Ninth Circuit Affirms Tax Court Ruling in Redlands Case

Since the 1998 issuance of Revenue Ruling 98-15, 1998-1, C.B. 718 ("Rev. Rul. 98-15"), which provides guidance on the tax treatment of exempt hospitals participating in whole hospital joint ventures with for-profit organizations, the tax-exempt status of several joint ventures has been evaluated by the Internal Revenue Service ("IRS"), the Tax Court, and, in at least one instance, a federal Circuit Court. The most prominent of these cases is Redlands Surgical Services v. Commissioner, 113 T.C. 47 (1999) (the "Redlands Case"), which was litigated in the Tax Court and ultimately appealed to the Ninth Circuit.

In a March 15, 2001 decision, the Ninth Circuit affirmed the Tax Court's ruling in the Redlands Case, thereby validating the Internal Revenue Service's blueprint in Rev. Rul. 98-15 (9th Cir., No. 99-71253, March 15, 2001). The decision by the federal appellate court was brief and contained no discussion save a blanket affirmation of the Tax Court's ruling in 1999. The opinion did emphasize the Tax Court's holding that Redlands Surgical Services was not exempt from federal income tax because it ceded effective control over the joint venture to the for-profit party, conferring impermissible private benefit.

Description of the Redlands Joint Venture

Redlands Surgical Services ("Redlands") was a non-profit corporation within a tax-exempt health care system. In 1990, Redlands entered into a General Partnership (the "GP") with a for-profit entity. Each entity held a 50 percent interest in the GP and the right to appoint two of the four managing directors. The GP obtained a 61 percent interest and became the sole general partner in Inland Surgery Center Limited Partnership (the "LP") which owned and operated a Surgical Center.

The LP agreement did not contain a statement of charitable purposes for the Surgical Center, nor did the Surgical Center provide free care to indigents or emergency room services. Furthermore, the LP granted a 15-year management contract for the Center to a subsidiary of the for-profit partner in the GP ("Management"). The management agreement provided that Management would receive 6 percent of the gross revenue from the Surgical Center and gave Management the unilateral
power to extend the management agreement for two 5-year extensions.

**Tax Court Decision**

In finding that Redlands was operated for private benefit, the Tax Court validated the Service’s contention that because the management and partnership agreements were structured to allow the Surgical Center to be controlled by a for-profit entity, Redlands had compromised its exempt status as a charitable organization. In addition to the factors relevant in Rev. Rul. 98-15, the Tax Court weighed a broader range of factors in determining whether the venture was charitable, allowing for the possibility of informal controls held by Redlands that could bolster the charitable nature of the venture. The Tax Court based its decision to deny exemption to Redlands on a number of characteristics inherent in the joint venture arrangements, each of which is discussed below.

The Court found that the for-profit parties involved in the Redlands Case lacked any express or implied obligation to put charitable objectives ahead of noncharitable objectives. Despite its affiliation with Redlands through the GP, the LP did not amend its governing documents to include charitable purposes. Redlands’ lack of voting control over the GP caused the Tax Court additional concern. The Court analyzed the facts of the Redlands Case for indications of any other formal or informal controls sufficient to ensure furtherance of charitable purposes; however, the Court came up empty-handed. Although in practice Redlands had on occasion managed to veto a particular course of action, it was not able to do so unilaterally. In order to guarantee that a charitable purpose would trump any other purpose, at least one managing director appointed by the for-profit partner would have to join with the two managing directors appointed by Redlands for a majority of votes in the GP.

The long-term contract giving Management control over day-to-day operations was detrimental to the argument for exempt status because the terms were deemed to give too much unchecked management authority to a for-profit entity. The Court also found the percentage-of-revenue incentive given to Management to undermine any charitable purpose because the logical consequences of such an arrangement would be the maximization of profits by Management to the detriment of community needs.

In identifying impermissible private benefit, the Tax Court noted the market advantages and competitive benefits secured by the for-profit affiliates as a result of their arrangement with Redlands. Since Redlands became involved in the joint venture in 1990, outpatient surgeries at Redlands Hospital (a tax-exempt organization within the same health system as Redlands) decreased in favor of surgeries performed at the Surgical Center; however, there was no corresponding increase in charitable care at the Surgical Center. The Court saw this as further evidence that no informal control by Redlands over the joint venture existed—otherwise, Redlands could have prevented this consequence.

Because the agreements were structured to allow the Surgical Center to be controlled by a for-profit entity, Redlands had compromised its exempt status.
The Redlands Case underscores the key elements of any joint venture entered into by an exempt organization: 1) the charitable purpose must trump any other purpose of the venture at all levels; 2) the exempt organization must have effective control over the venture, thereby ensuring that charitable objectives remain paramount; and 3) there must be no private inurement or benefit.

**Future Guidance**

Although joint ventures have been a common and effective tool for furthering charitable objectives, substantive guidance on how to set up and operate such ventures is sparse. Rev. Rul. 98-15, has direct applicability to partial joint ventures and has been extended to apply to partial and ancillary joint ventures; however, it does not provide guidance in the gray areas in which most joint ventures tend to be structured. The Redlands Case is likely the first of a number of cases to expand available precedent through litigation. Moreover, the IRS has recently given some indication through private letter rulings and at least one determination letter that it may find joint venture arrangements acceptable even though they do not fall squarely within the four corners of Rev. Rul. 98-15. These few rulings have been made on a case-by-case basis with the overarching principle being that the joint venture must be under the ultimate control of the tax-exempt venturer and dedicated to furthering the exempt purposes of that party.

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**Physician Recruitment Arrangement Gets OIG Okay**

The ability readily to access physician services has a direct impact on the well-being of members of a community. Increasingly, some communities—in both rural and urban settings—have found themselves with inadequate physician services in some specialty areas. With government and private health care payors seeking to contain health care costs, and physician practice expenses (such as liability insurance costs and medical education loan repayments) increasing, physicians have gravitated to more affluent areas.

Hospitals in underserved areas may attempt to recruit physicians to their communities. Sometimes, the only way to entice a physician to relocate to such an area is by offering financial incentives. However, both hospitals and recruited physicians involved in such arrangements face potential legal risks if recruitment arrangements are not properly structured. For example, a recruitment arrangement may violate the federal anti-kickback statute if it does not satisfy all requirements of a regulatory “safe harbor” for such arrangements. Recently, however, the Office of Inspector General (the “OIG”) issued an advisory opinion (AO 01-4) in which it concluded that it would not impose sanctions in the case of a proposed recruitment arrangement that did not meet the safe harbor requirements. The advisory opinion provides some lessons to hospitals that may recruit physicians to their communities and to the physicians who are recruited.

**Proposed Recruitment Arrangement**

The advisory opinion was requested by a tax-exempt hospital located in a rural region that had not been designated as a health professional shortage area (“HPSA”) by the Department of Health and Human Services (“HHS”), but had been designated as a medically underserved area (“MUA”). The hospital had concluded that there was a shortage of otolaryngologists and head and neck surgeons in its service area, based on a bona fide needs analysis conducted by the hospital using objective criteria.

The hospital proposed to enter into an arrangement with a recent medical school graduate who was starting a five-year residency training program in otolaryngology and head and neck surgery. Under the arrangement, the hospital would loan the physician funds necessary to cover the debt service on his school loans and other educational expenses during the period of this residency training. The loan would accrue interest at one percent over the prime rate. Upon completion of the residency, the physician would

*continued on page 4*
be obligated to establish and maintain for three consecutive years a full-time private medical practice in the hospital’s community. The hospital would forgive repayment of one-third of the amount it loaned for each of the three years that the physician practiced in the community.

The proposed recruitment arrangement did not meet the anti-kickback safe harbor for two reasons. First, the physician was not locating to a HPSA in his specialty, as is required for safe harbor protection. In fact, the HPSA requirement is very limiting, because an area can be designated as an HPSA for only seven health professional types: primary medical care (which itself is limited to MDs and DOs in general or family practice, general internal medicine, pediatrics and obstetrics, and gynecology); dental; mental health; vision care; podiatric; pharmacy; and veterinary. Thus, recruitment aimed at filling needs for a large number of specialty areas cannot meet safe harbor requirements. Second, the safe harbor requires that the benefits provided to the recruited physician may not be provided for more than three years; here, however, the time between the first payment to the physician and the repayment or forgiveness of the loan was as much as eight years.

OIG’s Analysis
In its analysis, the OIG characterized physician recruitment as an area that, although not always illegal, is subject to abusive practices. Yet, the OIG recognized that financial incentives may be needed to attract physicians to rural and urban underserved communities, and that the risk of kickbacks is more attenuated where the recruited physician does not have an established patient base in the area to which he is being recruited. The OIG identified four factors potentially relevant in evaluating the anti-kickback risks associated with physician recruitment arrangements that do not meet the safe harbor.

First, the OIG would consider relevant whether there is documented evidence of an objective need for the recruited physician’s services. This, of course, is the reason for the HPSA requirement in the safe harbor. But the OIG notes that an area can be deficient in a particular specialty even if it is not (and cannot be) designated as an HPSA in that specialty. In those cases, other evidence of need may be considered.

Second, the recruitment of physicians who do not have established and portable referral streams is less likely to involve a kickback, according to the OIG. Thus, greater suspicion would be associated with recruiting a physician to relocate a short distance in an urban setting, for example.

Third, the OIG indicates that the amount and duration of the benefit conferred on the physician is relevant. The benefit should be narrowly tailored to that which is reasonably necessary to recruit the practitioner. It is interesting to note that the safe harbor includes no such requirement, so there may be greater
latitude in the amount of benefit that can be conferred on a physician where an arrangement can meet safe harbor requirements.

Finally, whether other parties in a position to refer may benefit from the recruitment arrangement may also be relevant, according to the OIG. In particular, the OIG is concerned that so-called “joint recruitment” arrangements in which a hospital and a group practice or managed care organization contribute towards the recruitment of a physician may hide a kickback to the group practice or MCO for their referrals to the hospital.

In applying these factors to the proposed arrangement, the OIG concluded that minimal risk of fraud and abuse would be present because the community need had been documented, the physician would not bring an existing stream of referrals, the amount and duration of the benefit conferred on the physician would be reasonable under the circumstances, and no other referral source would indirectly benefit. The OIG also pointed to “safeguards” that would be in place, such as the facts that the physician would not be required to refer to the hospital and would not be restricted from referring to other hospitals, and the amount of the benefit to the physician was independent of his referrals. Finally, the OIG noted that the public would benefit because the entirety of the hospital’s service area is contained in MUAs.

Conclusions

Many physician recruitment arrangements do not fit within the narrowly crafted anti-kickback safe harbor. The advisory opinion reinforces a number of lessons that hospitals and physicians should keep in mind when considering physician recruitment arrangements.

• The recruitment of a physician to an area that is not an HPSA in his specialty is possible, but it is critically important in those cases to evaluate and document the community need for the physician’s services.

• The amount and duration of the benefit conferred on a recruited physician should bear some rational relationship to the circumstances of his recruitment.

• The OIG continues to be skeptical of “retention” payments and “cross town” recruitment, since the benefit conferred on a physician in those circumstances could be viewed as a kickback for referrals to the hospital from the physician’s existing patient base.

• Although the OIG has identified recruitment arrangements undertaken jointly by hospitals and established physician groups as more suspect, it has not said such arrangements are necessarily improper. Presumably, the degree of risk would be affected by the extent to which established physician practices, as distinguished from the recruited physician, could receive a benefit under the recruitment arrangements.

• Hospitals and physicians must also keep in mind the limitations on physician recruitment imposed by the federal Stark law, federal laws applicable to tax-exempt hospitals, and state laws. Although some areas of consistency exist among these requirements, they are not identical and a recruitment arrangement must satisfy all of these laws to the extent that they apply.

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Medicare’s New Enrollment Procedures for IDTFs

Beginning October 1, 2001, the Centers for Medicare & Medicaid Services (“CMS”) will have implemented major revisions to its Form 855 enrollment materials and to its enrollment requirements for Medicare providers and suppliers. Although most Medicare Carriers will be accepting the old forms for a short transition period, the new forms are expected to be required by year-end. The new forms and enrollment policies will soon be available to all providers on the CMS Web site, www.hcfa.hhs.gov.

Among the enrollment policy changes that have been made include significant changes to CMS’ treatment of independent diagnostic testing facilities (“IDTF”).

Overview

Medicare payment for diagnostic tests is permitted only if the service is performed by a physician, a physician group, an approved supplier of portable X-ray services, or an IDTF. The IDTF, replacing the old independent physiological laboratory, is the principal vehicle for free-standing imaging centers to relate to Medicare. Physicians who assume the “supervising physician” duties must be cognizant that their responsibilities for quality assurance of IDTFs are significant.

The rules for IDTFs are found at 42 C.F.R. § 410.33, and prescribe the requirements for the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualification of non-physician personnel who use the equipment. At least one supervising physician is responsible for quality operations, such as equipment calibration, while other physicians are responsible for the supervision of diagnostic tests and assuring the qualifications of the technologists performing tests under their supervision.

Supervision Requirements

CMS has instructed Carriers that supervising physician functions can be met separately at each IDTF location, regardless of the number of physicians involved. For example, a portable X-ray operation of a mobile ultrasound unit registered as an IDTF will be allowed to use different supervisory physicians at different locations. The IDTF must arrange for a specific physician to supervise the tests at each location. Many diagnostic tests can be performed under the general supervision of a physician, but some studies require direct or personal supervision.

Medicare rules define “general supervision” to mean that the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. For these studies, the training of the technologists who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician. Nevertheless, CMS does not impose a physical distance limit between where the test is performed and where the supervising physician is located. The only obligation is
that the supervising physician be licensed in the state where he or she is acting as a supervising physician.

For procedures that require “direct supervision” at an IDTF, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The physician need not be present in the room when the procedure is performed, however.

**IDTF Enrollment**

An attachment to the Form 855B enrollment application must delineate each supervising physician. A group practice of physicians cannot broadly be designated. Each physician member of the group practice who actually provides supervision services must be separately listed. It is not necessary that all supervising physicians are members of a medical group — the group can make arrangements with independent contractor physicians to perform the supervising service.

For all modifications or additions to the list of supervising physicians, the updated information must be communicated to the Medicare Carrier by adding any new supervising physician to the Form 855 within 30 days of the change. Medicare Carriers can be expected to check to determine that the supervision requirements for these facilities are being met. To substantiate this, the Carrier can ask for written procedures from the IDTF describing how this is being accomplished.

The Form 855 requires the applicant to supply a list of all procedure codes that the IDTF will perform. The applicant must also provide a list of the equipment it will use to perform those tests.

The identity of all physicians for whom the IDTF entity will bill for interpretations of the diagnostic tests they perform (i.e., global billings) must be furnished. The interpreting physician(s) listed should be qualified to perform the interpretations of the types of test codes listed in the application.

Each non-physician technologist who performs the diagnostic tests must also be identified. If the non-physician is state licensed or certified, the applicable license and/or certification must be attached for review by the Carrier. Technologists do not have to be W-2 employees of the IDTF and may contract with the IDTF.

**Ordering Diagnostic Tests**

A supervising physician at an IDTF, even for a mobile facility, is not authorized to order tests to be performed at the facility. Except for chiropractic studies and screening mammograms, the physician who orders the test must have a relationship with the beneficiary prior to the performance of the testing and must have been treating the beneficiary for a specific medical problem.

The rule specifically requires that the test be ordered in writing.

**Billing Issues**

Although an IDTF is a provider of the technical component of diagnostic testing services, it is not restricted to billing the technical component only. IDTFs can bill “globally” for both the technical and professional component of the diagnostic test and interpretative services.

To allow the IDTF to bill for the professional component, each interpreting physician must make individual reassignment to the IDTF. Group reassignments are not permitted. Carriers have been instructed to retain on file all reassignment forms. If the interpreting practitioner is an employee of the IDTF, in accordance with Medicare Carriers Manual Section 3060.1, the IDTF must submit a reassignment of benefits form (Form 855R), which must be signed by the interpreting physician.

The most typical scenario that can be anticipated is for the interpreting physician to be a member of a group with an independent contractor agreement with the IDTF for performing the interpretation on the premises that the IDTF owns or leases. In this situation, under Medicare’s rules (Carriers Manual section 3060.3C), the IDTF must submit to the Carrier a reassignment of benefits form signed by each independent contractor.

If an IDTF wants to bill for a professional interpretation performed by an independent practitioner off the premises of the IDTF, the IDTF must meet the conditions shown in Carriers Manual section 3060.5 for purchased interpretations. In this arrangement, Medicare would permit the IDTF to bill for diagnostic test interpretations when: (1) the tests are initiated by a physician or medical group that is independent of the IDTF and the
physician or medical group providing the interpretations; (2) the IDTF submits either an assigned or unassigned claim for both the tests and the interpretations thereof; and (3) the physician or medical group providing the interpretations does not see the patient. For the application of the purchased interpretation rule, no formal reassignment of benefits is necessary since the purchaser of the test – the IDTF – is considered the supplier of the test.

**Physician Office vs. IDTF**

A major question for some Carriers has been whether a physician office that performs diagnostic tests must enroll as an IDTF. This is a relevant question since many enrolled provider types may perform and bill for diagnostic tests on the physician fee schedule without becoming an IDTF. Basically, a physician’s office or a part of a hospital may bill for the diagnostic tests without being enrolled as an IDTF. CMS has developed criteria to distinguish between a physician office and an IDTF.

An applicant that is considered to be a physician’s office or a part of a hospital can bill for the diagnostic tests without being enrolled as an IDTF if:

- It is a physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital;
- The entity primarily bills for physician services (e.g., evaluation and management (E & M) codes) and not for diagnostic tests;
- It furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice; and
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions.

However, if a substantial portion of the entity’s business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficiently separate business to require separate enrollment as an IDTF. In that case, the physician or group may continue to be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF.

Special criteria have been developed to guide Carriers to permit radiologists’ offices to maintain enrollment as physician groups rather than IDTFs:

- The practice is owned by radiologists, a hospital, or both;
- The owner radiologists and any employed or contracted radiologists regularly perform physician services (e.g., test interpretations) at the location where the diagnostic tests are performed;
- The billing patterns of the enrolled entity indicate that the entity is not primarily a testing facility and that it was organized to provide the professional services of radiologists (e.g., the enrolled entity should not bill for
a significant number of purchased interpretations, it should rarely bill only for the technical component of a diagnostic test, and it should bill for a substantial percentage of all of the interpretations of the diagnostic tests performed by the practice; and

■ A substantial majority of the radiological interpretations are performed at the practice location where the diagnostic tests are performed.

Site Visits

An IDTF must receive a site visit prior to enrollment. The site visit should normally be accomplished within the 60-day processing time during which the Carrier will verify that the information on the Form 855 is correct, verifiable and in accordance with IDTF requirements. To the maximum extent practical, site visits are performed on an unannounced basis. Additional follow-up site visits are performed based upon Carrier judgment.

For tests performed at the facility, inspectors conducting the site visit must obtain from the non-physician personnel:

■ The name of the supervising physician(s) who are supervising the tests;

■ Information on how such personnel can get in contact with the supervising physician(s), and their knowledge of procedures to follow if they have a problem with diagnostic tests they are performing; and

■ Any procedures related to how the general supervision requirement is being met. However, written procedures are not specifically required and they can be furnished separate from the site visit. If no written procedures exist, a satisfactory written response to Carrier questions is required.

If an IDTF has more than 10 practice locations, but is not a mobile unit, the Carrier does not have to perform a site visit to each location, and a sampling of practice locations can be performed.

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The Administration also is taking a number of steps to improve the Medicare program for beneficiaries, the most notable of which is the new Medicare Prescription Drug Discount Card Program.

Over the past several weeks, the Bush Administration has announced a series of reforms aimed at making it easier for Medicare providers, suppliers, and beneficiaries to understand and comply with Medicare rules. While many of these reforms are being put into place under the Administration’s existing authority, several key members of Congress also are considering statutory changes designed to provide additional regulatory relief.

**Bush Administration Initiatives**

The administrative reforms, spearheaded by Secretary of Health and Human Services Tommy Thompson, received a high-profile kickoff in June with the renaming of the Health Care Financing Administration as the Centers for Medicare & Medicaid Services (“CMS”). In addition to a new name, the agency is being restructured into three Centers:

- **The Center for Medicare Management** will manage the traditional fee-for-service Medicare program, including the development of payment policy.
- **The Center for Beneficiary Choices** will provide beneficiaries with information on Medicare, Medicare Select, Medicare+Choice, and Medigap options. It also will manage the Medicare+Choice plans, consumer research and demonstrations, and grievance and appeals functions.
- **The Center for Medicaid and State Operations** will focus on state-administered programs, including Medicaid, the State Children’s Health Insurance Program, insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act.

To improve the agency’s responsiveness to the provider community and beneficiaries, CMS has created a series of “Open Door Policy Committees” which will serve as principle points of contact for seven provider and beneficiary groups (physicians, hospitals and rural health, nursing homes, health plans, nurses and allied healthcare professionals, home health and hospice, and end-stage renal disease and dialysis centers). In addition, CMS is undertaking a series of “open listening forums” across the country to give providers the opportunity to share concerns and suggestions. Moreover, the agency is forming in-house expert teams across CMS’s program areas to think innovatively about new ways of doing business that will simplify Medicare rules and regulations.

CMS also is working to improve its provider training and problem resolution systems through satellite broadcasts, web-based information, and other learning tools. In addition, the agency is attempting to revamp current policies that have been particularly burdensome for the provider community, such as the physician evaluation and management guidelines, hospital and skilled nursing facility Medicare cost reports, and the Medicare+Choice marketing material review process.

The Administration also is taking a number of steps to improve the Medicare program for beneficiaries,
the most notable of which is the new Medicare Prescription Drug Discount Card Program unveiled in July. Under this initiative, Medicare will endorse and promote a number of qualified privately administered prescription drug discount cards, which will prevent seniors from paying full retail price for at least some of their prescription drugs. The cards will be made available to seniors either free of charge or at a nominal, one-time enrollment charge. To control costs, card sponsors can adopt common strategies such as formularies, preferred networks, patient and physician education programs, and disease management.

The drug discount card program recently ran into a major roadblock when, on September 6, the U.S. District Court for the District of Columbia issued an injunction preventing its implementation. The Court ruled that the Administration lacked statutory authority to create the program and, further, failed to follow required procedures for promulgation of administrative regulations.

CMS also will undertake a Medicare education campaign, which will include 24-hour-a-day, 7-day-a-week telephone service to respond to questions from beneficiaries and caregivers; enhanced Internet tools to assist beneficiaries with health plan choices; and a $35 million national advertising campaign this fall to inform Medicare beneficiaries about these expanded services.

**Regulatory Relief Legislative Proposals**

In addition to these administrative reforms, many lawmakers — including key members of the House Ways and Means Committee — are advocating legislation that would streamline the regulatory process, enhance provider education and technical assistance, protect the rights of providers in the audit and recovery process, and provide the Secretary with flexibility in contracting with companies to administer the Medicare program.

Many provider groups have been lobbying in support of passage of H.R. 868/S. 452, the “Medicare Education and Regulatory Fairness Act of 2001,” or “MERFA,” which was introduced in March and is now cosponsored by more than half of the members of the House of Representatives and more than a third of the Senate. More recently, on August 2, 2001, the Chairman of the House Ways and Means Health Subcommittee, Nancy Johnson (R-Conn.), and the panel’s ranking Democrat, Pete Stark (D-Calif.), introduced H.R. 2768, the “Medicare Regulatory Reform Act of 2001.” The Johnson/Stark bill covers many of the issues included in MERFA, but is designed to address certain fraud and abuse concerns raised by the Office of Inspector General with respect to that proposal. The lawmakers hope to move the legislation through the Ways and Means Committee this fall.

**Debra A. McCurdy**

Washington, DC

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**Recent Reed Smith Client Memoranda Available**

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<td>HIPAA Update: (1) First HHS Guidance on HIPAA Privacy Standards; (2) What Covered Entities Should be Doing Now</td>
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*If you would like copies of any of the above-listed memoranda, please contact any of the members of our Health Care Group and we will be happy to send them to you. They are also available on our Web site at reedsmith.com/library/bulletins.asp.*
On May 29, 2001 the United States Supreme Court decided NLRB v. Kentucky River Community Care, 121 S.Ct. 1861 (2001), a case which will have significant ramifications both for unions seeking to organize nurses and for the employers of those nurses. At issue in Kentucky River was the lawfulness of the National Labor Relations Board’s (“NLRB”) test for determining the supervisory status of nurses, particularly nurses who direct other caregivers but do not have the authority to hire, fire or discipline employees. Because many nurses direct lesser-skilled employees to perform various patient care tasks, employers have always treated them as supervisors, but because they do not have the authority to hire, fire or discipline employees, unions have viewed them as regular employees. The fight over which side of the supervisory line these nurses belong, and what test should be utilized to decide this issue, were before the Supreme Court in Kentucky River.

**Factual Background**

In Kentucky River the employer operated a facility for residents who suffered from mental retardation and illness. The facility employed approximately 110 professional and non-professional staff (excluding managerial employees).

The Kentucky State District Council of Carpenters filed a petition with the NLRB seeking to represent all 110 employees at the facility. The employer asked the NLRB to exclude six registered nurses (“RNs”) from the proposed bargaining unit because, in the employer's view, the RNs were “supervisors” who responsibly directed less-skilled health care employees.

Under the National Labor Relations Act 29 U.S.C. § 151 et seq. (“NLRA”), an individual who is deemed to be a “supervisor” cannot be included in any union bargaining unit, and is not otherwise subject to the protection of the NLRA. As a result, the employer need not permit or tolerate a supervisor engaging in union activities, and may even enlist the supervisors’ help in lawfully opposing a union organizing campaign. A supervisor is defined under the NLRA as:

> [A]ny individual having authority, in the interest of the employer, to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing exercise of such authority it is not merely of a routine or clerical nature but requires the use of independent judgment.

29 U.S.C. § 152(11). Thus, an individual is a supervisor if that individual exercises the authority to do one or more of the above-listed functions, exercises that authority in the interest of the employer and uses independent judgment when exercising that authority. Under this definition an individual is deemed a supervisor even though that individual does not have the authority to hire, fire, promote or discipline employees.
The NLRB, however, has consistently taken the position that nurses who “responsibly direct” less-skilled health care employees in the giving of patient care, were not exercising “independent judgment” because their judgment was informed by their technical and/or professional training or experience. In other words, the nurses were not supervisors.

Thus, the NLRB concluded that the RNs employed by Kentucky River were not supervisors. An election was subsequently held, and the union won. The employer, however, refused to bargain with the union on the basis that the RNs had been improperly included in the bargaining unit.

U.S. Supreme Court Decision
Finding for the employer in Kentucky River, the Supreme Court rejected the NLRB's test. The Supreme Court concluded that the NLRB's distinction between independent judgment and professional and/or technical judgment was a false distinction, irrational, and contrary to the language of the statute.

Justice Scalia wrote for the Court as follows:

What supervisory judgment worth exercising, one must wonder, does not rest on ‘professional or technical skill or experience’? If the Board applied this aspect of its test to every exercise of a supervisory function, it would virtually eliminate ‘supervisors’ from the Act.

Kentucky River, 121 S.Ct. at 1868.

Conclusion
The Court's decision in Kentucky River will certainly make it more difficult for unions to organize nurses. At a minimum, there will be increased litigation on this issue which could significantly delay organizing efforts. Employers will assert that their RNs who responsibly direct less-skilled health care employees are supervisors, and under Kentucky River, it is more likely that these nurses will be deemed supervisors.

The Kentucky River decision also may have similar ramifications for physician organizing efforts. Physicians, like nurses, direct lesser skilled health care providers. Thus, under Kentucky River there is a fairly strong argument that physicians are supervisors and thus not entitled to organize.

Amy G. Macinanti, Esquire
Harrisburg
On February 6, **Gordon Schatz** was a speaker at the FDLI’s program “The Business of Clinical Trials—It’s Not ‘Business as Usual’ Anymore!” in Washington, D.C. Gordon’s presentation was titled “Medicare Coverage: A New Playing Field,” covering Medicare payment for clinical trials under the new rules.

**Julia Krebs-Markrich** gave three presentations in February at the American College of Obstetricians and Gynecologists’ course on Quality Management for Leaders in Women’s Health Care in San Diego, California. Topics included medical staff issues and legal issues under managed care.


On March 14, **Andrea Kahn-Kothmann** gave a presentation on “What It Means to Be ‘Provider-Based’: HCFA’s New Standards” at the Pennsylvania Bar Institute’s Seventh Annual Health Law Institute in Philadelphia, Pennsylvania.

On March 29, **Gordon Schatz** was a faculty member at the American Health Lawyers Association’s Institute on Medicare and Medicaid Payment Issues in Baltimore, Maryland. Gordon spoke on “Medicare Payment for Drugs and Biologicals.”

**Bob Hoffman** successfully represented the Pennsylvania Medical Society as an amicus curiae in *Duttry v. Patterson*, 771 A.2d 1255 (Pa. 2001), in which the Pennsylvania Supreme Court held that a physician’s alleged misrepresentations of his experience in performing a procedure did not state a claim for violation of informed consent.

**Thomas Greeson** published articles in the May and August issues of *Diagnostic Imaging* magazine and in the August issue of *Advance for Imaging and Oncology Administrators*.

**Karl Thallner** published an article titled “Stark II and Physicians’ Outside Relationships” in the May 2001 issue of *Physician’s News Digest*.

On May 3–4 in Arlington, Virginia, **Gordon Schatz** and **Gail Daubert** gave presentations at an AdvaMed seminar entitled “The Medicare Hospital Outpatient Prospective Payment System—Helping Hospitals Obtain Pass-Through Payment for Your Device.” Gordon and Gail gave an overview on the basics of HOPPS and APCs, the new pass-through categories, how to determine if medical devices fit into the new categories, and future developments of the device pass-through payment.
In May, Thomas Greeson was a speaker at the annual meeting of the American Roentgen Ray Society in Seattle, Washington on the topic of the impact of regulation on the quality of healthcare.

In June, Elizabeth Carder was elected to the Board of Directors of the American Health Lawyers Association. She also serves as co-chair of AHLA’s Annual Healthcare Fraud and Abuse Conference, co-sponsored with the Health Care Compliance Association, to be held October 1–2, 2001 in Washington, D.C.

Kevin Barry gave a presentation titled “Update and Overview of Stark II Developments” at the Health Care Compliance Association’s First Annual Region VIII Compliance Conference, held June 4–5, in Rapid City, South Dakota.

Gordon Schatz was a commentator at the National Comprehensive Cancer Network’s Cancer Policy Summit 2001 in June in Tampa, Florida. Gordon’s issue panel, “Advances in Cancer and the Ability of the Health Care System to Pay for Them,” was conducted as a Roundtable Discussion. Many of the issues raised in the agenda for the program included patient access to high quality care, ability of the health care system to pay, continuity in care from community to academic medical center, and Internet issues.

In July, Julia Krebs-Markrich gave a presentation with Jack Erickson entitled “Dealing with Problem Physicians” at the annual meeting of the Council on Resident Education in Obstetrics and Gynecology in Big Sky, Montana.


Gordon Schatz and Carol Loepere wrote an article for the July 2001 edition of o&p almanac, the Magazine for the Orthotics and Prosthetics Profession on “Avoiding Fraud and Abuse Pitfalls in Marketing and Promotional Practices.”

In July, Thomas Greeson was interviewed for the Fox Television News affiliate in Washington, D.C. and was quoted in the Washington Post regarding the firm’s representation of the Alexandria Medical Society in connection with obtaining legislation during a special session of the Virginia General Assembly.

Julia Krebs-Markrich’s article entitled “Confronting Overpayment Determinations: Lessons from Medicare” was published in the Fairfax County Medical Society’s FCMS News, Summer 2001 edition.

On August 6, Linda Baumann spoke the ABA Annual Meeting in Chicago on “Structuring Transactions Under the Stark II Statute and Regulations” and served on the panel at the program titled “Current Trends in Healthcare Fraud and Abuse.”

Bob Hoffman represented the Pennsylvania Medical Society as an amicus curiae in Bell v. Slezak, Panea v. Isdaner, and Baker v. Myers, 773 A.2d 2001 (Pa. Super. 2001), in which the Superior Court en banc held that physicians, as malpractice defendants, are not personally liable for amounts properly offset from payment of a judgment or settlement by the Pennsylvania Insurance Guarantee Association.

Gordon Schatz gave a presentation to the American Society for Extracorporeal Technology on September 9 in San Antonio, Texas on Hot Topics in Fraud and abuse for Perfusionists and Tips on Compliance.

In September, Julia Krebs-Markrich gave a presentation with Nancy Luque entitled “Criminal and Civil Prosecution of Nursing Homes: What Providers Confront and How They Can Defend Themselves” at the annual meeting of the Virginia Health Care Association in Hot Springs, Virginia.

On September 14, Gordon Schatz gave a presentation in Boston, Massachusetts to the American Society for Nuclear Cardiology on Medicare Reimbursement and RBRVS developments for nuclear cardiology.