



# practical health law

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Perspectives on health care legal issues

**Tax-exempt organizations  
IRS soft contacts hold  
hard lessons for unprepared**

**Don't push it**  
NPI deadline is  
not one to be missed

**Deficit Reduction Act**  
After six months, here  
are the issues to watch

**Think you aren't affected  
by Medicare Part D?**

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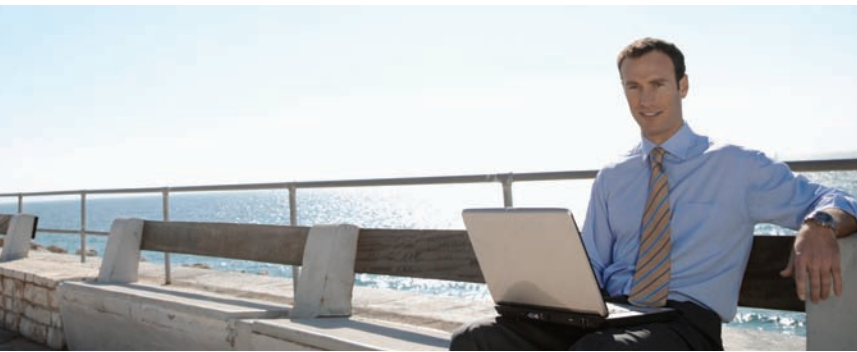
## Tax-exempt organizations

# IRS soft contacts hold hard lessons for unprepared

**C**oncerned that many tax-exempt organizations may be under-reporting the compensation their top employees receive, the IRS is looking more closely at how such compensation is determined, as well as how it's reported.

The IRS is using “soft contact” letters to ask hundreds of tax-exempt organizations, many of them in the health care profession, to explain their compensation packages. These letters fall short of true audits, but they do require you to justify the reasonableness of the compensation you give highly compensated employees and others as reported on your Form 990.

Though you can't predict whether you'll receive a soft contact letter, the IRS has indicated it will continue these contacts, and you should know in advance how you'll respond if you get one.



### Diligence is due

For many health care organizations, the highest-paid employees include physicians paid under physician compensation plans. You must be diligent in ensuring that compensation for those and other highly compensated employees is fair and reasonable for the services being provided. And when you're reporting executive compensation, be careful not to overlook perks such as

company-issued cell phones, country club dues, automobiles, vacation homes or travel expenses for spouses that weren't reimbursed by the employee.

In addition to verifying that all compensation is reported, the IRS may ask how you arrived at compensation package specifics, including who was involved in setting and approving the compensation, what internal research was done to verify that the compensation was fair and reasonable, and whether third-party consultants were engaged in the process.

The IRS focuses its inquiries on whether you did a compensation comparability survey and followed the resultant recommendations, how you reported the compensation, and whether a disqualified person used his or her influence to impact his or her own compensation or benefits. A disqualified person is anyone in a position to exercise substantial influence over the affairs of the organization. This includes executives and board members, but it can also encompass other employees — including physicians — if they can substantially influence the organization. Family members of disqualified persons are also considered disqualified persons.

### Penalties apply

If you're found to have provided excessive compensation to one or more disqualified persons — known as an “excess benefit transaction” — it can be very costly for the person receiving the excess compensation, the officers and directors who approved the compensation, and even your organization.

Excess benefit transactions are subject to excise tax penalties on the individuals who receive the excess benefit and possibly on the managers and directors who participated in the design or approval of the transaction. For the tax-exempt organization itself, the IRS continues to assert

that in abusive situations it can revoke the organization's tax-exempt status. Sanctions on individuals for participating in an excess benefit transaction include:

- > Repayment of the excess amount to the tax-exempt organization and a 25% tax on the excess, to be paid by the disqualified person who received the excess benefit,
- > A 200% tax on the excess benefit, to be paid by the disqualified person if he or she doesn't correct the excess benefit by repayment within the required period, and
- > A tax equal to 10% of the excess benefit, not to exceed \$10,000, which may be levied against any managers or directors who knowingly participated in the excess benefit transaction.

The soft contacts themselves are not audits, and the IRS can elect to not take action on what it finds. However, based on what the IRS does see, an audit and the imposition of sanctions could follow.

## Minimizing risk

The good news is that you can minimize the risk of sanctions if you take steps to establish a "rebuttable presumption" that the compensation paid to a disqualified person was reasonable.

To do that, you must:

1. Ensure that the compensation decision was made by an independent board or compensation committee who didn't have a conflict of interest,
2. Support compensation decisions with data showing that the compensation is reasonable in comparison to compensation paid by similarly situated organizations, and
3. Record the decision in meeting minutes that document the basis for the decision.

If you follow the rebuttable presumption three-step process, payments to a disqualified person are presumed to be reasonable, shifting the burden to the IRS to prove otherwise.

## How to prepare

Could you explain your highly compensated employee compensation payments to the IRS? To be sure you're prepared, conduct an internal review of your compensation policies and procedures. Look at these areas, and take whatever steps are required to:

- > Maintain updated, written job descriptions that list duties and responsibilities for each of your highest-paid employees,
- > Analyze compensation and benefits paid to employees and make sure they're properly reported on IRS Forms 990, W-2 and/or 1099,
- > For plan- or formula-driven production compensation, identify compensation that is in the highest percentiles compared to survey data and be prepared to defend it,
- > Maintain a written conflict-of-interest policy,
- > Identify all disqualified persons employed within the organization, including their family members,
- > Retain supporting compensation surveys prepared by third-party consultants,
- > Maintain internal assessment data for highly compensated employees, including a record of when the compensation was set, and
- > If you intend to qualify for the rebuttable presumption of reasonableness, create and retain the appropriate documentation, including meeting minutes that document the basis for the decision.

If you conduct a thorough review of your compensation policies and procedures now, you'll be ready to respond to whatever the IRS may send — be it a soft contact letter or a full audit.

## Preparation = security

For the foreseeable future, the IRS will continue to investigate tax-exempt organizations, scrutinizing the compensation paid to executives and other highly compensated individuals. You should be prepared to explain and defend your compensation decisions. Doing so will protect both your organization and the individuals who receive the payments. <

# Don't push it

## NPI deadline is not one to be missed

**T**he National Provider Identifier (NPI) number is part of the administrative simplification process that HIPAA mandates, and it's intended to help simplify the Centers for Medicare and Medicaid Services (CMS) payment process. Acquiring and using the numbers can be complex, however, and savvy providers will act sooner rather than later, because the deadline for compliance is rapidly approaching.

### Who needs an NPI?

All health care providers who submit electronic claims for CMS payment must be using NPI numbers by May 23, 2007 (May 23, 2008, for small health plans). After those dates, the NPI will be the only number that can be used to identify health care providers on standard electronic transactions. But you can anticipate that most health plans will require them even if you don't submit electronic claims.

Any person or organization that furnishes, bills or is paid for health care in the normal course

of business can obtain an NPI. Individual providers, including physicians, physician assistants, nurse practitioners, chiropractors, dentists and others, are allowed only one NPI number even if their services are billed through different organizations. Organizational providers, however, can and often should apply for an NPI for each subpart of the organization.

A subpart is a component of a covered entity, as opposed to a separate legal entity, that provides services. Essentially, any organizational program or unit that conducts standard transactions separately from the covered organizational health care provider must have its own NPI number. A subpart may or may not have a taxonomy (Medicare specialty description) that's the same as the organizational provider of which it is a part, but Medicare-covered organizational providers should obtain a separate NPI number for each subpart that currently has a Medicare number.

If you aren't among the providers that have already obtained NPIs, you may apply online at <https://nppes.cms.hhs.gov> or request a paper application by calling (800) 465-3203.

### Analyze your current system

Regardless of where you are in the application process, a complete analysis of your billing and reimbursement process, from claim preparation through accounts receivable management, will facilitate a smooth transition to use of the NPI and will help avoid reimbursement delays. Over the years, many providers have established internal systems that rely on legacy numbers — the numbers that the



## What the NPI won't do

It's important to remember that the National Provider Identifier (NPI) is solely an identifier, and obtaining one is entirely separate from the enrollment and certification process for Medicare, Medicaid and other payors. Health care providers are still, for example, required to complete the appropriate Medicare enrollment forms to enroll in the Medicare program.

It's still not clear how the NPI will impact some transactions, such as change of ownership for Medicare purposes, and under what circumstances, if any, a new owner will be able to obtain a new NPI — or will be required to use the existing NPI.

Additionally, an NPI won't replace your tax identification number or eliminate the need to be separately enrolled in or credentialed by each health plan. It won't replace your Drug Enforcement Agency number, nor will it guarantee reimbursement from payors.

NPI will replace. These systems either will need to be replaced or upgraded to relate legacy numbers to the NPI.

A detailed implementation plan with interim deadlines will also help facilitate a smooth transition. The plan should allow plenty of time to test the system and to ensure that you've shared all necessary individual and organizational numbers

with billing departments, clearinghouses, third-party payors and others who need the numbers to submit or process claims.

It's also critical that you know your payors' implementation plans. Although all standard transactions must use only the NPI by the

compliance dates, there's nothing to prevent a payor from requiring its use earlier, and Medicare is already accepting NPIs in addition to legacy numbers.

True administrative simplification will require that the health care industry move away from using multiple numbers to identify providers, and use of the NPI for purposes other than electronic claims may become common. The NPI could, for instance, be used for identification on medical records, in medical staff proceedings and in correspondence.

### Don't delay

You'll continue to need many existing identifying numbers for other regulatory purposes, but don't let that lull you into delaying the NPI process. It's critically important that you obtain and use an NPI prior to your compliance date. <

# Deficit Reduction Act

## After six months, here are the issues to watch

**T**he Deficit Reduction Act of 2005 (DRA) made some of the most significant legislative changes to Medicare payment provisions in years. The sweeping changes mandated under the act include an estimated \$6.4 billion reduction in Medicare spending over the next five years, with profound effects on hospitals, physicians, therapy providers and others in the health care field.

### Key changes

Certain key DRA changes are assuming greater visibility in 2006 as their 2007 effective dates approach:

**Venue-driven payments.** The DRA sets reimbursement for certain services based partly on where the services are provided. Payments for some Medicare Part B services provided in nonhospital settings, for example, can't exceed the hospital outpatient prospective payment system (OPPS) rate. The act affects payment for:

- > **Imaging services.** DRA Section 5102 reduces payment for certain imaging services provided in freestanding centers and physician offices, effective Jan. 1, 2007. It caps Medicare reimbursement for the technical component to the lesser of the OPPS rate or the Medicare Part B physician fee schedule payment. The technical component cap applies to x-ray; ultrasound, including echocardiography; nuclear medicine, including PET; MRI; CT; and fluoroscopy. But it excludes diagnostic and screening mammography. These drastic cuts have been strongly opposed by numerous medical organizations, manufacturers and patient advocacy groups. Medicare's position is that, because the changes are statutory, legislation would be required to amend them.
- > **ASC services.** DRA Section 5103 imposes OPPS payment limits on procedures performed in ambulatory surgical centers (ASCs), pending revision of the ASC

payment system. Beginning Jan. 1, 2007, ASC procedures will be paid at the OPPS rate if it's less than the ASC payment for the same procedure (without considering any geographic price differences).

- > **Therapy services.** The DRA addresses therapy caps for physical, occupational and speech language therapy provided in a non-hospital setting by directing Medicare to create an exceptions process for services that exceed the caps. The exceptions process is in place, including both automatic exceptions for some services and discretionary exceptions for other services if medically necessary and requested in writing. All exceptions, however, are limited to calendar year 2006.

**Hospital quality improvement.** The DRA further encourages hospitals to submit quality-of-care data for inpatient services by increasing the penalty for failing to submit the data. Currently, hospitals that don't report certain quality-of-care data receive a lesser increase in their Medicare payments. Beginning in 2007, Section 5001 of the DRA further reduces payment increases for hospitals that fail to report quality data.

**Physician investment in specialty hospitals.** Scrutiny of physician investment in specialty hospitals continues, as does the suspension on

enrollment of new specialty hospitals. Section 5006 of the DRA directs the Secretary of Health and Human Services to develop plans that address issues including ownership terms, ownership disclosure, care to Medicaid beneficiaries and charity care patients, and enforcement.

A final report on those plans is due to Congress in August, and the enrollment suspension will continue until the report is submitted or until August 2006, whichever comes first. If the final report isn't timely, however, the suspension may be extended to October 2006.

**Inpatient rehabilitation facility classification criteria.** Section 5005 of the DRA extends the phase-in of the "75% rule" that allows facilities to be classified as inpatient rehabilitation facilities (IRFs) and, thus, be paid at a higher rate. The "75% rule," which requires a facility to show that at least 75% of its patients in a 12-month period required treatment for at least one of 13 identified conditions, distinguishes IRFs from other facilities. The phase-in is extended to July 1, 2008.

### Pertinent provisions

While the therapy caps were effective Jan. 1, 2006, most of the changes created by the DRA are first effective in 2007. As 2007 approaches, nearly all providers in the health care field will need to monitor DRA provisions, to assess the details of how they will be implemented and the full impact of the changes. <

## Think you aren't affected by Medicare Part D?

**T**he new Medicare Part D program is having a profound impact on patients, pharmacies and health plans, but its direct effect on health care facilities and physicians may be more limited. Nonetheless, you need to know how the Part D program operates so you can coordinate the various benefits and

respond to patients' questions. In particular, you need to know which part of Medicare applies to which services.

### Part D eligibility and participation

Part D is a new outpatient prescription drug benefit for Medicare and Medicaid beneficiaries, administered through private prescription drug

plans (PDPs) or Medicare Advantage plans. Individuals who are eligible for either Medicare Part A or Part B may elect to enroll for the Part D benefit.

Those who are eligible for both Medicare and Medicaid are automatically enrolled in Part D. They may choose a PDP, or accept one randomly assigned by the Centers for Medicare and Medicaid Services (CMS).

### Inpatient questions

Part A reimburses inpatient hospital and skilled nursing facility care, which includes drugs administered during such care. Typically, such drugs are considered “bundled” into Medicare payment for Part A stays, and you can’t bill for them separately.

A greater difficulty arises with drugs, such as clotting factors, that aren’t bundled. In such cases, Part B or Part D coverage may apply, depending on what coverage the patient has and which drugs the patient’s Part D PDP includes.

Part D coverage in the long-term care setting becomes even more complex once Part A benefits have been exhausted and Medicaid takes over. Medicaid patients’ drug benefits are primarily provided by their Part D PDPs, and pharmacies must have contracts with each patient’s PDP in order to be paid.

### Outpatient questions

Drug coverage outside the inpatient setting is the province of Part B or Part D. As a general rule, if it’s covered by Part B, it’s excluded from Part D.

Part B covers certain drugs administered in physician offices, those administered via durable medical equipment (such as nebulizers), and certain drugs administered to hospital outpatients. When an outpatient receives a drug from a hospital or a physician’s office, that drug may be covered by Part B. Self-administered drugs aren’t covered by Part B.



Though Part B coverage is primary, if a patient isn’t enrolled in Part B, Part D coverage could be possible — if the drug is covered by his or her PDP. In this situation, the patient may need to pay first, and then seek reimbursement from the PDP.

### And then there are the audits

Anticipating the potential for massive fraud in the implementation of Part D, federal agencies are creating numerous, overlapping and nearly constant audits of Part D benefits. While the audits will focus on the PDPs, pharmacies, and beneficiaries, health care facilities and physicians may be caught up in the audit process, being required to respond to audit requests at their cost and with no potential benefits to themselves.

### Prepare for confusion

Given the complex rules surrounding Medicare Part D coverage, you should anticipate confusion and complaints from your Medicare patients. While you may have little to do directly with Part D, patients are likely to look to you for help. In providing that assistance, you’ll need to be mindful of CMS prohibitions on recommending a particular PDP based on the financial interest of the provider.

You’ll also need to be sure your staff understands at least the general Part D provisions and knows where to refer patients for additional assistance. Medicare Part D may be beneficial to you and to your patients, but it’s going to take some getting used to for everyone involved. <

## A message to our clients and friends:

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We understand the value of good information when making sound business decisions. *Practical Health Law* is written by Hall Render's health law attorneys, each with extensive experience handling the legal issues of health care providers. We trust the information in each issue will be a valuable resource. Our attorneys stand ready to respond promptly to your questions and needs; please contact us if there are specific topics you'd like to see addressed.

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