Farrell Fritz, P.C.

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HEALTH LAW ADVOCATE™

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Welcome!

Welcome to the second issue of Health Law Advocate™ newsletter. The response from our first issue was overwhelmingly positive, and we hope to continue the momentum.

Much is happening in the health care legislative arena in New York. This issue touches upon three recent legal developments that have important business implications for health care providers.

Please feel free to forward this newsletter to colleagues who may have an interest. Contact us with your comments and suggestions about topics that are of particular concern or interest to you. We welcome your feedback.

Christopher J. Kutner, Esq.
Michael E. McDermott, Esq.

Inside

A Taxing New Issue
for Not-for-Profit Hospitals

By Michael E. McDermott, Esq.

A recent Internal Revenue Service ruling represents a new challenge for not-for-profit hospitals that utilize captive arrangements with professional corporations (PCs).

IRS Private Letter Ruling 200716034, issued in April 2007, found income generated by six captive PCs affiliated with a not-for-profit hospital constituted unrelated business income that was taxable. The PLR caught many hospital administrators and advisors by surprise. Historically, many tax-exempt hospitals that do not have faculty practice plans utilize captive PC arrangements with physician groups to permit them to capture professional fees that they would not otherwise be permitted to bill and collect. By controlling ownership of the PC (typically the PC stock is owned by a physician employed by the hospital) and aligning its corporate purposes with those of the tax-exempt hospital, the income generated by these captive PCs is considered by the IRS to be tax-exempt.

At the June 2007 meeting of the American Health Lawyers Association, Marvin R. Friedlander, chief of the IRS's Exempt Organizations Technical Branch, Office of Rulings and Agreements, in Washington, D.C., said the PLR was "an anomaly" and was limited to the facts described and should not be read as signaling the IRS's view with respect to affiliations between tax-exempt hospitals and captive professional corporations that involve differing facts.

Two significant factors led to the IRS's ruling. First, the IRS found that the PCs did not serve the hospital's patients. Second, the IRS found that the PCs carried on activities on a larger scale than was reasonably necessary for the hospital's performance of its tax-exempt functions.

Hospitals that are currently utilizing captive PC arrangements should review these arrangements periodically to ensure that the activities of the captive PCs are in fact furthering the charitable purposes of the hospital and that they are not conducting themselves in a manner that could jeopardize the tax-exempt status of the hospital.

Farrell Fritz BRIEFS

Charles M. Strain, managing partner of Farrell Fritz, is an active member of the firm's health care practice group.

Charlie represents health care providers in contract negotiations, real estate transactions and regulatory matters.

He serves as chairman of Winthrop-University Hospital's board of directors. His other board memberships include the New York State Health Foundation and the Winthrop South Nassau University Health System, Inc.

Charlie is also a member of the Joint Planning Committee of the Long Island Health Network. He can be reached at: cstrain@farrellfritz.com.

A New Take On Take-Backs

State limits health plans' ability to recover overpayments

By Christopher J. Kutner, Esq.

One tactic employed by Managed Care Organizations (MCOs) and abhorred by health care providers is the take-back of alleged claims overpayments through the creation of a "debit balance." These are usually the result of a claims audit or software used by MCOs to analyze the frequency of a particular billing code or to detect claims reimbursement patterns. The provider will typically receive the MCO's determination claiming that due to past claims overpayments, future entitlements for reimbursements will be applied first to offset past overpayments. This communication may be the provider's first notice of the overpayments. If the provider is non-participating with the MCO and submits claims to the MCO infrequently, the MCO may simply demand repayment in a lump sum.

Upon receipt of such a letter, a health care provider has a choice: spend countless hours disputing the alleged overpayments, or simply concede to the MCO's determination. Either alternative is painful.

A new insurance law in New York State provides a slight improvement for the protection of providers. Insurance Law 3224-b places conditions and limitations on MCOs attempting to recover overpayments from providers.

Under the new law, a health plan may not seek to recover overpayments made more than two years after the alleged overpayment. This limitation does not apply, however, to recoveries 1) based upon a reasonable belief of fraud or other intentional misconduct or abusive billing; 2) required, initiated or requested by a self-insured plan; or 3) required by a state or federal government program.

The health plan must also provide 30 days prior written notice identifying the claims that were allegedly overpaid. The notice must include patient names, dates of service, payment amounts, proposed

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NY State Tightens Regulations On Office-Based Surgery

By Michael E. McDermott, Esq.

Under current New York State law, there is no regulatory agency with authority over physician private practices that conduct office-based surgery (OBS). In July 2000, and again in 2004, the New York State Department of Health (DOH) issued clinical guidelines for OBS. However, these guidelines were not mandated and were not enforced by the DOH. Concerned that OBS procedures were becoming increasingly complicated and more invasive, the DOH reconvened its Committee on Quality Assurance in Office-Based Surgery. The Committee issued a report and recommendations in 2006 concluding that the DOH should seek legislative authority to require accreditation status of physicians performing OBS and to require reporting of adverse patient events. The New York State Senate and Assembly recently passed such legislation, which was signed by Governor Spitzer, that provides such authority to the DOH.

Under the new law, physicians who perform OBS procedures (defined as any surgical or other invasive procedure requiring general anesthesia, moderate sedation or deep sedation, and any liposuction procedure) will have to obtain and maintain accreditation status within 18 months of the effective date of the law from a nationally recognized accrediting agency recognized by the Commissioner of the DOH (e.g., American Association of Accreditation of Ambulatory Facilities, Accreditation Association for Ambulatory Healthcare, or the Joint Commission). The new law gives the DOH Commissioner authority to enter into agreements with such accrediting agencies. Additionally, under an amendment to the New York State Education Law, physicians who conduct OBS and fail to obtain full accreditation status will be guilty of professional misconduct.

Also under the new law, physicians will have to report adverse patient events to the DOH patient safety center within one day. Adverse events are defined as (1) patient death within 30 days; (2) unplanned transfer to a hospital; (3) unscheduled hospital admission within 72 hours of the OBS; and (4) any other serious or life-threatening event. Current confidentiality laws are extended to protect these reports. The accrediting agencies, however, are given the authority to report to the DOH aggregate data for all OBS physician practices. The DOH is authorized to release such aggregate data to the public.

Physicians who perform OBS in their private practice should become familiar with the applicable accreditation standards for their practice and, if they have not already done so, adopt policies and procedures to ensure compliance and avoid the imposition of misconduct proceedings.

Events Calendar

September 27
"Update on Health Care"
Hofstra University, Hempstead, NY

Speaker: Richard F. Daines, M. D., NYS Health Commissioner

To reserve a place, contact Marilyn Foley at 516-739-1700; email foley@senate.state.ny.us

October 3
Farrell Fritz Health Care Roundtable, Uniondale, NY

Topics:
"NYS Legislative Update on Hospital Indigent Care," Sen. J. Kemp Hannon, Chair of the NYS Senate Health Committee;

"Stark Regulations Update," Michael E. McDermott, Esq.

To reserve a place, contact Lindsay Gaddis: phone, 516-227-0718; email, lgaddis@farrellfritz.com

A New Take on Take-Backs

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adjustments and reasonable explanations for the proposed adjustment. No notice is required to recover a duplicate payment made for the same claim. Also, if a physician claims underpayment on claims going back further than two years, the health plan may assert as an offset any overpayments made to that physician but limited to the same period in question.

Although this statute provides only minor improvement to previous conditions, physicians can help themselves by limiting take-back provisions in their contracts with MCOs and by understanding the reimbursement parameters of MCOs before submitting claims in the first place. In my experience working within MCOs, most health care providers don't negotiate such provisions, but simply sign the contract and put it on the shelf. Providers should take the time to review and negotiate such key provisions in their contracts if for no other reason than to avoid being surprised by rules that could result in the loss of reimbursement. Providers may have more leverage than they realize in negotiating with various payers.

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