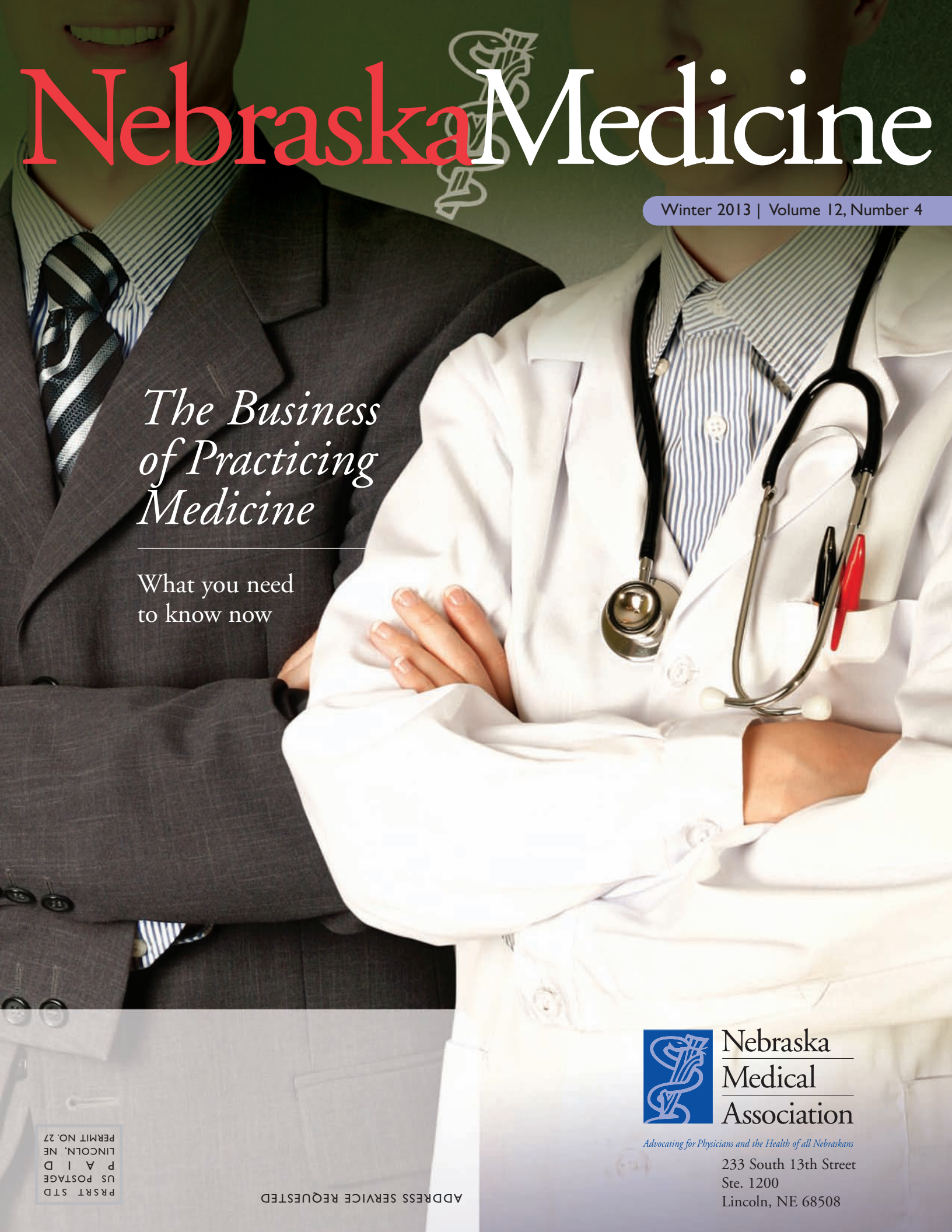

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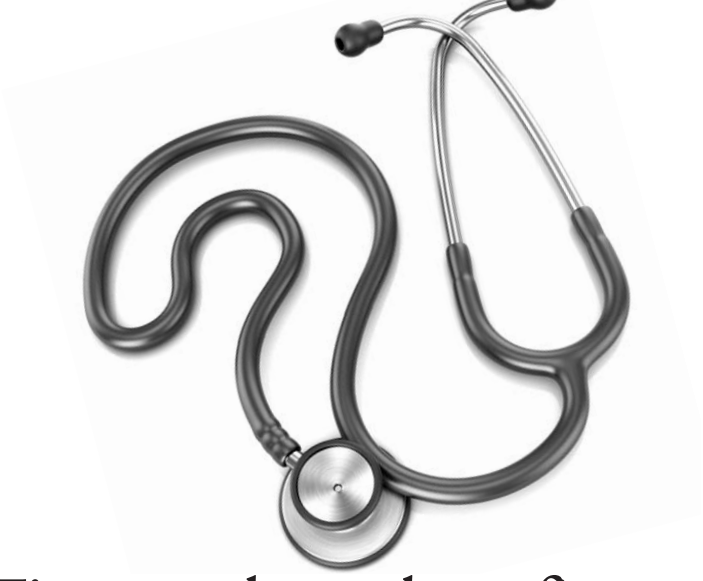

Five employee benefits and Affordable Care Act issues to consider before 2014

by Keith T. Peters, Partner
Cline Williams Wright Johnson & Oldfather, L.L.P.

As we look forward to 2014, employers face a number of changes in the laws that govern employee benefits. You have no doubt heard about changes due to the Patient Protection and Affordable Care Act (the "ACA") that dominate the news cycle. This article highlights five employee benefits-related items for employers to consider before the end of 2013.

1. Shared responsibility rules delayed until 2015.

The federal government has delayed the shared responsibility rules that apply to "applicable large employers." While the rules are difficult to concisely summarize, an applicable large employer generally means an employer with 50 or more full-time employees. A full-time employee generally means an employee who works 30 or more hours per week. An employer must add part-time employees to the total using a full-time equivalency. The Shared Responsibility Rules require an applicable large employer to provide full-time employees with the opportunity to purchase group health coverage that is affordable and provides minimum value. An employer who does not meet these requirements faces a penalty if employees obtain subsidized coverage from the Exchange or Marketplace.

IRS rules allow an applicable large employer to determine the identity of its full-time employees using the Lookback Measurement Period method. Generally, this means that the employer determines its full-time employees for a Stability Period according to employees' hours of service during a Measurement Period. The rules also contain safe harbors regarding the affordability of coverage.

In Notice 2013-45, the IRS announced the delay in enforcement and reporting requirements for the Shared Responsibility Rules until 2015. We recommend that applicable large employers use the delay to implement the Lookback Measurement Period method and confirm that the coverage will meet the affordability requirements.

2. Amend Health Flexible Spending Account ("Health FSA") Plans to limit contributions to $2,500; consider whether to offer the Health FSA carry-over.

The ACA amended Code Section 125 to limit employee contributions to Health FSA plans to $2,500 per year, beginning with the 2013 Plan Year. The IRS allows employers to adopt an amendment to apply these rules no later than the last day of the plan year that begins in 2013. An employer that sponsors a Health FSA should confirm that it has amended the Plan to implement this change, or that it will do so by the end of the year. The $2,500 limit is indexed for inflation, but the IRS made no adjustment for 2014.

The IRS recently issued new guidance that allows an employer to amend its Health FSA to allow a carry-over of up to $500 for the following Plan Year. To implement the change for 2014, the employer must adopt the amendment by the end of 2014.

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Final HIPAA regulations alter breach notification rules

by Sean D. White, Associate
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In January, final Health Insurance Portability and Accountability Act ("HIPAA") regulations were published implementing the Health Information Technology for Economic and Clinical Health Act ("HITECH"). These regulations finalized aspects of HITECH which have fluctuated since it was enacted in 2009. The regulations have many important implications for physicians, including business associate relationships, compliance documents (such as business associate agreements and notice of privacy practices disclosures), and specific rights maintained by patients with respect to their protected health information ("PHI"). This article, however, will focus on HIPAA's breach notification scheme as altered by the recent final regulations.

The final regulations change several aspects of prior guidance regarding breach notification. In short, prior regulations defined a breach as a use or disclosure of unsecured PHI in a manner not permitted by HIPAA which posed a significant risk of financial, reputational, or other harm to the individual. A breach is now defined as "the acquisition, access, use or disclosure of protected health information in a manner not permitted [by HIPAA] which compromises the security or privacy of the protected health information." 45 CFR § 164.402. Furthermore, "an acquisition, access, use, or disclosure of protected health information in a manner not permitted under [HIPAA] is *presumed* to be a breach unless [the covered entity] demonstrates that there is a low probability that the protected health information has been compromised." Id. (emphasis added). In other words, when confronted with a potential breach covered entities will often start with a presumption that a breach has occurred. The covered entity would then need to rebut this presumption or begin notification procedures. On the other hand, the old guidance required a showing of harm to implicate a breach which necessitated notification. HHS noted that these changes were implemented because the "harm" language could be construed to create a higher than intended threshold for triggering breach notification. 78 Federal Register 5566, 5641, Jan. 25, 2013.

In order to rebut a presumption that breach notification is necessary, the final regulations require covered entities to perform a risk assessment. This risk assessment includes several factors. It is the covered entity's burden to rebut the presumption by demonstrating that these factors indicate that a low probability exists that the impermissible acquisition, access, use or disclosure compromised PHI. Specifically, these factors include:

(i) The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

(ii) The unauthorized person who used the protected health information or to whom the disclosure was made;

(iii) Whether the protected health information was actually acquired or viewed; and

(iv) The extent to which the risk to the protected health information has been mitigated.

45 CFR § 164.402(2). HHS intended for this factor analysis to be less subjective than the prior "harm" standard. 78 Federal Register 5566, 5641-5642, Jan. 25, 2013.

However, there are also several exceptions which could apply. First, notification of a breach is only necessary if the PHI is "unsecured." 45 CFR § 164.404. PHI is considered "secured" if it has been encrypted in accordance with certain guidance outlined by HHS. Id.; see also http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brguidance.html. PHI is also considered "secured" if it is in paper, film, or hard copy media form and has been shredded or destroyed such that PHI cannot be read or otherwise reconstructed. Id. If PHI is in electronic media form, it will be "secured" if it is cleared, purged, or destroyed consistent with certain guidance outlined by HHS. Id. It is important to note that HHS can change this guidance in the future.

Other exceptions could also apply. For instance, assume a workforce mem-

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Peer review under the Health Care Quality Improvement Act

By Mark A. Christensen, Partner
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The Health Care Quality Improvement Act[1] was enacted in 2011. The Act significantly expands the protection provided to peer review and quality improvement activities in Nebraska. Its predecessor, Neb. Rev. Stat. § 71-2048, applied only to hospital-wide medical staff committees and hospital-wide utilization review committees. It provided for a peer review privilege as follows:

> The proceedings, minutes, records, and reports of any medical staff committee or utilization review committee as defined in section 71-2046, together with all communications originating in such committees are privileged communications which may not be disclosed or obtained by legal discovery proceedings unless (1) the privilege is waived by the patient and (2) a court of record, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure of such proceedings, minutes, records, reports, or communications.

In 1974, the Nebraska Supreme Court recognized the importance of a peer review privilege stating:

> The basis for the privilege extended to medical staff committees and utilization review committees is the public interest in the improvement of the care and treatment of hospital patients. The Joint Commission on Accreditation of Hospitals requires there be constant analysis and review of the clinical work done in a hospital. The importance of communication of information to the committees and full and open discussion in the committees during the review of clinical work can be easily seen.[2]

However, years later, the Court very narrowly construed the scope and extent of the privilege. In State ex rel. AMISUB, Inc. v. Buckley,[3] the Court held that an incident report and lists of patient falls at the hospital were not protected by the peer review privilege established by statute in 1971. The Court held "Because the documents were not specifically requested by a hospital-wide medical staff committee or hospital-wide utilization review committee, we conclude that the documents sought to be protected by AMISUB are not subject to the privilege outlined in § 71-2047."[4] The Court held that the privilege established in the 1971 statute extended only to documents requested by either a medical staff committee or a utilization review committee and did not extend to documents requested by departmental or unit-based committees.

The Health Care Quality Improvement Act specifically states that the purposes of the Act "are to provide protection for those individuals who participate in peer review activities which evaluate the quality and efficiency of health care providers and to protect the confidentiality of peer review records."[5] Peer review is defined as "the procedure by which health care providers evaluate the quality and efficiency of services ordered or performed by other health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, root cause analysis, claims review, underwriting assistance, and the compliance of a hospital, nursing home, or other health care facility operated by a health care provider with the standards set by an association of health care providers and with applicable laws, rules and regulations."[6] A health care provider is defined as: (1) a facility licensed under the Health Care Facility Licensure Act; (2) a health care professional licensed under the Uniform Credentialing Act; and (3) an organization or association of health care professionals licensed under the Uniform Credentialing Act.[7] The peer review privilege under the Act applies to the proceedings, records, minutes, and reports of a peer review committee as well as the persons who attend a meeting of a peer review committee, works for or on behalf of a peer review committee, provides information to a peer review committee, or participates in a peer review activity as an officer, director, employee or member of a governing board of a facility which is a health care provider. Those persons are not to be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings or activities of a peer review committee or as to any

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Is the Stark in-office ancillary services exemption on the way out?

by Jill Jensen, Partner
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An important Stark exception may be due for another overhaul by policymakers in the near future if recent U.S. Government Accountability Office ("GAO") reports, the president's proposed budget, and a House bill introduced in late summer are any indication.

The Stark Statute and its regulations prohibit physicians from making referrals of certain "designated health services" ("DHS") to entities that perform or bill Medicare for those services if the referring physician has a financial relationship with the entity receiving the DHS referral. This is the case unless an exception under the Stark Statute, 42 U.S.C. § 1395nn or its regulations, 42 C.F.R. Part 411, Subpart J., apply. Designated health services include the following services if paid for wholly or in part by Medicare:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and outpatient speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.[1]

The "in-office ancillary services exception" ("IOASE") permits physicians to make referrals for DHS services where those services are provided within the physician's own office, however. This is the case provided a number of requirements are met. The exception has been relied upon widely by physicians to permit them to provide X-ray, lab, pathology, imaging, and other DHS services to patients within the physician's own office or within a centralized facility.

The exception is under increased scrutiny because of two GAO reports, one that was issued in the fall of 2012, the other issued this past July. The fall 2012 GAO report highlighted the apparent correlation between referring physicians' ability to self-refer for advanced imaging services such as MRIs and CTs and the growth in Medicare expenditures for such services. The report found that from 2004 through 2010, self-referred and non-self-referred advanced imaging services—magnetic resonance imaging (MRI) and computed tomography (CT) services—both increased. However, a larger increase in numbers of such services was seen in self-referred services. Self-referred MRIs grew by more than 80 percent, compared to an increase of 12 percent for non-self-referred MRI services. The report further noted that expenditures for self-referred MRIs and CTs were higher than those for the same non-self-referred services. The GAO estimated that in 2010, those physicians making self-referrals for MRIs and CTs likely made 400,000 more referrals for those than they would have made if the physicians had not been self-referring, costing Medicare about $109 million and putting Medicare beneficiaries at greater health risks because of higher CT services being provided.[2]

The July 2013 GAO report focused on self-referrals in anatomic pathology, which involves examining tissues and other specimens to diagnose disease. The report found that self-referred anatomic pathology services grew at a higher rate than non-self-referred services from 2004 to 2010, and during that time, self-referred anatomic pathology services more than doubled while non-self-referred services grew about 38 percent. Unsurprisingly, Medicare expenditures for self-referred anatomic pathology services were higher than for non-self-referred services. According to the report, dermatology, gastroenterology, and urology comprised 90 percent of referrals for self-referred anatomic pathology services in 2010, and substantially increased the year after the physicians began to self-refer. The GAO stated that its findings suggest that the financial incentives related to self-referrals were a "major factor driving the increase in referrals."[3]

The scrutiny of physician use of the IOASE is nothing new. When the Patient Protection and Affordable Care Act was enacted in 2010, the Stark

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Statute was amended to require physicians relying upon the exception to make certain disclosures to patients if the physician was self-referring advanced imaging services. Section 6003 of PPACA amended the Stark Statute to add an additional disclosure requirement to the IOASE for certain advanced imaging services such as MRIs, CTs, PETs, and any other radiology services determined appropriate by the HHS Secretary. To comply with the IOASE, physicians providing such services would have to inform individuals in writing at the time of the referral that the individual could obtain the same services from another provider, and further required that the physician provide a written list of other persons who could provide the same services near where the patient resides. 42 U.S.C. § 1395nn(b)(2).[4]

After PPACA, the Medicare Payment Advisory Commission ("MedPAC"), in a report to Congress in 2011, recommended changes in how physicians are paid for self-referred diagnostic imaging services and other self-referred diagnostic tests as a way to curb perceived overutilization of such services and self-referrals.[5] Nevertheless, like the more recent GAO reports, the MedPAC report did not recommend actually changing the Stark exception. Concerns raised by MedPAC and the GAO are reflected in the President's proposed budget for FY 2014. Unlike the MedPAC and GAO reports, however, the President's budget would change the exception itself. In an effort to create "[a]dditional provider efficiencies," the President's FY 2014 budget would exclude certain services from the in-office ancillary services exception.[6]

This past August, HR 2914, the Promoting Integrity in Medicare Act of 2013 was introduced by Representative Jackie Speier (D-California) and Representative Jim McDermott, MD, (D-Washington) to further curb self-referrals related to in-office ancillary services. As proposed, the bill would "Maintain the in-office ancillary services exception" and "preserve its original intent" by removing advanced imaging, anatomic pathology, radiation therapy, and physical therapy from the exception's scope. In doing so, the bill is intended to protect "patients from misaligned provider financial incentives" and to save billions of dollars for Medicare. At the same time, however, the bill would not alter the rural provider exception.[7] The bill provides for higher civil money penalties for referrals related to certain "specified non-ancillary services" and would target and apply greater levels of review to entities the Secretary determines represent a high risk of noncompliance with the revised exception on a prepayment basis, through claims audits, focused medical review, and computer algorithms. This level of review would be used to identify payment or billing anomalies and would provide enhanced screening of suspect claims.

The bill defines a "specified non-ancillary service" as "a service that the Secretary has determined is not usually provided and completed during an office visit." Such "non-ancillary services" would include

- Anatomic pathology services, as defined by the Secretary; and
- The technical or professional component of
  - Surgical pathology.
  - Cytopathology.
  - Hematology.
  - Blood banking.
  - Pathology consultation and clinical laboratory interpretation services.
  - Radiation therapy services and supplies, as defined by the Secretary.
  - Advanced diagnostic imaging studies (as defined in section 1834(e)(1)(B)).
  - Physical therapy services.

Thus, the bill would reclassify some current designated health services and declare them outside of the scope of the IOASE. Further, the bill appears to provide the Secretary of H.H.S. substantial discretion in determining other types of ancillary services to exclude from the Stark exception. By doing so, the bill could radically alter the services provided in physician offices across the nation. Nonetheless, X-rays and ultrasounds would still remain within this important Stark exception's protections.

Over 30 physician organizations, including the AMA and American Medical Group Association among others, reacted strongly in opposition to the bill's introduction. These organizations sent a joint letter to members of Congress shortly after the bill was introduced asserting that the bill would limit patient access to in-office services

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Tax allocations when a partner leaves a practice

by Tara Wisdom, Healthcare Manager
Lutz & Company, PC

Let's say a partner in your medical practice exits part way through the firm's tax year. How are partnership tax items for that year allocated between the departing partner and the remaining partners? There is more than one way to handle this situation.

Here is a quick summary of how three methods can work.

1. Proration Method

This option is very simple, but it may not accurately reflect economic reality. Under the proration method, the departing partner's share of the firm's tax items for the entire year are determined based on:

- The portion of the year that he or she is a partner; and
- His or her percentage share of profits and losses during that period.

EXAMPLE: A partner with a 10 percent share of profits and losses leaves on June 30 of the current year. The partnership uses a calendar tax year and the proration method. Since the departing partner was present for half the tax year (six months out of 12), he is allocated five percent (10 percent times ? equals five percent) of all partnership tax items for the year - including any gains or losses from asset depositions.

As you can see, the proration method is very simple. However, it may not be very fair if, for example, the firm earns 75 percent of its income from professional services in the second half of the year and has a large capital gain in December from selling its office building. In that case, using the proration method would effectively allocate "too much" income and gain to the departing partner and "too little" to the remaining partners.

2. Interim Closing of the Books Method

As an alternative to the proration method, the partnership can conduct an interim closing of the books at the time the partner departs. Under this procedure, the partnership's books are closed on the exit date, and the tax items from the beginning of the tax year up to the exit date are totaled.

Then, the departing partner is allocated his or her normal percentage share of those amounts.

The partner is allocated zero percent of the tax items for the period after his or her exit. This method more accurately reflects economic reality, but it is more complex. In some cases, the cost of conducting an interim closing of the books is deemed to be prohibitive.

EXAMPLE: Assume the same basic scenario as in the example above. Assume the firm earns 75 percent of its income from professional services in the second half of the year and has a big capital gain in December from selling its office building. Under the interim closing of the books method, the departing partner is allocated only 2.5 percent (10 percent times 25 percent equals 2.5 percent) of the income from professional services and zero percent of the capital gain from selling the office building. Obviously, this is a much better reflection of economic reality than allocating the departing partner five percent of the income from professional services and five percent of the capital gain, as would happen under the proration method.

3. Another "Reasonable Method"

Federal tax regulations also allow partnerships to use "other reasonable methods" to allocate tax items to departing partners. For instance, your partnership could choose to allocate most tax items using the simple proration method while allocating tax items arising from certain non-recurring events (such as income from major litigation settlements and gains or losses from major asset sales) only to those partners who are actually on board when the transactions occur.

EXAMPLE: Again, assume the same basic facts as in the first example when a partner with a 10 percent share of profits and losses leaves on June 30 of the current year. Except in this case, assume the firm's income from professional services is earned relatively evenly throughout the year. Therefore, a decision is made to allocate income from professional services using the proration method and gain from selling the office building only to those partners who are still with the firm on the sale date.

Under this "reasonable" method, the departing partner is allocated five percent (10 percent times 1/2 equals five percent) of the income from professional services and zero percent of the capital gain from selling the office building. This is a reasonable reflection of economic reality that is likely to be acceptable to all concerned, and it doesn't

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Selling your private medical practice

by Michael C. Pallesen, Partner, and Heather A. Carver, Associate
Cline Williams Wright Johnson & Oldfather, L.L.P.

A recent study published by the American Medical Association confirms a national trend that has received considerable attention in the media: the declining numbers of physicians remaining in independent private practice. The study, published this year, indicates that the number of physicians who are full or part owners of a medical practice has decreased by eight percent in just the last five years.[1] While the trend was already well underway in the early 1990s, with the number of physicians owning medical practices decreasing by 11 percent between 1983 and 1994,[2] recent health care reform may play a major role in perpetuating the trend.

The challenges of practicing under the Affordable Care Act are causing independent private practice physicians, who already faced a myriad of challenges including paying soaring malpractice insurance costs, dealing with revenue cycle difficulties, and managing staff, to evaluate their present practice arrangements. Private practice physicians not wanting to meet these challenges alone or in small practices may choose to sell or combine their practices. However, the decision to sell a medical practice should not be taken lightly. This article will address some of the basic considerations that should be taken into account in determining whether to sell a medical practice and how to structure the transaction.

Once a physician has made the decision to sell his or her practice, the physician is faced with the challenge of locating a buyer. In order to effect a smooth transition, the selling physician should locate a buyer that shares the selling physician's skills, specialties, and philosophies, such that the buyer will be able to retain as many of the selling physician's patients as possible.

Having found a buyer, the essence of the transaction is initially articulated in a confidentiality agreement and, if the parties have determined the structure of the transaction with greater detail, a letter of intent, which is signed by both parties. The letter of intent, while non-binding as to material terms of the transaction, generally sets the parameters of the negotiations and in a sense commits the parties mentally to the agreement. The letter of intent may be completely non-binding or may include certain terms that the parties agree to be binding. For example, the letter of intent may include binding terms as to confidentiality and non-solicitation of employees and/or patients (whose information will be shared as part of the transaction discussions). Following the letter of intent the buyer will conduct a "due diligence" investigation of the seller's practice. This process allows the seller to satisfy itself that the practice being purchased is worth the consideration being paid and does not carry unknown risks or liabilities.

The sale/purchase transaction itself may be structured as either an asset purchase or a stock purchase (or in the case of a limited liability company the purchase of the membership interests), depending on the preferences of the parties. In an asset purchase transaction, the buyer buys only the practice's assets and does not inherit any liabilities unless specifically agreed. In a stock purchase agreement the buyer acquires both assets and liabilities. Thus, the more typical arrangement in the context of a physician practice sale transaction is an asset purchase.

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The precise nature, terms and complexity of the transaction can vary widely from deal to deal. The purchase price agreed upon by the parties should account for both the practice's tangible and intangible assets, in order to reflect the fair market value of the practice. It is important to note that under federal law, valuation of the practice must not include the value of existing or future referrals. However, payment for goodwill, which is based on the practice's reputation, location, and profitability, is appropriate, subject to certain restrictions. Beyond the purchase price, other terms in a typical transaction include representations and warranties by the seller as to ownership of assets, compliance, and any liability which could affect the value of the assets or practice being sold. A covenant not to compete is another likely provision in the purchase agreement as the buyer will want to ensure that the selling physician cannot become quickly dissatisfied with his or her decision and significantly reduce the value of the purchased practice by establishing a

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Prevent revenue leakage with effective internal controls

by Tara Wisdom, Healthcare Manager
Lutz & Company, PC

There are three main factors that contribute to fraud in the small office setting: inadequate employee pre-screening—small practitioner offices rarely spend money to check work references or records of potential hires; limited controls—the entity usually has insufficient personnel to adapt adequate controls; and too much trust—the very thing that makes a small practitioner office a pleasant place to work also enables thieves within it to succeed.

Small practitioner offices rarely spend the money to check work references, criminal records, or professional recommendations of potential hires or require applicants to undergo drug screening, psychological testing, and other vetting procedures. Undesirable applicants know this and thus gravitate to smaller office settings.

The foundation of fraud prevention is the division of responsibilities between employees. No employee should handle a financial transaction from beginning to end. Employees who handle cash should not have access to the books. The reason is straightforward enough: It is one thing to steal by yourself but quite another to enlist the aid of a coworker. Practitioner's offices rarely have sufficient personnel to adapt adequate controls; "one-person accounting departments" are the rule, not the exception. Consequently, it becomes important for the practitioner to overcome this deficiency with reasonable oversight, which can be accomplished two ways. First, the practitioner should actively understand and verify the financial information reported to him or her. Second, the practitioner can engage a CPA to attest to the credibility of the financial information, even if the practice doesn't have a regular audit. In addition, the threat of an audit can be a powerful deterrent in its own right.

Another factor contributing to fraud losses in a small office setting involves the human element. In a situation where employees know each other well, it is natural for them to trust one another. Indeed, the intimate familial atmosphere of a small business is one of its most appealing features. Most of the time, believing in your coworkers is well founded, but not always. The dichotomy is that trust is an essential element of business as well as an essential element of fraud. Never having faith in your employees is a bad thing; so is always trusting them. The goal is to strike a balance between the two.

A common misconception is if the owner or practitioner is the only one with check signing authority "they would notice anything unusual" on checks prepared and presented to them for signing. This may seem a logical conclusion but in many cases, the simple truth is the owner or practitioner is not intimately familiar with every one of the practices vendors. As long as the check amount isn't substantial the trust placed in their employees provides a comfort level that the disbursement is legitimate. After all, practitioners are very busy and "my employees wouldn't dare, they're good people."

Practitioners should become informed about the contributing factors of fraud and the related schemes to understand the implications they may have in fraud prevention in their practices. Above all, the owner/practitioner should receive an unopened bank statement so he or she can review it for suspicious transactions. Moreover, the owners/practitioners need to ensure they understand the practice's revenue and expense streams so they will be able to notice unusual trends. All material misappropriations of cash eventually show their signs: reduced cash, combined with increased expenses and/or decreasing revenues. □

Common employment law mistakes in a medical practice

by Susan Kobert Sapp, Partner
Cline Williams Wright Johnson & Oldfather, L.L.P.

Many small business owners do not get too concerned about employment law issues until after a discrimination claim is made or the Department of Labor arrives at the door to conduct a Wage and Hour audit. The best way to avoid a time consuming complaint or a costly audit is prevention. Set forth below are the most common mistakes and how to avoid them.

1. Thinking that employment laws do not apply to small offices with a limited number of employees.

Federal discrimination laws prohibiting discrimination on the basis of gender, marital status, pregnancy, disability, age and race apply whenever an employer has 15 or more employees. Local ordinances, however, reduce that number down as low as one employee (Grand Island); four employees (Lincoln); or six employees (Omaha).

Family Medical Leave Act ("FMLA") does not apply unless the employer has 50 or more employees, but employers must still be prepared to deal with maternity leaves, employee disabilities, illnesses, injuries, and discretionary leave requests.

Having an up-to-date employee handbook and providing in-house employee and supervisory training is the best defense. Our attorneys do many in-house trainings each year on a variety of employment law topics at a minimal cost.

2. Not recognizing employer responsibilities under USERRA.

USERRA protects returning veterans by prohibiting discrimination after deployment. USERRA is violated when veteran status is a motivating factor in an employer's adverse action. Recent changes to the Family Medical Leave Act provide additional leave eligibility for active duty employees and immediate family members of active duty employees.

3. Not educating employees, managers, and supervisors regarding anti-harassment, Americans with Disabilities Act, USERRA, how to make reasonable accommodations and how to avoid retaliation claims.

Training for your decision-makers is crucial in protecting your practice from legal liability for violation of state or federal employment laws. Providing periodic anti-harassment training for all employees is key. It is also important to have an up-to-date anti-harassment policy that informs employees how to make a complaint, to whom they should make the complaint, and what to expect in terms of resolution.

Harassment is illegal if it is based on membership in a protected class, i.e., gender, race, marital status, religion, national origin, disability, pregnancy, and age. The most common complaint is sexual harassment, but religious harassment has grown in frequency over the last decade. Reasonable accommodations for religious beliefs is a hot topic and employers must proceed carefully when responding to an employee's concerns.

Employers need to make sure that their managers and supervisors are trained to recognize when an employee is making a Family Medical Leave Act request for time off due to a serious health condition; when an employee with a disability is asking for a reasonable accommodation; what constitutes a reasonable accommodation; and how the Americans with Disabilities Act interrelates with workers' compensation laws in the case of a workplace injury or accident. Most managers and supervisors can be properly trained during a one to two hour presentation regarding the key legal issues.

4. Not staying up to speed on personnel matters.

A common mistake is for physicians and practice owners to rely heavily on office managers and practice managers to handle personnel concerns. If the office manager or practice manager acts illegally on behalf of the practice, the office manager is not personally liable, the practice is liable. It is important for practice owners to become familiar with each situation before termination decisions are made.

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Five employee benefits and Affordable Care Act issues to consider before 2014 *(continued)*

Employers interested in this change should contact their Health FSA provider or counsel for an amendment.

3. Possible changes to Health Reimbursement Arrangements ("HRAs").

The ACA will significantly limit employers' use of HRAs that are not "integrated" with a group health plan beginning January 1, 2014. Unless the HRA is integrated, it cannot satisfy certain requirements of the Public Health Service Act ("PHSA") that were added by the ACA. The PHSA contains new rules that prohibit group health plans from imposing lifetime limits and require preventative care services without deductibles.

Prior to the ACA, employers often used an HRA to reimburse employees individual health insurance policies. The recent IRS guidance indicates that these premium reimbursement plans will no longer satisfy the PHSA beginning January 1, 2014. Unless an HRA is integrated with an underlying group health plan, it cannot satisfy the new PHSA requirements.

To be integrated, the HRA must meet one of the following requirements: (1) the HRA must be used to pay co-pays or deductibles that are not paid by the employer's group health plan (provided the Plan meets the minimum value requirements); or (2) the HRA must be available only to employees who are enrolled in the employer's group health plan or in a group health plan of a family member. An HRA that reimburses premiums for individual insurance policies does not satisfy these rules. If your employer has provided health insurance through a premium reimbursement HRA, we recommend that you contact counsel as soon as possible.

4. Consider individual mandate issues.

As of the date this article is due, Congress has not delayed the individual mandate of the ACA. The ACA requires each taxpayer to obtain "minimum essential coverage" or pay a tax. For 2014, the tax is equal to the greater of 1% of adjusted gross income or $95 times the number of individuals in the taxpayer's household (maximum of three). Minimum essential coverage includes employer-sponsored health coverage, policies available on the individual market, Medicare, Medicaid, a grandfathered health plan, and certain state health benefits risk pools. Individuals should continue to monitor the status of the individual mandate, as problems with the www.healthcare.gov website and other issues regarding implementation of the federal health exchanges could result in a delay of the individual mandate.

5. Implications of the U.S. v. Windsor decision.

The U.S. Supreme Court ruled in June 2013 that the federal Defense of Marriage Act is unconstitutional. See U.S. v. Windsor, 570 U.S. ___ (2013). The Windsor Court concluded that marriage will be defined by state law. The IRS, DOL, HHS, and other federal agencies have been issuing guidance to implement the decision. The guidance from these agencies will impact retirement, health, and employee benefits plans, as well as FMLA, COBRA, HIPAA special enrollment rights, and other fringe benefits. We recommend that employers work with counsel to determine how these changes will affect their benefits. □

Final HIPAA regulations alter breach notification rules *(continued)*

ber unintentionally acquires, accesses, or uses PHI. In that situation, a breach will not occur to the extent the acquisition, access, or use was made in good faith, within the scope of authority of the workforce member, and does not result in further impermissible uses or disclosures. 45 CFR § 164.402(1)(i). Similarly, no breach occurs if a person authorized to access PHI at a covered entity inadvertently discloses PHI to another person who is authorized to access PHI at the same covered entity and the PHI is not further impermissibly used or disclosed. 45 CFR § 164.402(1)(ii). Finally, no breach results from an impermissible disclosure of PHI by a covered entity when the covered entity has a good faith belief that the unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information. 45 CFR § 164.402(1)(iii).

Despite these exceptions, the final regulations create many situations where a detailed risk assessment will be required. This can require physicians to make difficult judgment decisions in a relatively short amount of time. The covered entity will generally only have 60 days to properly notify individuals of the breach, and potentially to report the breach to local media and HHS. 45 CFR §§ 164.404-408. However, it is critical to conduct a thorough and documented risk assessment when a potential breach is uncovered. In order to guide this analysis, covered entities should have updated policies and procedures which address the new breach notification standards under the final regulations. It is also prudent to involve advisers who are knowledgeable regarding HIPAA breach notification rules. Such advisers should be involved with revising policies and procedures in addition to addressing potential breaches. □

Is the Stark in-office ancillary services exemption on the way out? *(continued)*

that physicians provide and would "limit access to life-saving services for many patients." The groups contended that the bill's requirements would "stifle new innovative reforms already underway to improve care delivery and quality improvement."

Given the President's top priorities for the remaining days of 2013, post-government shutdown, physicians will want to monitor closely further developments concerning the in-office ancillary services exception and whether this important Stark exception will be subject to further limits through H.R. 2914 or other governmental action.

1. Designated Health Services do not include certain services that are reimbursed by Medicare as part of a composite rate, however, such as dialysis services, ambulatory surgical services, or Medicare Part A services in a skilled nursing facility. This is the case unless the services themselves listed as DHS are paid for by a composite rate, such as home health services or inpatient or outpatient hospital services. 42 C.F.R. § 411.351.
2. U.S. General Accounting Office, *Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions,* Report to Congressional Requesters, Washington, Sept. 2012.
3. U.S. General Accounting Office, *Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer*, Report to Congressional Requesters, Washington, June 2013.
4. The implementing regulation for this requirement is found at 42 C.F.R. § 411.355(b)(7).
5. Medicare Payment Advisory Commission ("MedPAC"), *Report to Report to the Congress: Medicare and the Health Care Delivery System*, Washington, June 2011, 2-2, 2-3, 2-4.
6. Office of Management and Budget, *Fiscal Year 2014 Budget of the U.S. Government*, Washington, April 2013 at 197.
7. H.R. 2914, 113th Congress, 1st Sess. (2013) 5-6. □

Peer review under the Health Care Quality Improvement Act *(continued)*

findings, recommendations, evaluations, opinions or other actions of the peer review committee or any members thereof.[8] In addition, incident reports and risk management reports and the contents of an incident report or risk management report are not subject to discovery, and are not admissible in evidence in the trial of, a civil action for damages for injury, death or loss to a patient of a health care provider.[9]

The plain language of the Act substantially expands the scope of the privilege as it applies to documents or information gathered by peer review committees. However, perhaps more significantly, the Act arguably extends the privilege beyond hospitals to surgical centers, physician's offices, or other organizations or associations of health care professionals.

The purpose of peer review is the improvement, through self-analysis, of the efficiency and safety of medical procedures and techniques. Confidentiality is essential to the effective functioning of peer review committees or quality improvement committees. If peer review discussions and deliberations are subject to discovery in civil litigation, deliberations will be abbreviated, cryptic, or terminated. "Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleagues conduct in a malpractice suit."[10] Now, under the Health Care Quality Improvement Act such self-critical analysis will be better protected, even in the context of a private physician's clinical practice.

With the availability of the expanded protection offered by the Nebraska Health Care Quality Improvement Act, every organization or association of health care professionals should consider establishing a peer review committee that meets the definitions set forth in the Act and enacting policies and procedures to comply with the Act to protect peer review and quality improvement discussions and actions.

1. Neb. Rev. Stat. § 71-904, et seq.
2. Oviatt v. Archbishop Bergan Mercy Hospital, 191 Neb. 224, 226, 214 N.W.2d 490, 492 (1974).
3. State ex rel. AMISUB, Inc. v. Buckley, 260 Neb. 596, 618 N.W.2d 684 (2000).
4. 260 Neb. 596, 611, 618 N.W.2d, 695.
5. Neb. Rev. Stat. § 71-7905.
6. Neb. Rev. Stat. § 71-7909.
7. Neb. Rev. Stat. § 71-7907.
8. Neb. Rev. Stat. § 71-7912.
9. Neb. Rev. Stat. § 71-7913.
10. Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (U.S. Dist. Ct., D.C. 1970). □

Tax allocations when a partner leaves a practice *(continued)*

impose any extra accounting burden on the partnership.

CONCLUSION: Federal income tax regulations allow the partners in your medical practice to select a method that will be used to allocate tax items between a departing partner and the remaining partners. The firm's partnership agreement could stipulate that one specific method will always be used. Alternatively, the method to be used could be determined on a case-by-case basis by agreement between the partners (this option could also be specified in the partnership agreement).

The important factor to understand is that the allocation method used can have significant positive or negative tax ramifications for the partner who is leaving and the remaining partners. Your tax adviser can explain the best option in your practice's situation. □

Selling your private medical practice *(continued)*

competing practice shortly following the sale. Again, however, every transaction is different and great care must be taken to ensure that the needs of the particular situation are addressed in the agreement as appropriate.

A selling physician must also provide adequate notice of the impending sale to the practice's patients to ensure continuity of medical care. Careful planning is important here because what constitutes adequate notice varies with each patient's individual treatment and failure to provide such notice could result in exposure for professional negligence. Often, at the time the practice is sold, a letter is sent to practice patients notifying them of the sale and introducing the buying physician or new group arrangement. This letter might also contain an authorization to continue medical care, which gives the buying physician the right to view the patient's medical records. It is important to note that, due to their confidential nature, medical records cannot be sold along with the practice. Patient medical records are retained by the buying physician for a statutorily specified period, but the buying physician may not view them until he or she receives implied or express consent from the patient.

The physician selling his or her practice must arrange for disposal of controlled substances in accordance with local and federal laws. If the selling physician is retiring upon completion of the transaction, the physician may wish to cancel his or her malpractice insurance, but should first take a close look at what type of policy he or she has in order to ensure that he or she is protected against future claims, despite cancellation of the policy (e.g., a so-called "tail"). Finally, prior to selling his or her medical practice, a physician must consider whether the practice is a party to any agreements and whether those agreements will or are desired to survive the sale of the practice. Agreements that are deemed to be personal to the selling physician terminate upon the transfer of the practice, while other agreements are assumable by the buying physician or group and thus, add value to the transaction. Leases for office space and equipment are examples of agreements that may not be immediately terminable or that the purchaser may want to assume as part of the transaction.

1. Carol K. Kane & David W. Emmons, *Policy Research Perspectives: New Data on Physician Practice Arrangements*, American Medical Association, 8 (Sept. 17, 2013), http://www.ama-assn.org/ama/pub/news/news/2013/2013-09-17-new-study-physician-practice-arrangements.page.
2. Carol K. Kane & David W. Emmons, *Policy Research Perspectives: New Data on Physician Practice Arrangements*, American Medical Association, 8 (Sept. 17, 2013), http://www.ama-assn.org/ama/pub/news/news/2013/2013-09-17-new-study-physician-practice-arrangements.page. ☐

Common employment law mistakes in a medical practice *(continued)*

5. Committing Illegal Retaliation against an employee.

In Nebraska, an employer cannot retaliate against an employee for making a complaint of discrimination or for having a workers' compensation injury or taking FMLA leave. If an employee who has made a discrimination complaint, has had a workers' compensation injury, or has taken FMLA leave has a performance issue requiring termination, documentation should be thorough. Make sure that termination is consistent with how similar issues have been handled for employees who have not made complaints, had a workplace injury, or taken FMLA leave.

6. Ignoring Wage and Hour laws.

Owners of small businesses often assume they will not be audited by the Department of Labor, or if they treat their employees well their employees will not make a Wage and Hour claim. Therefore, little attention is paid to the Federal Wage and Hour Laws ("FLSA") and the Nebraska Wage Payment and Collection Act, resulting in some common and expensive mistakes.

a. Misclassifying hourly employees as exempt.

Only certain employees can be salaried employees. An employee who is not entitled to be salaried cannot agree to be salaried. Rather, the position has to fall within one of the specific exemptions often referred to as "white-collar" exemptions.

The most common exemptions are the **executive exemption**, which has as one of its requirements that the position must directly supervise two or more employees and have the authority to fire or hire; the **administrative exemption** which requires the employee to perform management or general business operations while exercising "discretion and independent judgment" with respect to matters of significance; the **professional exemption**, which requires a certain degree in order to be performed (lawyer, doctor, nurse); and the **outside sales exemption** which requires the employee's position to consist largely of sales or obtaining orders or contracts for services.

Problems arise when an employee is paid a salary (rather than paid by the hour) and the employee is not properly exempt. The Department of Labor can conduct an audit and make the employer go back and pay the employee overtime for the hours he or she worked in excess of 40 hours a week, along with penalties. Often, the employer does not have records to show how many hours the employee worked; therefore, the employee will be believed when he or she recounts the approximate number of hours worked, even if the number is exaggerated.

Employers should undertake a periodic legal review of all job descriptions and duties to make sure that all non-exempt employees are being paid by the hour and receiving overtime, unless their positions fall squarely within one of the exemptions that allow the employees to be salaried.

b. Failing to accurately calculate overtime pay.

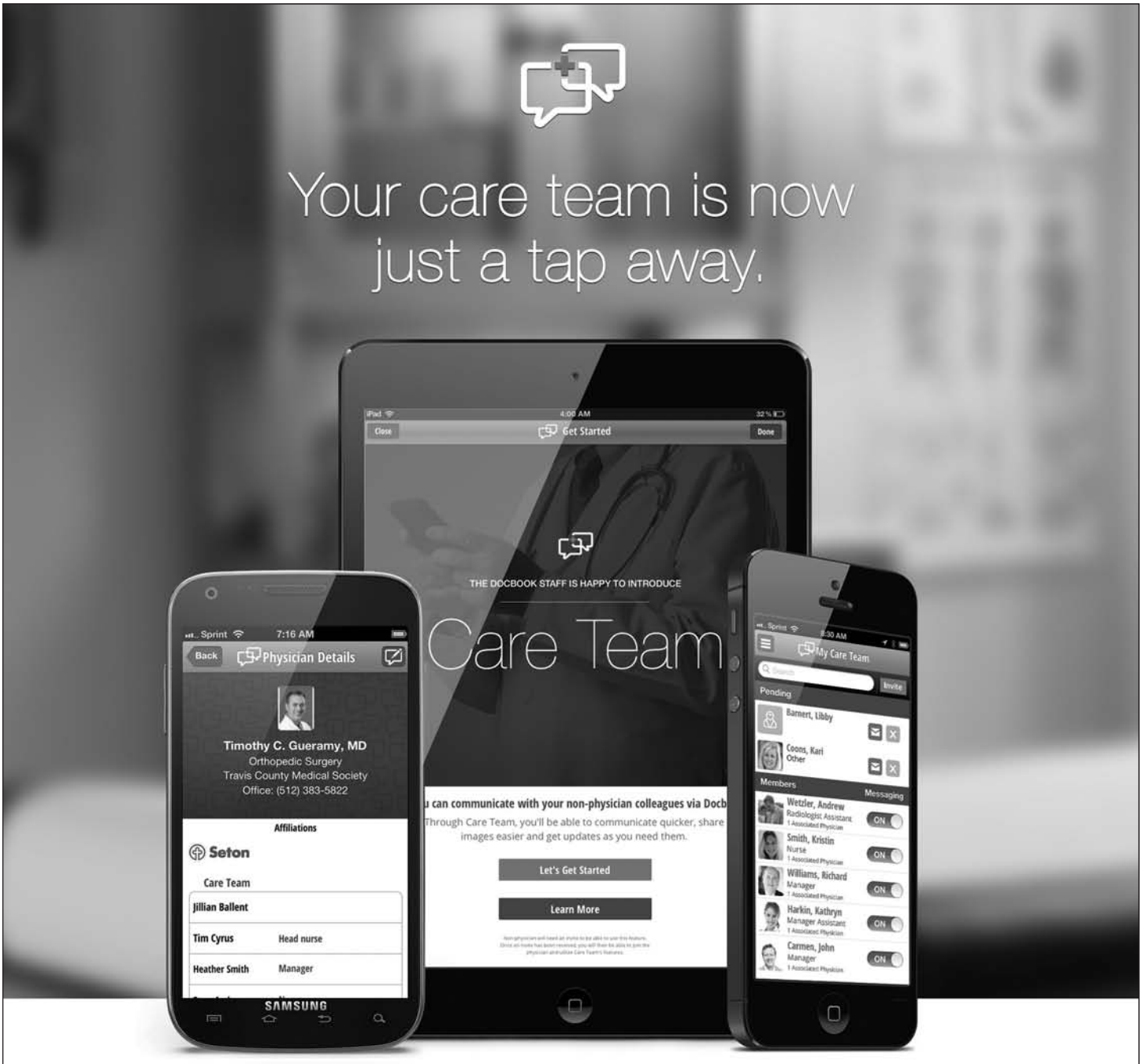
If employees are paid by the hour and receive bonuses on a periodic basis, in most cases those bonuses have to be included in the regular rate of pay *before* overtime is calculated. This does not apply to a discretionary holiday gift or unexpected bonus. If the employer has a bonus program where employees know what they need to do to earn a bonus, then it is a non-discretionary bonus which has to be included in their total wages before overtime is calculated.

c. Allowing employees to work "off the clock."

Overtime compensation must be paid for all overtime work, whether or not overtime is formally authorized. To the extent the employer is aware, or should be aware, that employees are working overtime, the employees must be paid time and a half for all hours in excess of 40 per week. The reason for their work is immaterial. If they take work home, that has to be compensated (unless they are properly salaried). Employees cannot "volunteer" their work to the employer. If employees are paid by a time clock, they should be paid to the minute, or their time should be rounded to the nearest quarter hour, according to the "seven minute rule."

d. Giving compensatory time off.

Many private employers mistakenly believe they can allow hourly employees to take "comp time" in lieu of overtime. Private employers are not allowed to pay comp time. If employees work more than 40 hours in a work week, they must be paid time and a half for all overtime hours. □



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Tax Mitigation: Making the Most of Your Losses

by Ross Polking
Provided by the Foster Group

One crude reality of life is that nearly every investor will experience investment losses at some point. It is possible, however, to enhance wealth even in the midst of negative returns. One such strategy is tax loss harvesting (TLH), where securities with losses are sold to offset capital gains (current and, perhaps, future) in a taxable investment account. The ultimate idea is to mitigate tax liability you would otherwise experience as a result of these capital gains. A few things must be kept in mind, though.

The 'Wash-Sale Rule' was devised to ensure investors were not harvesting losses merely as a tax-avoidance strategy, or "sham transaction." It prohibits a taxpayer from claiming a loss on the sale of a security if they purchase a "substantially identical" security within 30 days of the sale date. Since most investors don't want to lose their position in a given investment simply to lower their tax burden, the cash resulting from TLH can be allocated to similar stocks or securities that maintain comparable asset-class exposure.

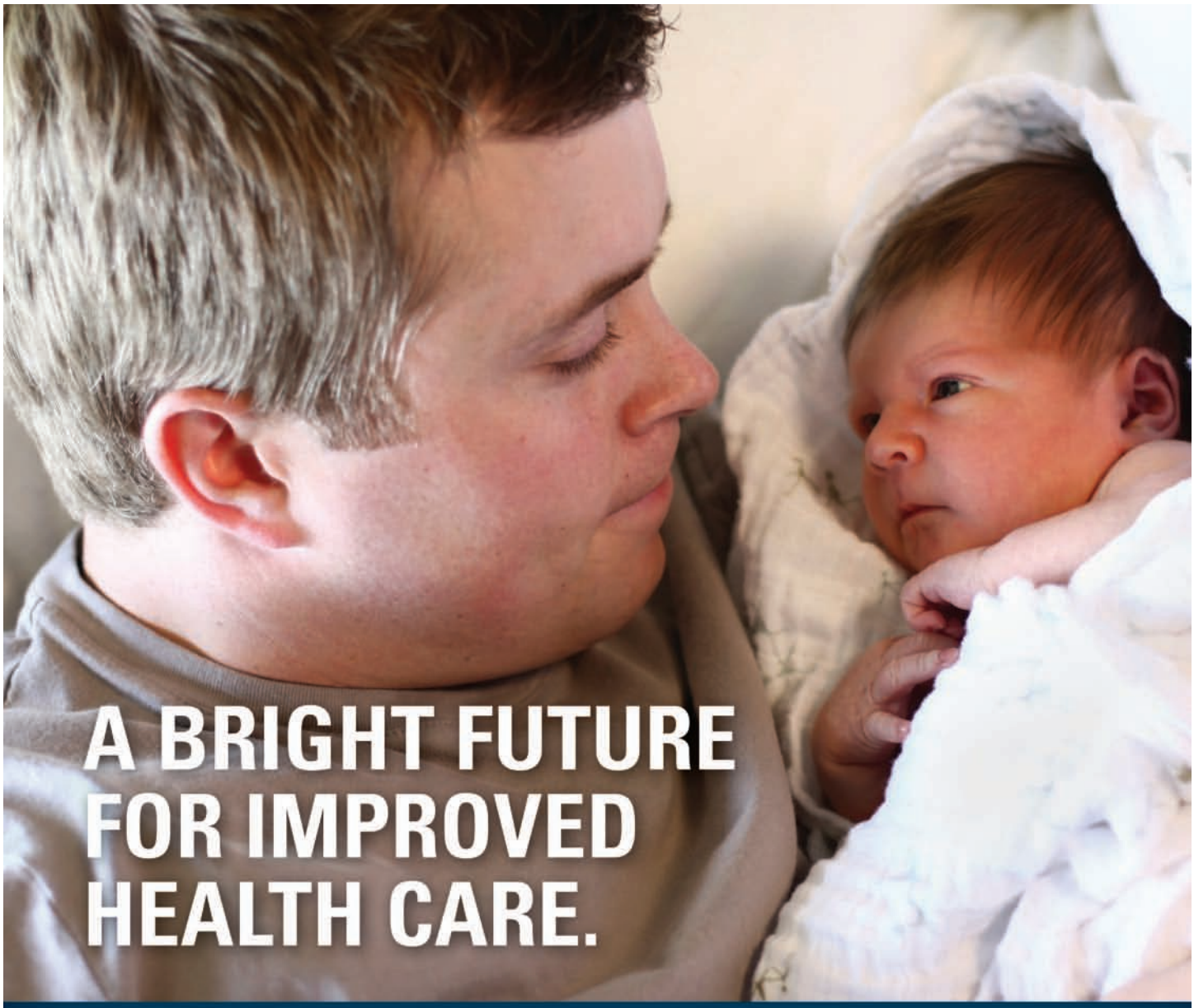
Recent tax changes also come into play. The American Taxpayer Relief Act of 2012 (ATRA) introduced a new top capital gains rate of 20 percent, applying to thresholds of $400,000 for individuals and $450,000 for married couples. In addition, as part of the Patient Protection and Affordable Care Act, a 3.8% tax on net investment income—including annuities, dividends, interest, passive income, rents, royalties and any recognized taxable capital gains—was added. This tax applies to thresholds of $200,000 of Adjusted Gross Income (AGI) for individuals and $250,000 of AGI for married couples. So how does this tie into TLH?

Let's say a married couple has $251,000 of AGI after recognizing gains and incorporating deductions. Their 15 percent tax rate just went up, after crossing the threshold, to 18.8 percent thanks to the new tax! TLH may then come into play by reducing their AGI, allowing them to stay in the 15 percent bracket. The same is true of an individual who has $425,000 in AGI. But they face an even steeper increase with both the investment income tax and the new 20 percent long-term capital gains tax rate. All told, taxpayers in the highest bracket face a combined 43.4% marginal tax rate on their investment income such as short-term capital gains, dividends and interest, as well as a 23.8 percent tax on all long-term capital gains! For these investors, TLH could make a huge difference IF they plan ahead. These strategies are only relevant and effective if they're completed in the calendar year in which these income levels are reached.

The IRS allows taxpayers to deduct investment losses equivalent to any capital gains they have on a dollar-for-dollar basis, without limitation. Any investment losses unused in a particular year may be carried forward for use in future years with no "expiration date." Additionally, $3,000 can be deducted each year against ordinary income.

When you're realizing losses for tax purposes, it's good to have a plan for maximizing the benefits available to you. As you can see, TLH is an important tool that can help the overall enhancement of wealth in the context of a sound *long-term* financial plan. Be certain to consult with your tax advisor to see how any actions will apply to your specific circumstances…and stay diversified.

The information and material provided in this article is for informational purposes and is intended to be educational in nature. We recommend that individuals consult with a professional advisor familiar with their particular situation for advice concerning specific investment, accounting, tax, and legal matters before taking any action. □



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