

KAMENSKY RUBINSTEIN HOCHMAN & DELOTT, LLP

Spring 2006 LAW UPDATE

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IN THIS ISSUE

Employment Law: First District Appellate Court Rules Company Communications May Form Basis for Defamation Suit.

Estate Planning: Right to Die Issues;

Health Care: Medicare Overpayments; New Provider Number Required by CMS; Exposure to Hepatitis B; Responding to HIPAA Investigations; New CMS Documentation Requirements for Consultants; MEDPAC Targets Therapy.

Real Estate: Tenant in Common Deals.

Tax: Proposed Regulations Would Tax Partnership Interests; Circular 230 Regulations; Tougher Laws for Auto Donations.

TAX: PROPOSED REGULATIONS WOULD TAX PARTNERSHIP INTERESTS

The IRS has recently proposed new regulations under Section 83 of the Internal Revenue Code that address the taxation of a partnership interest transferred in connection with the performance of services. Under the proposed regulation, the issuance of either a capital or a profits interest in a partnership interest in connection with the performance of services will constitute property, the fair market value of which is currently taxable under Section 83. The exemption from taxation of profits interest will end. The new regulations make it clear that a partnership does not recognize any gain upon the issuance of an interest for services.

The regulations include rules for an elective safe harbor for a partnership's transfer of interests. The safe harbor is intended to simplify the application of Section 83 to partnership interests and to coordinate the provisions of Section 83 with the principles of partnership taxation. If the partnership and its partners qualify for the safe harbor, the fair market value of an interest will be its liquidation value. Liquidation value is the amount of cash the partner would receive if the partnership sold all of its assets for cash equal to the fair market value of its assets and liquidated.

Until the regulations are finalized, taxpayers may not rely upon the proposed safe harbor but continue to rely upon the existing law in this area. For further information regarding these proposed regulations, please contact the Firm's tax department.

HEALTHCARE: PROVIDER RESPONSE TO MEDICARE OVERPAYMENTS

Providers who have had to return overpayments to Medicare will have more incentive to find the source of the error that led to the overpayment. The Medicare Modernization Act allows Medicare to hire contractors to review claims submitted by a provider following an overpayment to make sure that any problems have been and continue to be addressed.

Potential sources of accidental overpayments that frequently occur include: (1) hiring a new biller or coder; (2) physicians who do not supply sufficient information; (3) implementation of a newly approved procedure; and (4) billing software error. Once an error is located, providers must inform Medicare and document the steps

taken to correct the problem and the educational activities implemented. Documenting how these actions decreased the practice's error rate will help providers demonstrate a good faith effort to reduce overpayment errors.

Providers should also conduct periodic audits to ensure that problems leading to overpayment have been fixed. If able to show an auditor that new claims have been reviewed to ensure that such problems no longer exist, then a decision may be made by Medicare that further audits are no longer required.

HEALTHCARE: NEW PROVIDER NUMBER REQUIRED BY CMS

The Centers for Medicare and Medicaid Services ("CMS") has announced the availability of a new identifier number, the National Provider Identifier ("NPI"), to be used in all standard electronic health care transactions. The NPI will be the one identifier that will replace all other identifiers providers currently use for each health care plan with which providers do business. The NPI is a requirement of HIPAA and must be used by all HIPAA-covered entities that conduct electronic transactions. **All HIPAA entities must accept and use NPIs in standard transactions by May 23, 2007. After this date, all health care providers must use only their NPI to identify themselves in standard transactions whenever a provider number is required.**

Providers may now apply online for their NPIs at the National Plan and Provider Enumeration System (NPPES) web site: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

For questions regarding the application process, call Enumerator at 1-800-465-3203 or e-mail any questions to customerservice@NPIenumerator.com.

INFORMATION & ARTICLES IN THIS ISSUE SUBMITTED BY:

Ericka Adler, Adrienne Butler, Ben M. Roth.

NEWSLETTER COORDINATORS:

Lauren Hernandez and Sandra Weisenberg

KRHD NOTES

Ericka Adler is serving as a benefits partner for the Center for Disability and Elder Law.

Marvin Kamensky was recently nominated to appear in Marquise Who's Who in the World. Mr. Kamensky was previously nominated to appear in Marquise Who's Who in American Law.

Philip Pomerance will be speaking on legal ethics issues at the Seventh Annual Conference on Healthcare Transactions in Chicago on April 6, 2006; Mr. Pomerance will be speaking on Legal Ethics and Professional Responsibility in Handling Health Care Transactions at the 18th Annual Health Law Conference at the University of Texas in Houston.

Sam Young has been designated a laureate of the Illinois State Bar Association for 2006.

Miles Zaremski will be moderating a program at the Annual Meeting of the American College of Legal Medicine on the use of expert testimony in the Courtroom in early March in Las Vegas; Mr. Zaremski will be speaking in Honolulu, HI in August with regard to the DOJ's challenge of Oregon's Death With Dignity Act.

ESTATE PLANNING: RIGHT TO DIE ISSUES

Many people are familiar with the Terry Schiavo case which brought to the world's attention the importance of having a power of attorney for health care, a power of attorney for property and a living will. Terry Schiavo did not have advance medical directives in place, she did not nominate an individual to act as her agent to advocate her intent and she did not express her desire under a living will. In Illinois, even if Terry Schiavo had a living will, her feeding tube would not have been removed because the standard in Illinois is different than that of Florida. In Illinois, only an agent under a power of attorney can take such action to remove feeding. Understanding and putting into place the following documents can prevent a similar situation to Schiavo for you and your family.

Power of Attorney.

- Sign a power and select an agent and successor agent in whom you have trust. It should be someone who will work in your best interest. An agent is not required to act, so try and select an agent who will act on your behalf when necessary.
- Divorce revokes the power granted to a former spouse.
- Indicate your personal or medical preferences to the agent to provide guidance.
- A properly drafted power of attorney can avoid the need to go in to court for guardianship appointment in the event of permanent disability.

Living Will. A living will is the expression of your intent to provide instructions concerning specific types of treatment you may, or may not, want to receive. Many people feel strongly that they should have the right to reject certain extraordinary life sustaining treatment in the event of a terminal illness or injury. This is where such preference should be indicated.

Anatomical Gifts. Nationally, there is a need for organ donations for those requiring a transplant. In Illinois, at the time you renew your driver's license you can authorize anatomical gifts. By placing such directive in a will or another document that can take days to produce, it would be too late.

Feel free to call our office with any questions you may have regarding these documents. We will also be happy to prepare them on your behalf.

HEALTHCARE: RISK OF EXPOSURE TO HEPATITIS B IN THE WORKPLACE

Providers should be aware that the Occupational Health and Safety Administration ("OSHA") requires that employers must offer the three-injection Hepatitis B ("HBV") vaccination series free of charge during work hours to all health care employees who are exposed to blood or other potentially infectious materials as part of their duties on the job. If an employee must travel away from the workplace to receive the vaccination, the employer must pay travel expenses. Injections must be offered within ten (10) days of initial assignment to a job where exposure to blood or other potentially infectious materials can be "reasonable anticipated." The second injection is given one (1) month after the first, and the third is given six (6) months after the first dose.

If an employee is exposed to HBV in the workplace, such as by a needle stick or blood splash to the eye, confidential medical evaluation by a health care professional must be available. Under the recommended confidentiality standards, the employer should be informed only whether a vaccination was recommended and whether it was received. A health care professional should offer counseling to the employee at the time vaccination is offered. An employee has the right to decline vaccination, and if so, the employer should have a declination form available to sign. Employers must keep such forms on file so that the vaccination status of exposed employees is known.

Employers are required by OSHA to provide training for all employees with potential occupational exposure to infectious agents. This training must at a minimum include: an explanation of the epidemiology and modes of transmission of blood borne diseases; the employer's plan to control such risks; recognition of tasks that involve risk; explanation of methods to decrease risk; information on the HBV vaccine; and procedures to follow if exposure occurs in the workplace. Employers should ensure that employees receive instruction in following safe work practices and the use of protective clothing or equipment to reduce the risks of exposure to infectious materials.

TAX: REVISED CIRCULAR 230 REGULATIONS

The IRS has revised Treasury Department Circular 230 regulations which govern practice before the IRS. The changes add three types of advice that are excluded from the strict standards for covered opinions and refine what it means to "prominently disclose." The revisions also add a new definition of what qualifies as the "principal purpose" of tax avoidance.

The IRS expanded the definition of "excluded advice" to include the following:

- •Written advice prepared for and provided to a taxpayer solely for his use after he has filed a tax return reflecting the tax benefits of the transaction described in or referred to in the written advice, provided that the practitioner neither knows or has reason to know that the taxpayer will rely upon the advice to take a position on a return filed after the date on which the advice is provided;
- •Advice provided to an employer by a practitioner in his capacity as an employee solely for purposes of determining the employer's tax liability; and
- •Written advice concluding that a federal tax issue will not be resolved in the taxpayer's favor, unless the written advice also reaches a conclusion favorable to him at any confidence level.

The new regulations provide that an item is "prominently disclosed" if it is readily apparent to a reader of the written advice. At a minimum, the item must be set forth in a separate section (not in a footnote) in a font that is the same size or larger than the typeface of any discussion of the facts or law in the written advice.

The "principal purpose" of any plan or arrangement is tax avoidance or evasion if that purpose exceeds any other purpose. The principal purpose is not to avoid or evade tax if its purpose is to claim tax benefits in a manner consistent with the statute and Congressional purpose. The IRS has warned that even if a transaction's principal purpose is not tax avoidance, practitioners must also check to see if the transaction is a covered opinion under either Regulation § 10.35(b)(2)(i)(A) or § 10.35(b)(2)(i)(C).

HEALTHCARE: RESPONDING TO HIPAA-RELATED COMPLAINTS AND GOVERNMENT INVESTIGATIONS

Although most medical practices and other providers that are considered to be a "covered entity" under HIPAA have prepared the necessary paperwork and assigned an individual to act as a privacy officer of the covered entity, most practices are still unprepared if an investigation for a HIPAA violation occurs.

The practice's designated privacy officer should be trained to take the following steps in any HIPAA investigation:

1. Verify the identities and authority of the investigators;
2. Attempt to ascertain the nature of the investigation and the alleged violations;
3. Determine whether there are any law enforcement personnel present (this will help assess the severity of the situation);
4. Alert outside legal counsel and other key personnel; and
5. Ensure that everyone is aware of the situation and is receiving consistent information.

Cooperating with investigators involves not only providing the required information to facilitate the investigation but also ensuring that only information which is specifically sought is disclosed. Steps to follow in this process include the following:

1. Determine which workforce members are needed to comply with the investigator's request;
2. Keep those workforce individuals who are not necessary to the investigation out of the way;
3. Instruct those members of the work force who are present to be cooperative and not to hide or conceal facts or otherwise mislead investigators;
4. Demand inspection of any warrant, subpoena or other authority for the investigators being present to verify, with the assistance of legal counsel, the authority if the investigators to review the information being required and to determine that such information is directly related to a legitimate investigatory purpose.

It is essential that only those records specifically identified in a warrant, subpoena or other authority be surrendered or provided for review. There are other state and federal laws which may limit the extent to which the records sought may be disclosed. If investigators seek records that are not specifically described in a warrant, subpoena or other authority, the covered entity may decline to provide them and ask for a request in writing so there will be no misunderstanding about the documents that are being sought. There is no need for investigators to be left alone in the offices of the covered entity, and the security officer, or another authorized member, should at all times escort and monitor the investigators while they are present. In addition, this individual should document the areas searched and the list of information seized. Once investigators have completed their work, the designated individual should request an exit conference to learn additional details of the investigation, if any violations have been discovered and if the company will be involved in any further investigative activity.

If no violations are discovered following an investigation, the entity will typically receive a notification in writing and the matter will be considered closed. However, if any violation is discovered, the covered entity will be given an opportunity to resolve the matter through informal means, such as a corrective action plan. This does not mean that the covered entity will not pay significant penalties and fines if the informal resolution is not successful. Covered entities may be subject to civil monetary penalties of not more than \$100 for each violation of the privacy rule or security rule up to a maximum of \$25,000 for all violations of the same provision or requirement in any single calendar year. In determining the amount of the fines, the Department of Health and Human Services may consider the nature of the violation, how the violation occurred, the covered entity's degree of culpability, the entity's history of prior offenses, the entity's financial condition and other factors.

In the event the fines are imposed, the covered entity should contact legal counsel to appeal the decision of the administrative law judge if it has any doubt regarding the outcome of the hearing. Otherwise, the entity will be precluded from doing so later. When no fines have been assessed, a covered entity does not have a right to appeal the determination. It is important to remember that the ability to impose fines is in addition to, but not exclusive of, other penalties prescribed by federal or state laws. If you have questions about HIPAA, how to protect your practice or have become subject to an investigation, call us for guidance and direction.

EMPLOYMENT LAW: COURT RULES THAT INTERNAL COMPANY COMMUNICATIONS MAY FORM BASIS FOR DEFAMATION SUIT BY EMPLOYEE

The 1st District Appellate Court of Illinois recently ruled that internal company communications regarding an employee's conduct or performance may form the basis for a defamation claim against the employer. In *Popko v. Continental Casualty Co.*, Popko was fired based on statements made in internal memorandums drafted by his supervisor and another manager regarding his alleged use of profanity and insubordination. Popko claimed the statements were false and defamatory and filed an action against the company, his supervisor and the manager alleging defamation and tortious interference with prospective economic advantage. The employer asked the Court to rule that internal communications could not support a defamation claim because the statements were not "published" to a third party and argued that when corporate employees communicate among themselves regarding a matter within the scope of their employment, such communications are essentially the company communicating with itself and not "publishing" to a third party.

The Court disagreed with the employer. It ruled that such corporate communications are subject to a "qualified privilege" and can form the basis for a defamation claim, provided that the plaintiff establishes not only the falsity of the statements but also that they are made with "actual malice" or reckless disregard for their truth. Although this ruling does not change existing Illinois law, it may lead to more tort claims against employers based solely on internal corporate communications. Employers must be aware of potential legal liability arising from internal company memos or conversations about employee performance or misconduct.

TAX: IRS EXPLAINS TOUGHER LAWS FOR AUTO DONATIONS

The IRS has issued guidance on new and tougher charitable contribution rules that will apply to autos (as well as boats and planes) donated after 2004. The deduction for "qualified vehicles" (defined as cars, boats and planes that are not inventory or held for sale in the ordinary course of business) for which the claimed value exceeds \$500 depends upon the charity's use of the donated property. The donor's charitable deduction cannot exceed the charity's gross proceeds from the sale of the vehicle unless one of two conditions applies: (1) the charity has made "significant intervening use" of the vehicle (i.e., the charity has significantly used the vehicle to substantially further its regularly conducted activities); or (2) there has been "material improvement" (i.e., major repair or improvement) of the vehicle.

In addition, the guidance creates a new exception for autos given or sold at low price by the charity to needy individuals. Under such circumstances, the donor may deduct the auto's fair market value. The guidance also informs donors of what they must do to substantiate their charitable contributions. Please contact the firm if you would like additional information.

HEALTHCARE: MEDPAC TARGETS THERAPY

As the Medicare Payment Advisory Commission (“MedPAC”) continues to investigate new ways to curb medically unnecessary therapy claims, they appear to be targeting comprehensive outpatient rehabilitation facilities, skilled nursing facilities, outpatient rehabilitation facilities and physical therapists and private practice. These entities bill the most on average per patient for outpatient therapy, as compared to hospital outpatient departments and physicians.

MedPAC intends to scrutinize payments for high paying outpatient therapy codes that providers most frequently bill to see if they are over-utilizing these codes to boost their revenues. In particular, MedPAC is expected to watch spending for physical therapy evaluations, neuromuscular reeducation, manual therapy and self-care management training. Also targeted will be services for therapeutic exercises such as gait training on stairs and strengthening and mobility exercises, because they account for half of all therapy spending.

Other approaches to curb improper and medically unnecessary claims that MedPAC and CMS are entertaining include flagging claim for multiple services in cases where only one service a day is typically necessary, as well as claims with an unlikely number of time-based services on a given day. In addition, searching for patterns by comparing claims from similar providers will be considered.

Finally, CMS may create the equivalent of a safe harbor for outpatient therapists impacted by the therapy caps which went into effect January 1, 2006 and which limit therapy payments to \$1740 per patient per year. To qualify for protection, providers may have to endure more medical reviews, audits and tough reporting requirements. Although the caps are intended to reduce the number of medically unnecessary and improper claims for therapy, critics have complained that the caps restrict care for extremely debilitated patients. To extend caps for truly needy patients, CMS is considering two (2) possibilities to take effect July 1, 2006:

1. Therapists can submit a written request for exceptions, along with documentation to justify additional therapy services.
2. Patients with certain medical conditions would be exempted, such as close head injuries and patients who undergo hip replacement surgery and then suffer an additional injury later in the same year.

HEALTHCARE: NEW CMS DOCUMENTATION REQUIREMENTS FOR CONSULTATIONS

The Centers for Medicare and Medicaid Services (“CMS”) issued Transmittal #R788, effective January 1, 2006 containing new documentation requirements for consultations. The new requirements include:

- The written request for a consultation must be included in the requesting physician’s (or qualified NPP) plan of care; and
- Although the request may be verbal, the verbal interaction identifying the request and reason for the consultation must be documented in the patient’s medical record by the requesting physician and the consultant.

Formerly, documentation of a request by either the requesting physician or the consultant was permitted. Satisfaction of these new requirements are conditions for payment and failure by the requesting physician to properly document a request may subject

the consultant to a penalty for Medicare overpayment. Problems in compliance might arise because the consulting physician may not know whether the requesting physician has properly documented the consultation request. Please contact our health law department with any questions or concerns.

REAL ESTATE: TENANT IN COMMON DEALS RISING IN POPULARITY

In late 2002, the IRS issued guidelines that validated an ownership structure allowing capital gains deferral on property exchanges. Over the past three years, tenant-in-common (TIC) transactions, as they are known, have increased nationally by 400%. Investing in TIC properties, also known as fractional ownership, allows investors to buy into portions of an investment property. This approach, when combined with a “1031 exchange”—an investment strategy that enables real estate owners to first sell their property and then buy another similar property of equal or greater value within 180 days without having to pay capital gains taxes—provides the advantage of tax breaks to real estate investors. Individuals can sell real estate holdings and defer the capital gains taxes by investing in a TIC property as long as the investor purchases an undivided financial interest in real estate property of equal or greater value. TIC properties may allow investors to buy into portions of large properties which would sell for hundreds of millions of dollars for as little as \$250,000. These low equity requirements appeal to small individual investors, who may be able to achieve a bond-like annual return of 6% to 8% from the property’s stream of rental income. The IRS has set forth guidelines on these TIC transactions, including:

- Each investor must hold title to their interest in fee simple. You are not allowed to hold title as a partner in a partnership or in any other investment entity set up by the promoter;
- Each investor must have the right to sell their unit without restriction from the other investors and must annually approve the promoter’s management agreement. The promoter may not lock the investor into the TIC for a specified amount of time or force an investor to sell property back to the promoter; and
- The requirement of unanimous consent of owners for leasing, financing and sale could result in deadlock by a minority interest holder. Promoters have devised various strategies to circumvent this problem.

If you need more information about TICs, feel free to contact the Firm for guidance.

April 6, 2006
CHICAGO CULTURAL CENTER
78 East Washington Street, Chicago, Illinois
Registration Starts at 5:30 p.m.
Dinner Will Be Served During Event
PHYSICIAN STRATEGIES
FOR IMPROVING BOTTOM LINE
THROUGH DIAGNOSTIC SERVICES

The Firm will be sponsoring a seminar with LaSalle Bank on April 6, 2006 at which Ericka Adler will discuss methods by which physicians can introduce ancillary services into their practices or form joint ventures involving diagnostic equipment and services. If you would like more information or to attend, please e-mail Ericka Adler at eadler@kr-law.com or Sarah Sobieski at (773) 244-7466.