promote the use of Provider Self-Disclosure Protocols ("SDP") to mitigate civil monetary penalty ("CMP") liability in cases where a provider has violated either the federal self-referral or anti-kickback statute. The OIG has the authority to impose penalties of up to $15,000 for each service billed in violation of the Stark II self-referral law and assessments of up to three times the amount of claims. The Anti-Kickback Statute authorizes penalties of $50,000 for each kickback, plus an assessment of not more than triple the total unlawful remuneration offered or received.

One strategy for providers to mitigate these penalties is to voluntarily disclose conduct that violates fraud and abuse laws. Voluntary internal compliance programs create an internal control system which enables a provider to become aware of improper conduct before it leads to a criminal investigation, imposition of penalties and even exclusion from federal health care programs. When a provider uncovers such problems, self-disclosure provides a vehicle to reduce the resulting liability.

The new SDP initiative provides guidance on how the OIG will handle providers' voluntary disclosures. Although more detail is still to be provided by the OIG, it is clear the OIG will: (a) confer with the Department of Justice before allowing a provider to participate in the SDP; (b) focus on situations in which a hospital knowingly conferred a financial benefit on physicians (such as when a hospital provides a physician with an office space at below fair market rent in exchange for referrals); and (c) generally settle matters for a monetary amount near the lower end of the penalty scale for providers participating in the SDP.

If you have any questions about federal regulations prohibiting self-referrals or kickbacks or if you believe your practice would benefit from an internal compliance plan, please feel free to call our office.

LITIGATION: EXPERT TESTIMONY IN THE COURTROOM

Many of our clients request assistance when they are asked to render expert opinions in cases. Often confusion exists as to whether to become involved, knowing that their opinions will be "dissected" through vigorous cross examination in a deposition and potentially at trial. The answer lies in understanding that to be of value in a case, the presented expert testimony must generally be found relevant and reliable (in federal courts) or premised on methodologies, facts and data that are "generally accepted" within the given field of the expert (in Illinois courts).

Testimony is relevant if it is material to a genuine issue of fact. A fact is material if, under the substantive law that is applied to the case, it is essential to the proper disposition of the case. An issue is genuine if there is sufficient evidence on each side so that a rational trier of fact (like a jury) could resolve the issue either way. In other words, relevant testimony is testimony that "fits" the issues that a jury must confront in order to decide which side prevails.

Testimony is reliable if the expert's opinions are based upon a methodology, science and expertise that satisfies a non-exclusive list of factors, such as whether the theory or technique be tested, whether the results have been peer reviewed and whether the technique has a known or potential rate of error. In addition, it is also significant whether the theory has gained general acceptance in the relevant community. Reliability focuses upon the expert's principles and methodology and not the scientific conclusions they may generate.

After expert testimony is given, the party to a lawsuit who opposes the expert may file a motion for summary judgment, even if the judge has already decided that the expert's testimony is relevant and reliable. Summary judgment is a legal concept meaning that there is no material issue of fact to be decided against the party who presented the expert for deposition. This might seem surprising to the expert who believes that he is qualified, experienced in his or her field and able to testify regarding the issues for which he or she was retained.

In most situations, such a motion should fail because the expert's testimony is relevant and reliable. The only occasions where a summary judgment might be granted on contested facts is when the testimony does not satisfy elements of a party's burden of proof (i.e., what a party needs to prove in order to obtain relief from a trier of fact), when the testimony goes against prevailing law, or when the testimony is to be heard by a judge who will act in place of a jury.

An expert whose opinions are found relevant and reliable on contested facts will know that his or her opinions will go to a jury to determine whether they are persuasive enough to enable the party who retains the expert to prevail in the lawsuit.