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Six Rules to Help You Identify Protected Health Information

The HIPAA privacy regulations are now final. Health care organizations (a term that includes physician practices) have until April 14, 2003 to comply with the regulations, which impose tough new restrictions on the use and disclosure of protected health information (PHI) by health care organizations and their employees. You'll need to establish policies to help you to maintain the confidentiality of PHI. Keep watching the *Insider*—in future issues we'll give you some model policies and procedures that will help you handle HIPAA. To get started, you must first understand what PHI is so you know when to comply with the new privacy regulations. You may think that PHI is simply a patient's computer records. But PHI can be a lot more than that. To help you recognize it in all its forms, we'll tell you what the regulations say and give you six rules for identifying PHI.

WHAT REGULATIONS SAY

The HIPAA privacy regulations define PHI as health information that's individually identifiable and created or received by a health care organization.

If you improperly use or disclose PHI, you or your practice may face stiff penalties for violating the HIPAA privacy regulations. These penalties include:

- Federal fines of $100 per accidental violation;
- A maximum fine of up to $250,000 for malicious violations; and
- Federal prison sentences of up to 10 years for selling PHI or using it to harm someone.

In addition, your practice must have its own policies on improper disclosure and use of PHI by employees, and those policies could include disciplinary action—including termination.

SIX RULES TO HELP YOU IDENTIFY PHI

To help you identify PHI, follow these six rules.

Rule #1: PHI Can Be Written or Oral

A patient's medical record or file is PHI. But PHI includes many other written materials that you may not have thought were PHI. For example, depending on the circumstances, each of the following might be PHI:

- A sign-in sheet that includes the patient's name and the reason for her visit;
- A code that documents a specific health procedure or test; and
- A patient identification bracelet or badge, or an insurance card.

Oral communications can also be PHI, points out health care attorney M. Peter Adler. "Conversations can be overheard," he notes.

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PROTECTED HEALTH INFORMATION (continued from p. 1)

That means the following examples might be PHI:

- A conversation about a patient's health over lunch with a colleague;
- An appointment reminder message left on an answering machine;
- A telephone call to verify health insurance coverage; and
- A patient's medical records dictated onto a tape.

Rule #2: PHI Can Be Recorded on Paper, Computer, or Other Media

PHI can be information that's written or typed on paper, as well as information recorded on or sent by a computer. It can also be information in any other media, such as X-ray film. The proposed HIPAA privacy regulations covered only computer records. The final regulations cover paper, computer, and other media.

So paper documents stored in a patient's medical file are PHI. Other forms of PHI can include:

- Physician dictation that has yet to be transcribed;
- Patient status boards;
- Eligibility printouts—that is, information sheets printed by managed care companies outlining if the health care services required by the individual are covered by the plan;
- Financial records;
- Hospital face sheets, cover sheets, and head sheets—copies of patient demographic information used on files by large health care organizations to avoid collecting the same information over and over again;
- Fax sheets; and
- Test results.

Computerized PHI can include:

- Data appearing on computer monitors and screens;
- Information transferred by magnetic or optical devices from one location to another;
- Data stored or communicated on the Internet, extranet, or an intranet;
- Data stored on electronic memory chips; and
- Magnetic tapes, discs, or CDs.

Rule #3: Information that Reveals the State of a Person's Health Can Be PHI

PHI can be any information related to:

The past, present, or future physical or mental health or condition of a person. For example, saying the words "Mr. Smith has cancer" or jotting notes about Mrs. Jones' next dialysis appointment in her file both convey information related to the person's past, present, or future health.

The following examples might also disclose information related to health or condition and so might be considered PHI under the HIPAA privacy regulations:

- An announcement sent to a local newspaper by a hospital of babies born that day—since birth information is information on a health condition; and

■ A postcard from a clinic reminding a patient it's time for her next mammogram—since the reminder discloses that the patient has been and will be receiving treatment.

Health or condition can encompass a variety of situations beyond what you might typically expect. For example, "condition" isn't limited to illnesses—being healthy is also a condition for the purposes of the HIPAA privacy regulations. That means a casual comment that a patient is "doing fine" could be PHI.

"Be careful," cautions Gwen Hughes, professional practice manager with the American Health Information Management Association (AHIMA). "Only a little piece of data can give a lot of information about someone's condition or health status," she cautions. Just knowing, for example, that a person has an appointment with Dr. X, who happens to be an AIDS specialist, might qualify as PHI, since it indicates that the individual may have, or suspect he has, AIDS.

The process of providing health care to a person. This can be information about all kinds of services beyond treatment and diagnosis, explains privacy expert Wes Porter. For example, information about the sale or dispensing of drugs or the sale of medical equipment and devices—like crutches or nebulizers—can be PHI.

The process of obtaining payment for health care services provided to a person. Billing, coding, claims, and financial information created or received by your health care organization can be PHI. That means PHI can be used or disclosed when:

■ A billing clerk from Doctor A's office calls a clerk from Doctor B's office to get coding information for a patient they've both treated;

■ An admissions clerk calls an insurer requesting verification of a new patient's health insurance coverage; and

■ A treatment code is used to obtain payment from Medicare, Medicaid, or a children's health insurance program.

Rule #4: Information Must Be 'Individually Identifiable' to Be PHI

Not all health information is PHI. According to the regulations, it must also be "individually identifiable." Generally, this means that someone seeing or hearing the health information can identify the person it's about.

Certain information is unique to an individual and by itself can identify that person. If health information is linked with the following unique items, it's PHI:

- Name;
- Social Security number;
- Driver's license number;
- Telephone or fax number;
- Address;
- E-mail address or URL;
- Patient identification number—including account number;
- Health insurance plan identification number;
- Finger or voice print, or other biometric identifiers; or
- Likeness or photograph.

Example: After Patient A is discharged from a hospital, an empty prescription bottle is found in her room. The bottle label shows Patient A's name, her doctor's name, the drug's name, and dosage instructions. The label is considered PHI because it discloses both the patient's name and information about her health or condition—namely, that she takes a certain drug.

While a patient may not care if such information is known if the drug is a mild painkiller, the story may be very different if the bottle label reveals that the patient is taking the latest treatment for HIV, points out Adler.

Rule #5: Health Information Can Be PHI, if It Gives a Reasonable Basis for Determining a Person's Identity

Sometimes, one item of information alone won't identify a person. For example, a ZIP code by itself doesn't reveal a patient's identity. But a combination of items may give you a reasonable basis for linking health information to a particular person. If it does, the health information is PHI.

This rule closes a loophole, says health privacy consultant Errick Woosley. It covers the situation where no names are mentioned, but an individual's identity can be determined fairly easily with a little legwork.

A reasonable basis for determining a person's identity means that, without taking any extraordinary measures, someone could link health information to a specific person. "It's what's reasonable, given the health care organization's systems," says Jackie Selby, a health care attorney with Oxford Health Plans.

Example: A hospital billing clerk overhears two nurses discussing a patient discharged that day after a serious asthma attack. The nurses remark that the patient had trouble arranging transportation home, mention her neighborhood, and refer to the patient as "she."

None of the items of information by itself—the neighborhood, the patient's sex, the date of discharge, or health information (the asthma attack)—would be enough to identify the patient. But together, they provide a reasonable basis for that identification. The key is if the

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hospital has electronic medical records that would allow the billing clerk to search by a particular field—like ZIP code or discharge date, says Selby.

"This example works in an electronic system, but would be unreasonable in a different setting," Selby notes. "But there are all kinds of possibilities in both paper and electronic settings where a little information might form a reasonable basis for determining the identity of a person," she adds.

Rule #6: Health Information Can Be PHI Whether Your Organization Creates It or Receives It

It doesn't matter whether your organization creates health information or receives it. The regulations say that if individually identifiable health information is created or received by a health care organization covered by the regulations, the information is PHI.

This includes a wide range of health care organizations, from hospitals and doctors' offices and their staffs to health care plans. In addition, it covers such organizations as:

- Dental offices;
- Pharmacies;
- Laboratories;
- Chiropractors;
- Home health agencies;
- Hospices;
- Ambulance services;
- Nursing homes; and
- Any person or entity who furnishes or bills for health care as a part of their normal business.

The regulations stress that information a health care organization receives can be PHI, not only information the organization creates. "In the past, some organizations made distinctions between health information they created and health information they received from other organizations," points out Hughes. "The idea was to protect information received from others from redisclosure by not technically including it as a part of the individual's health record." But under the HIPAA privacy regulations, both information created and received by your health care organization can be PHI and should be protected by your organization in the same way for use and disclosure purposes.

Example: A physician gets copies of individually identifiable health information from a lab. That information is PHI that must be protected according to the same standards as any PHI the physician collects directly from the patient while she is under his care. ■

Insider Sources

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ASK THE *INSIDER*

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Billing for MRI Sedation

Q We have an imaging practice that gets many referrals from pediatricians. Many of these children must be sedated before their MRIs, and the expense of providing the sedation adds up. Is there a legitimate way to bill for this expense?

A Depending on the insurer, you may be able to get reimbursed for at least some of the costs associated with MRI sedation as long as the sedation is medically necessary, says Atlanta health care consultant Jackie Miller. For instance, Medicare will usually reimburse the cost of the sedative medication. And you can bill many non-Medicare insurers for overseeing and monitoring a patient under conscious sedation. But some insurers bundle the cost of sedation into the reimbursement for the technical component of the MRI. So you must review each of your insurer contracts separately to determine which insurers you can bill for any part of sedation expenses, she advises. ■

Insider Source

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What's New in CPT 2002

The AMA has released CPT 2002, and it's time for you and your staff to get familiar with the changes. Luckily, most of this year's changes involve only rewording or updating, says Georgia-based radiology coding consultant Melody Mulaik. But there are a number of new codes that you should learn. We'll explain some of the changes to definitions of existing codes and give you a list of the new codes that radiology practices are likely to use.

Changes to Definitions of Existing Codes

The AMA has refined the definitions of a number of existing codes, but that shouldn't change the way you use them, Mulaik explains. For example:

■ The words "small intestine" replace the words "small bowel" in CPT codes* 74245, 74249, and 74250.

■ The word "axial" was added to the definitions of CPT codes 76070, 76355, 76360, 76370, 76375, and 76380—so those codes now describe "computerized axial tomography."

■ The word "ultrasound" replaces the word "echography" in CPT codes 76536, 76604, 76645, 76700,76770, 76778, 76800, 76805, 76819, 76830, 76856, 76870, 76880, 76885, and 76886.

A number of other codes have minor changes in their definitions for this year, Mulaik says.

New Codes for Radiology Procedures

Mulaik notes that there are a number of new codes that will be particularly useful for radiation oncology and general radiology—especially interventional practices, she says. For example:

■ CPT 2002 introduces new codes for digitizing mammography films for further physician review, Intensity Modulated Radiological Therapy (IMRT), and several transcatheter placement procedures, among others.

■ The codes for fine needle aspirations (88170 and 88171) have been deleted, and replaced with the codes 10021—fine needle aspiration without imaging guidance, and 10022—fine needle aspiration with imaging guidance.

A complete list of the new CPT codes for radiology appears in the box below. ■

Insider Source

Melody Mulaik, MSHS, CPC: President, Coding Strategies Inc., 168 N. Johnston St., Ste. 103, Dallas, GA 30123.

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▶ *New Codes for Radiology Practices*

CPT 2002 introduces a number of new codes that radiology practices are likely to use. Here are the new codes with their definitions.

RADIOLOGY PROCEDURES

- ■ 76085—digitization of film radiographic image with computer analysis for lesion detection and further physician review for interpretation, screening mammography (list separately in addition to code for primary procedure);
- ■ 76362—computerized axial tomographic guidance for, and monitoring of, tissue ablation;
- ■ 76394—magnetic resonance guidance for, and monitoring of, tissue ablation; and
- ■ 76490—ultrasound guidance for, and monitoring of, tissue ablation.

RADIATION ONCOLOGY

- ■ 77301—intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications; and
- ■ 77418—intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams (e.g., binary, dynamic MLC) per treatment session.

RELATED PROCEDURES

- ■ 0003T—cervicography;
- ■ 10022—fine needle aspiration with imaging guidance;
- ■ 38220—bone marrow aspiration;
- ■ 38221—bone marrow biopsy, needle or trocar;
- ■ 47382—ablation, one or more liver tumors, percutaneous, radiofrequency;
- ■ 36002—injection procedures (e.g., thrombin) for percutaneous treatment of extremity pseudoaneurysm
- ■ 0005T—transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous, initial vessel;
- ■ +0006T—transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous, each additional vessel (list separately in addition to code for primary procedure);
- ■ 0007T—transcatheter placement of extracranial cerebrovascular artery stent(s), percutaneous, radiological supervision and interpretation, each vessel;
- ■ 0001T—endovascular repair of infrarenal abdominal aortic aneurysm or dissection, modular bifurcated prosthesis (two docking limbs); and
- ■ 0002T—endovascular repair of infrarenal abdominal aortic aneurysm or dissection, aorto-uni-iliac or aorto-unifemoral prosthesis.

RELATED RADIATION ONCOLOGY PROCEDURES

- ■ 57155—insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy;
- ■ 58346—insertion of Heyman capsules for clinical brachytherapy; and
- ■ 92974—transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (list separately in addition to code for primary procedure).

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IN THE NEWS

OIG Releases 2002 Workplan

The OIG released its annual workplan for 2002. The document describes the issues the OIG will be looking into during the coming year. Knowing what's in the workplan can help a practice focus its compliance efforts on those areas that the OIG is particularly concerned about at the moment, says New York health care attorney Matthew I. Kupferberg. And in 2002, the OIG plans to concentrate on five issues that are particularly relevant to radiology practices.

Duplicate Claims by Part B Providers

The OIG intends to review the extent to which Part B providers like radiologists submit duplicate claims for services that are reimbursed to the hospital, such as X-rays performed on hospital inpatients.

Under Medicare rules, the hospital is reimbursed—under Part A—a specific amount depending on the inpatient's illness and its diagnosis-related group (DRG) classification. This amount includes payment for certain services such as X-rays, Kupferberg explains. So it's improper for a hospital or a Part B provider to submit a claim for services that are already covered under the Part A reimbursement the hospital gets under the DRG. Radiologists should make sure that they're not submitting separate claims—under Part B—for services rendered to hospital inpatients that are included in the Part A reimbursement the hospital gets under the DRG.

Procedure Coding of Outpatient and Physician Services

The OIG is concerned about inconsistencies in the way physicians and hospitals code for hospital outpatient services. In its 2002 workplan, the OIG says that in the past it has identified a 23 percent rate of inconsistency in the way that hospitals and physicians code for the same procedure performed in a hospital outpatient setting. In 2002, the OIG intends to examine the effect this inconsistency has on the Medicare program and whether it results in overpayments to hospitals or physicians.

Because the OIG has identified this as a problem in the workplan, it may be a new focus for carrier audits, Kupferberg cautions. If your claims consistently show a different code than the hospital shows for the same procedure, you could be courting trouble. As always, be careful to code based solely on what's in the medical record, Kupferberg emphasizes. As long as your documentation supports your code choice, you're unlikely to have a serious problem, even if the hospital used a different code.

Access to Screening Mammography

In 1997 a change to the Medicare law expanded the preventive services that Medicare covered to include, among other services, screening mammography for women over 40. According to the 2002 workplan, the OIG plans to evaluate whether access to these preventive services is a problem for Medicare beneficiaries.

This should be welcome news for radiologists and patients, Kupferberg explains, because low reimbursement for mammograms has limited access to these services. If the OIG can quantify the extent of the problem, the radiology community may stand a better chance of getting the reimbursement for screening mammograms increased, he believes—which should mean patients will have better access to these services.

Advance Beneficiary Notices

The OIG continues to be concerned about the proper use of ABNs. And that concern is reflected in the 2002 workplan, which says that the OIG intends to investigate the financial impact of ABNs on beneficiaries and providers. The workplan also mentions that the OIG is concerned about a wide variation in the way that providers use ABNs. The implication is that the OIG suspects that some providers may be using ABNs improperly to bill patients for services, Kupferberg remarks.

The OIG has identified ABN usage as a continuing focus, so you should take the opportunity to re-educate the physicians and staff in your practice about proper use of ABNs, Kupferberg suggests. And look for CMS to introduce a new ABN form in the coming months.

E/M Codes and Consultations

Physician billing for E/M codes and consultations represent over $20 billion annually—that's over half of Medicare spending for physician services. According to the 2002 workplan, the OIG plans to investigate whether physicians are billing for E/M services and consults accurately and following the appropriate documentation guidelines. The OIG also plans to investigate the types of corrective actions carriers take when they discover inaccurate billings for E/M services and consults. Finally, the OIG hopes to assess the reasons for inaccurate billings, in order to recommend improvements in the way coding guidance is provided to physicians, Kupferberg says.

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If your practice has interventional radiologists, radiation oncologists, or other physicians who frequently bill for E/M services or consults, it's probably worthwhile to send out a reminder about documentation guidelines for these services, Kupferberg remarks.

Insider **Says:** You can get a copy of the OIG's workplan at www.hhs.gov/oig/wrkpl/2002/Work_Plan_2002.htm. ■

Insider Source

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How to Avoid IRS Interim Sanctions

You and your physicians probably try hard to stay on top of developments in the Stark law, the antikickback law, and Medicare regulations so that the practice can comply with them and avoid the scrutiny of CMS and the OIG. But many physicians—specifically those who have relationships with tax-exempt institutions like charitable or nonprofit hospitals and nursing homes—aren't aware that the IRS may be scrutinizing them, too.

A 1997 law gave the IRS the authority to impose "interim sanctions" on certain individuals who the IRS decides have derived an improper benefit from a tax-exempt institution, says Philadelphia health care attorney Joan Roediger. Recently the IRS issued interim sanctions regulations explaining the way it intends to apply its interim sanction authority. Physicians should be concerned about these regulations, she says. Although physicians may believe that any penalty for a transaction the IRS decides is "improper" would be imposed on the tax-exempt institution, that's not always the case, Roediger remarks. She believes many physicians may be subject to interim sanctions.

We'll explain what interim sanctions are and what the regulations say about whom the IRS may punish with interim sanctions. We'll also tell you what the IRS thinks is an "improper benefit" that triggers these sanctions. And we'll tell you how to analyze your relationships and transactions with hospitals to determine if they—and your physicians—may be vulnerable to IRS scrutiny. Finally, we'll give you some tips on how to document your relationships and transactions to protect your physicians from IRS interim sanctions.

What Are Interim Sanctions?

Interim sanctions are excise taxes—in essence, fines—that the IRS may impose when it determines that someone has derived an improper benefit through a relationship or transaction with a tax-exempt institution, Roediger says. A tax-exempt institution must work to further its charitable mission, she notes. So it isn't allowed to enter into a business relationship or transaction in furtherance of a private purpose—that is, one that financially benefits the institution or an individual—rather than a charitable purpose. If it enters into such a relationship, any resulting financial gain will be considered an improper benefit under the tax code.

In the past, if a tax-exempt institution engaged in business practices the IRS determined were improper, the IRS could only revoke the institution's tax-exempt status. But the interim sanction authority gives the IRS the ability to penalize both the tax-exempt institution and the individuals who derived an improper benefit from a relationship with that institution, Roediger explains.

The individual would be fined an excise tax that's a percentage of the improper benefit that the IRS determines the individual received. The percentage ranges from 10 percent to 200 percent of the improper benefit, depending on the circumstances, she says.

Which Individuals Are Subject to Interim Sanctions?

The IRS calls individuals who may be subject to interim sanctions "disqualified individuals."

Disqualified individuals are people who are or were in a position to exercise substantial influence over the affairs of the tax-exempt institution at any time during the five-year period immediately before the questionable transaction—regardless of whether they were involved in the transaction. Obviously, members of the institution's governing body and its top executives will be subject to interim sanctions because they make the business decisions for the institution.

But according to the regulations, the IRS may consider many physicians disqualified individuals—so they are subject to interim sanctions, too. That's because the regulations also say that the following people are considered disqualified individuals:

■ Persons whose compensation from the institution is primarily based on revenues from activities the individual controls. This would include, for example, interventional radiologists who are paid based on the number of procedures they perform at the institution; and

■ Persons who manage a segment or activity of the institution that rep-

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AVOID IRS INTERIM SANCTIONS
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resents a substantial part of the activities, assets, income, or expenses of the institution as a whole. This might include radiologists who control a department that's responsible for a significant portion of the hospital's operating expenses.

But Roediger explains that the regulations establish an exception that may help some physicians avoid being subject to interim sanctions. This is called the "initial contact rule." It says that any individual who enters into a contract for a fixed payment with an institution won't be a disqualified individual as long as he and the institution negotiated an arm's-length contract and there was no prior relationship between them. So for example, a radiology department head may not be a disqualified individual if his contract with the hospital was negotiated at arm's length and calls for a fixed salary and he had no relationship with the hospital prior to his employment there. But Roediger notes, if his contract calls for any discretionary payments or other nonfixed payments, then he's a disqualified individual and the discretionary payments or nonfixed payments potentially are subject to the excise tax.

Which Transactions Are Subject to Interim Sanctions?

Not every relationship or transaction between a tax-exempt institution and a disqualified individual is subject to interim sanctions. The IRS imposes interim sanctions only when it detects an "excess benefit transaction." An excess benefit transaction occurs when a tax-exempt institution directly or indirectly provides a benefit to an individual that exceeds the fair market value of the goods or services that the individual provided to the institution.

Many common arrangements and transactions between a physician and a tax-exempt institution could be considered excess benefit transactions if they don't reflect fair market value, Roediger explains. For example, practice sales, employment arrangements, medical director agreements, and independent contractor agreements may all be subject to IRS scrutiny to determine if they involve excess benefits.

When the IRS looks at an arrangement to determine whether it involves excess benefits, it doesn't just look at the compensation the disqualified individual receives directly from the institution. The IRS also considers other benefits the disqualified individual may receive directly or indirectly—for example, paid travel to professional conferences for a spouse, luxury travel for any purpose, bonuses, and even certain insurance policies.

So just because a disqualified individual's salary appears to be fair market value, it doesn't mean that he or the institution is off the hook—the IRS will also look at any other benefit the disqualified person receives. Then, the IRS will determine if the *total package* of benefits is fair market value by comparing it to the amount that similar institutions "ordinarily" would pay for similar services.

How Severe Are Interim Sanctions?

Interim sanctions can be severe, Roediger cautions. The regulations establish a system of penalties that the IRS can impose on the giver and the recipient of an excess benefit:

- First, the IRS will impose a "tax" of an amount equal to 25 percent of the excess benefit on the benefit's recipient.

- If the recipient doesn't pay the tax within a time frame the IRS specifies, an additional tax equal to 200 percent of the excess benefit is imposed.

The IRS may also impose a tax of 10 percent of the value of the benefit on all of the institution's managers who knowingly and willingly participated in the arrangement that led to the excess benefit. The managers are personally liable for this tax, up to a maximum of $10,000.

Example: A hospital department head attends a professional conference at a European resort, and the hospital reimburses her $12,000 of luxury travel expenses for her and her husband. The IRS may decide that $10,000 of that amount represents an excess benefit to the physician and impose an excise tax under the interim sanctions regulations. The physician will have to pay the IRS $2,500 (25% of $10,000). And if the physician doesn't pay the fine within a time frame the IRS sets, it will impose an additional fine of $20,000 (200% of $10,000). Plus all the hospital's managers who participated in or approved the decision to pay the physician's luxury travel expenses will have to pay $1,000 each.

How Can You Minimize the Risk of Interim Sanctions?

There's a way to minimize the likelihood that the IRS will determine that a particular transaction between a disqualified individual and a tax-exempt institution is an excess benefit transaction, Roediger says. But it requires the cooperation of the institution and the institution's board.

So whenever one of your physicians who may be a disqualified individual considers a transaction with a tax-exempt institution, she should seek the advice of an attorney. If the attorney thinks the transaction could be subject to IRS scrutiny as an excess benefit transaction, then the physician shouldn't enter into it unless the institution takes the three steps described below, Roediger cautions. As the recipient of any excess benefit, your physician will be the one who has to

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pay the bigger tax if the IRS questions the transaction. So make sure you get legal assistance to protect your physician's interests, she emphasizes.

The interim sanction regulations give three requirements for the institution to meet. If the institution meets all three requirements, the IRS must infer that the transaction isn't an excess benefit transaction, unless it can prove otherwise (in legalese, this is called a "rebuttable presumption"). It's a way that you can be innocent until the IRS proves you guilty. Although the institution has to jump through some hoops for both it and your physician to get the benefit of the presumption, it's worth it to avoid the severe penalties that the IRS can impose, Roediger advises. If the institution resists, get your attorney to explain that if it doesn't take these steps, the individual decision-makers at the institution can be hit with penalties, too—and they'll be personally liable for paying them.

Here's what the institution should do:

1) Get board approval. The governing body of the tax-exempt institution must approve the transaction between the institution and the disqualified person. So make sure the institution gets the okay of its governing body—usually be its Board of Directors or Board of Governors—before your physician signs the contract or other legal document.

2) Establish fair market value. When reviewing the transaction to determine whether to approve it, the governing body must rely on appropriate data to determine that the transaction price represents fair market value. It's difficult to establish that a certain transaction represents fair market value, but the interim sanctions regulation suggests using "comparability data." Examples of comparability data are real estate appraisals (if the transaction involves a property sale or lease), or compensation surveys prepared by a consultant familiar with the medical market in your area, or national data prepared by a professional organization (like the American Hospital Association or the Medical Group Management Association). But the governing body must be careful that the data it uses describes situations that are analogous to the transaction that it's considering.

3) Provide documentation. The governing body must carefully document the basis of its determination that the transaction reflects fair market value. So the governing body should record its attempts to validate the comparability data to make sure that it accurately reflects the prevailing market in your locality. And the governing body must promptly document its approval of the transaction and provide your physician with a copy of the documents.

***Insider* Says:** You can download a copy of the interim sanctions regulations from the IRS Web site. Go to www.IRS.gov/tax_regs/regslist2.html, and scroll down to "Excise Taxes on Excess Benefit Transactions." ■

Insider Source

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