



# KSDB Health Law INSIGHTS

Spring 2009

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## Five reasons to review your estate plan now

*By Stephanie P. Kalogredis, Esquire<sup>1</sup>*

Just like an annual physical, your estate plan needs periodic checkups. A good checkup will include a review of your estate planning documents (Wills, trusts and powers of attorney), beneficiary designations (for your retirement plans, life insurance and annuities), and the value and titling of your assets. How do you know if it is time for a checkup? Here are five reasons why the right time may be now.

### No will

I am surprised at how many people, affluent people, do not have Wills. Married individuals often rely on holding their homes and bank/investment accounts in joint names

with their spouses and naming their spouses as primary beneficiary of their life insurance policies and retirement plans. This works but it is only partially effective. What about assets such as your medical or dental practice or other health care related equity interest? In most situations these assets cannot be owned jointly with your spouse and they do not allow for a beneficiary designation. Without a Will, these assets will pass in accordance with your domiciliary state laws of intestate succession.<sup>2</sup> In Pennsylvania and New Jersey your spouse would receive approximately one half and your children or grandchildren (your issue) the remainder. If you do not have issue, then one half goes to your spouse and the other to your parents. Your spouse will only get your entire estate if you have no issue and are not survived by either of your parents. This is not the distribution that most of my clients want. Having a Will allows you to override the state laws and customize your

— continued on page 2



Front row: Jeff, Bill Back row: Karilynn, Mike, Dave

<sup>1</sup>Stephanie P. Kalogredis is an attorney with Lamb McErlane PC in Bryn Mawr, Pennsylvania and practices in the fields of estate and trust planning and administration, pre and post nuptial agreements and related areas. She can be reached through our office or directly at 610-527-9200 or [skalogredis@chescolaw.com](mailto:skalogredis@chescolaw.com).

<sup>2</sup>The distribution of an intestate estate (one without a Will) is governed by laws of the state in which the decedent is domiciled or resides in at the time of his or her death which vary from state to state.

## Review you estate plan

— continued from page 1

distribution scheme to meet your own needs.

## Change in marital status

Whether you are newly divorced or newly married, a change in marital status requires a thorough review of your estate plan. In Pennsylvania, all bequests and references to a former spouse appearing in a Will that predates the divorce are void and ineffective for all purposes unless it appears from the Will that the provision was intended to survive the divorce. So far, so good, at least for those who die as residents of Pennsylvania. However, the statute does not apply to beneficiary designations for life insurance policies or retirement plans executed before a divorce and the effect of the divorce may be different for each policy or plan.

In a very recent Supreme Court case, *Kennedy v. DuPont*,<sup>3</sup> the decedent never got around to removing his former wife as a beneficiary of his employer's Savings and Investment Plan (SIP). Like most pension and profit sharing plans, the SIP is governed by ERISA.<sup>4</sup> The Supreme Court held that even though the divorce decree specifically divested the former spouse of her interest in the SIP, the plan administrator was bound to distribute the SIP in accordance with the "documents and instruments governing them," the beneficiary designation form on file: meaning, the former spouse got

the money in the SIP.<sup>5</sup>

Contrast this to the rights of a new spouse where the deceased spouse did not revise his or her estate plan after the marriage. Barring a prenuptial or post nuptial agreement, if the deceased spouse died without a Will or did not execute a new Will after the marriage, the new spouse is entitled to the intestate share (discussed above). Depending on the family structure (second marriage, children of prior marriage, etc.) this may prove to be too generous or too sparse of a bequest. A new Will can alter the statutory scheme to meet your personal needs. Again, IRAs and life insurance plans will be distributed to the beneficiary on record without any adjustments for the subsequent marriage. But under ERISA, the new spouse is entitled to an interest in an ERISA plan which supersedes the beneficiary designation on file.

## Children

The birth of a child is one of the strongest motivators for clients to formulate and execute an estate plan. The issue foremost on the parent's mind is appointing a guardian to raise his/her children in the event both parents die. As part of your Will, you can nominate a person to serve as guardian of minor children. While the ultimate decision rests with the court, the parent's recommendation for guardian is given great deference and is appointed unless it is not in the child's best interest.

If there is no Will to guide the court, the court will use its own judgment in selecting a guardian.

Almost as important as who will raise the children, is who will manage their finances. This need can arise while one parent is still living if the other parent dies without a Will. As I described above, if a parent dies without a Will the children will inherit approximately one-half of the probate estate (or the entire estate if there is no surviving spouse). This can be a very large sum especially in cases where the death was due to another's negligence and the estate receives an award in a survival action. In Pennsylvania, the child's surviving parent cannot serve alone as guardian of the minor's money. In addition, there are statutory restrictions on how the money can be invested and what the money can be used for. Finally, the child will receive the entire amount when they turn eighteen. Just the thought of a child having a million dollars at the age of eighteen drives most parents to include trusts for their children under their Wills. Trusts allow you to determine who will manage the child's funds (including the sur-



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<sup>3</sup>*Kennedy v. DuPont* 172 L.Ed. 2d 662; 2009 U.S. Lexis 869 (2009).

<sup>4</sup>The Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq.

<sup>5</sup>All is not lost, the Supreme Court did say that the other beneficiaries may have a civil action against the former spouse to recover the funds based on the divorce property settlement agreement.

living parent), how the funds will be invested, when distributions will be made and what they will be made for, and to address any special needs or concerns.

### Wills written before 2002

Prior to 2002, a very large segment of the professional community with otherwise simple estate plans – everything outright to the surviving spouse – needed to incorporate trusts into their estate plan for the sole purpose of reducing the federal estate tax payable at the death of the surviving spouse. At that time, a couple with combined assets<sup>6</sup> totaling \$675,000 in 2001 or \$1 million in 2002 (federal estate tax exemption) were faced with a potential federal estate tax of 55% on the value of their combined estates that exceeded the federal estate tax exemption when their estate passed to next generation. Because each individual was entitled to his or her own federal exemption, trusts were established and funded at the first death equal to the deceased spouse's federal exemption amount sheltering the assets from federal estate tax at the second death. This allowed the surviving spouse to use his or her federal exemption to shelter an additional amount at their death virtually doubling the amount that passed to the next generation free from federal estate tax.

Today, an individual's federal estate tax exemption is \$3.5 million. Fewer couples require the tax planning trusts that were so integral to a prudent estate plan formulated in 2002. Upon review,

<sup>6</sup>Assets include but are not limited to real estate, cash, stocks and bonds, investment accounts, life insurance, annuities and retirement plan accounts.

you may be able to simplify your estate plan and remove the mandatory funding of the exemption trust.

### Retirement

Retirement is the perfect time to simplify your life, consolidate your assets, organize your files and update your estate plan. Relationships and family situations may have changed since you last looked at your documents. Do you still need to name a guardian for your now 38 year old daughter and mother of two? What about the trusts for your children? Should they be discontinued or continued for a longer period of time and permit distributions for your grandchildren's needs? Are there concerns with creditors or difficult marriages? Do you want to include a bequest to your grandchildren? Are you now in the position to make charitable bequests or gifts? Unnecessary provisions should be removed and trusts and distributions modified to reflect current situations and needs.

A big trend that you, as health care professionals, should be wary of is the tendency to volun-

tarily take retirement funds from a plan governed by ERISA (401(k), 403(b), pension and profit sharing plans, etc.) and moving them into IRAs. While IRAs may afford greater flexibility and more investment options, ERISA plans provide greater asset protection from claims of malpractice creditors. Some plans may require you to take your retirement funds out of the plan and roll them into an IRA upon retirement. If that is the case, you will have no option but to comply. But where there is a choice, make sure you understand the potential exposure and risks involved.

### Conclusion

Each major juncture of our lives: marriage, divorce, birth of children and grandchildren, retirement, and changes in the tax law signal a time to review your estate plan. The checkup may be quick and painless, reassuring you that everything is as it should be. Or, it may require changes in your documents and beneficiary designations. Knowing everything is in order will make you feel better. ■

## CMS finalizes Medicare anti-markup rule

*By Michael R. Burke, Esquire*

In the 2009 final Medicare Physician Fee Schedule, the Centers for Medicare & Medicaid Services ("CMS") finalized the rule which prohibits a physician or other supplier from "marking up" the technical component or professional component of a diagnostic test that is ordered by the physician or other supplier (or by a related party) under certain cir-

cumstances. The initial version of this rule, which was finalized in the 2008 Medicare Physician Fee Schedule, was delayed from its proposed January 1, 2008 effective date so that CMS could consider public comments that were made on this rule. The final rule adopted in the 2009 Medicare Physician Fee Schedule was effective on January 1, 2009.

The new anti-markup rule is

more flexible than the earlier proposals promulgated by CMS. CMS established two alternatives by which physicians and other suppliers are able to satisfy the requirements of the rule, and if these requirements are satisfied, the anti-markup prohibition does not apply. Under alternative one, where the performing physician (i.e., a physician who supervises the technical component or performs the professional component, or both), performs “substantially” all (at least 75%) of his or her professional services for the billing physician or other supplier, none of the services furnished by the physician on behalf of the billing physician or other supplier will be subject to the anti-markup rule. CMS utilized the definition of “substantially all” that is included in the Stark regulations in an attempt to avoid confusion in attempting to comply with both the Stark regulations and anti-markup rule.

If alternative one is not satisfied, an analysis under the requirements of alternative two is required on a test-by-test basis to determine whether the anti-markup rule’s payment limitation applies. Under the alternative two “site-of-service” approach, only technical components conducted and supervised in and professional components performed in the “office of the billing physician or other supplier” by an employee or independent contractor physician will avoid application of the anti-markup rule’s payment limitation. The “office of the billing physician or other supplier” is defined as being any medical office space, regardless of the number of locations, in which the or-

dering physician or other ordering supplier regularly furnishes patient care, including space in which the billing physician or other supplier furnishes diagnostic tests if the space is located in the same building (defined in the same manner as the Stark regulations) in which the ordering physician or other ordering supplier regularly furnishes patient care. When a billing physician or other supplier is a “physician organization” as defined under the Stark regulations, the “office of the billing physician or other supplier” is space in which the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally. CMS also clarified under the anti-markup rule that the performance of the technical component includes both the conducting of the technical component as well as the supervision of the technical component, even though the latter requirement may impose a more stringent supervision requirement for a given diagnostic test than is present under Medicare’s billing rules for such a test.

In the final 2009 Medicare Physician Fee Schedule, CMS declined to provide further guid-

ance on the definition of “net charge” as defined in the anti-markup rule. When the anti-markup rule applies, the technical component or professional component of a diagnostic test may not exceed the lowest of the following amounts: the performing supplier’s net charge to the billing physician or other supplier (which must be determined without regard to any charges intended to reflect the costs of equipment or space leased to the performing supplier by or through the billing physician or other supplier); the billing physician or other supplier’s actual charge; or the fee schedule amount for the test that would be allowed if the performing supplier billed directly.

Since the application of the anti-markup rule is not necessarily consistent with the Stark regulations in every instance, it is important for physicians and other suppliers to insure (at a minimum) that they are complying with both sets of rules when billing for diagnostic tests ordered by such a physician or other supplier. If you have any specific questions with regard to the application of these rules to you or your practice, please feel free to contact me. ■

## Retirement plan update

*By Jeffrey B. Sansweet, Esquire*

There is good news once again in the retirement plan area for doctors. Cost-of-living adjustments have increased the maximum allowable defined contribution pension and/or profit sharing plan annual contribution per participant from \$46,000 to \$49,000 for plan years beginning in 2009.

The annual compensation which may be taken into account in computing one’s contribution has also increased from \$230,000 to \$245,000 effective with plan years beginning in 2009. For those practices that have a “permitted disparity” feature in their plans, these changes and the increase in the Social Security Taxable Wage

Base from \$102,000 to \$106,800, mean that the practice may contribute an additional \$3,000 in 2009 for the physicians while contributing 0.043% less for the typical staff person. For those of you with 401(k) plans, the annual elective deferral limit for 2009 has increased from \$15,500 to \$16,500, and if you are at least age 50 by the end of the plan year, an additional “catch-up” 401(k) contribution is allowed up to

\$5,500 in 2009. This will not make up for your investment losses, but it should help a little.

The not-so-good news is that for most practices, their retirement plans are required by the IRS to be amended and restated to comply with various tax laws, most of which do not affect the operation of the plans. Most plans must be amended by April 30, 2010, and although not required, should be submitted to the IRS in order to

obtain a favorable determination letter. This letter signifies the IRS’ stamp of approval on the provisions and structure of the plan design. This process also provides a good opportunity to re-visit optional plan design and administrative provisions, including adding a 401(k) feature or implementing a new comparability “class allocation” formula. If you have questions about the plan restatement process, please give me a call. ■

## Freedom of Information Act ruling protects doctor’s privacy

By David R. Dearden, Esquire

A nonprofit consumer group, Consumers’ Checkbook, filed suit under the Freedom of Information Act to gain access to an extraordinary number of Provider billing records submitted to Medicare. The Court of Appeals protected the privacy interest of physicians by reversing the District Court which had allowed Consumers’ Checkbook to gain access to this sensitive Provider information. The majority opinion recognized the substantial privacy interests that a physician has in business-related financial information, including the payments that they receive from Medicare for covered services. However, this recent decision contained an alarming and lengthy dissenting opinion.

Consumers’ Checkbook, located at [www.checkbook.org](http://www.checkbook.org), allows subscribers to obtain information about physicians, including but not limited to, licensure and other publicly available information. It claims that “Medicare has been remarkably slow in do-

ing what could be done to improve the quality and efficiency of the physician services [to] Medicare beneficiaries.” Consumer Checkbook touts its pro-consumer efforts to obtain a release of information from Medicare for the purpose of determining the quality of the physicians who provide services to Medicare to market its services. In the website, Consumers’ Checkbook pledges to continue its effort to obtain sensitive Provider information from Medicare.

Consumers’ Checkbook sought to compel the Department of Health and Human Services to provide the diagnosis, the type and place of service and the unique physician identifying number of all physicians who performed services reimbursed through Medicare in the District of Columbia, Illinois, Maryland, Washington and Virginia for 2004. Consumers’ Checkbook contended that it required this information to evaluate the quality of care Medicare patients are re-

ceiving. The request for information was opposed, not only by the United States Department of Health and Human Services, but also the American Medical Association.

The majority opinion reasoned that the data

would not assist the public in determining whether Medicare is enrolling quality physicians and such raw data could be used in a misleading manner. The court determined

that the strong interests that a physician has in the privacy of business records justified the denial of the Freedom of Information Act request by the consumer group.

The dissent pointed out that the Freedom of Information Act is designed to pierce the veil of administrative secrecy and explained that practitioners who

***The majority opinion recognized the substantial privacy interests that a physician has in business-related financial information***

contract with the government to provide medical services in exchange for federal payments perform a quasi-public function. This judge felt that the privacy invasion at issue would not be overly intrusive to physicians because the data showing a physician's receipt of government funds would not reveal a physician's take-home earnings and did have an "incremental value" for ascertaining the qual-

ity of services performed by providers. Finally, the dissent indicated that production of the requested Medicare data would shed light on HHS's fraud detection and fraud prevention efforts. For example, if the data provided identified providers who perform a "suspiciously large number of procedures in a given time period," the data could facilitate public monitoring of a HHS detection and prevention of fraud.

While this case is a victory for physicians, we bring this case to your attention to demonstrate it is more important than ever to periodically audit your own Medicare/Medicaid billing records. Not only is the government carefully monitoring these procedures with its computer system, but consumer watchdog groups are attempting to monitor this very same information. ■

## Key changes in the Family and Medical Leave Act

By Karilynn Bayus, Esquire

As of January 16, 2009, some key changes came into effect to the Family and Medical Leave Act of 1993 ("FMLA"). There has been no change as to which employers the FMLA applies to. So if your practice or business was not

***Under the new regulations, an employee may substitute any type of paid leave for unpaid FMLA leave if they qualify for the leave under the employer policy***

subject to the FMLA requirements previously, it will not be so now. This article highlights some of the changes that were made.

Last January, the National Defense Authorization Act for FY 2008 ("NDA") amended the FMLA to include FMLA leave rights in certain situations for employees whose family members are members of the military. The new regulations specify the criteria for employees to utilize military leave. There are two types

of military leave that came into effect pursuant to the NDA. These should not be confused with military leave when the employee is the military member. Rights for employees who are members of the military are spelled out in the Uniformed Services Employment and Reemployment Rights Act of 1994.

Under the FMLA, an employee is entitled to twelve (12) weeks of FMLA leave during a twelve (12) month period on account of a "qualifying exigency" because of a spouse, parent or child's (who is a member of the military) active duty or impending call to active duty. The new regulations spell out what exactly constitutes a "qualifying exigency." Qualifying exigencies include instances such as attending official military ceremonies related to the active duty, making necessary new childcare arrangements, attending children's school meetings on account of the military member's leave and making financial and legal preparations (such as preparing a Will) on account of the active duty.

The other type of military-as-

sociated FMLA leave is to care for a spouse, parent, child or next of kin who is an eligible service member recovering, receiving treatment, therapy or otherwise in outpatient care due to a serious illness or injury incurred in the line of duty ("servicemember leave"). Unlike FMLA leave for other reasons, employees are entitled to up to twenty-six (26) weeks of servicemember leave during a single twelve (12) month period.

Beyond leave for military-associated regulations, the changes to the FMLA regulations include those that the U.S. Department of Labor ("DOL") has included based upon comments and experience with the prior regulations.

One change went to employee eligibility for FMLA leave. Currently, an employee must have been employed for at least twelve (12) months and for at least 1250 hours of work. Under the revised regulations, the twelve (12) months need not have been consecutive. There must not, however, have been a gap of longer than seven (7) years.

The revisions to the FMLA include new notice requirements for employers. This includes a general notice about FMLA rights that must be posted at the worksite. If an employer has a handbook or FMLA policy, this information must be included in the policy. If the employer does not, the employer must provide the general notice to new hire employees. An employer must also provide an employee with a notice of eligibility for FMLA simultaneous with a notice of and rights and responsibilities under the FMLA. There is also a requirement to provide employees with a notice of designation of FMLA leave. The U.S. Department of Labor has available on its web site approved forms to meet the requirements.

If any dispute arises between the employer and employee about whether leave counts as FMLA leave, the new regulations say that the employer and employee should try to resolve the dispute through discussions, and those discussions (and decision relative thereto) must be documented.

Similarly, there have been changes to the regulations regarding requests for medical certification for FMLA leave. An employer now has five (5) business days from the date of notice or the date on which FMLA leave commences to request an employee obtain a medical certification. The DOL also has medical certification forms posted on its web site.

Continuing with changes to the medical certifications, the FMLA allows that when an employee submits a non-complete or insufficient certification from a health

care provider, the employer may contact the health care provider for purposes of clarification and authentication only of the medical certification after the employer has given the employee written notice of such and an opportunity to cure the deficiency. With the advent of the Health Insurance Portability and Accountability Act, the new regulations provide that only a health care provider, human resources professional, leave administrator or a management official may contact the health care provider. In no case may the individual contacting the health care provider be the employee's direct supervisor. No additional information may be asked from the health care provider beyond what is needed by the certification form.

While the six individual definitions of a "serious health condition" remained in place, the regulations spell out some additional requirements for some of the definitions. For one definition of a serious health condition, it must involve three days of incapacity plus two visits to a health care provider on account of the condition within a thirty (30) day period. The first visit to the health care provider must occur within the first seven days of incapacity.

The new regulations attempted to streamline employee use of paid time for FMLA leave. Under the new regulations, an employee may substitute any type of paid leave for unpaid FMLA leave if they qualify for the leave under the employer policy (rather than distinguishing between types of time off such as sick time and vacation time).

For those businesses that are subject to the FMLA, it is important to be aware of the changes that have been made the regulations. Human resources personnel will need to be instructed to act in accordance with the new regulations. If you have an FMLA policy, it should be updated to reflect the changes. The DOL's six (6) new forms are available for use on the Final Rule web site at <http://www.dol.gov/esa/whd/fmla/finalrule.htm>. The site also contains helpful information and useful answers to common "FAQs." ■

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## NEWSLETTER SPRING 2009

### Speaking and Writing Information and Website

We have extensive experience in speaking and writing on topics of interest to healthcare practitioners. Whether it be your local, state or national society; a group of residents/fellows; or a study group, we would be interested in talking to you about speaking and/or writing opportunities. For more information on our areas of expertise please visit our Website at [www.KSDBHealthlaw.com](http://www.KSDBHealthlaw.com).

Bill Kalogredis spoke to the Department of OB-Gyn at Reading Hospital in West Reading, Pennsylvania on Negotiating an Employment Agreement on February 26, 2009. He spoke

in San Francisco at the American Academy of Dermatology Practice Management Symposium on March 5, 2009 on Employment Agreements, Negotiation Tips, and Five Practical Tips. On June 2, 2009, in Hershey, Pennsylvania, Bill will speak at the 2009 Health Care Conference of the Pennsylvania Institute of CPAs on Recruitment and Retention of Physicians.

Jeff Sansweet spoke at the University of Pennsylvania School of Dental Medicine on March 11, 2009 on Beyond Your First Employment Contract.

Bill has also been authoring

a monthly article on healthcare law for the *Legal Intelligencer*.

Jeff authored an article on Pension Plan Amendments and Opportunities which is scheduled for publication in *Physician's News Digest* in May.

Mike Burke authored an article entitled "What Can We Learn from Recent OIG Advisory Opinions?" published in the March 2009 *Physician's News Digest*. Mike also will be speaking at the AAPM&R Annual Assembly on October 23, 2009 on "Negotiation Strategies for Optimal Outcomes."