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More disclosure requirements from your friendly neighborhood IRS - Reporting "uncertain tax positions"

by Albert Y. Lin, LLM, CPA

Continuing a trend towards increasing detailed taxpayer disclosures (which tax-exempt healthcare providers have seen through the recently re-vamped Form 990), the Internal Revenue Service (IRS), in Announcement 2010-9, 2010-7 (Jan. 26, 2010) (Announcement),[1] set forth the IRS's development plans for a new schedule to be attached to certain taxpayers' annual tax returns. The proposed tax form schedule is said to be applicable to "*business taxpayers with total assets in excess of $10 million*, if the taxpayer has one or more *uncertain tax positions* of the type required to be reported on the new schedule." The IRS is soliciting comments to this Announcement by March 29, 2010, and the new schedule is anticipated to be required for tax returns filed for the years following the year the actual schedule is finalized. This article identifies the key components of the Announcement that have potential impact on healthcare organizations.

Organizations potentially subject to the new schedule. The Announcement only uses the generic term "business taxpayer with total assets in excess of $10 million." "Business taxpayer" is undefined, but the tax returns referenced are "Form 1120 . . . or other business tax returns." In final form, this may or may not include tax-exempt organizations. In terms of healthcare organizations, the large, publicly traded organizations and large private hospital systems are clearly impacted. Physician groups, ambulatory surgery centers, and sub-$10 million real estate ventures will not. Large tax-exempt organizations will want to review developments relating to the Announcement. However, since the revised Form 990 already requires disclosure of FIN 48 footnotes, the author of this article believes it would be overkill for the IRS to further extend this proposed Schedule to Form 990 filers (particularly since the focus on the Announcement is to provide more detailed information on traditional federal income tax abuses).

Disclosure of "uncertain tax positions." The IRS's goal is to "identify quickly and efficiently" significant issues (including uncertain tax positions) underlying the tax return. The significant issues and "uncertain tax positions" requiring disclosure will include:

(1) Positions for which taxpayers are required under Financial Accounting Standards Board (FASB) Interpretation No. 48 (FIN 48), *Accounting for Uncertainty in Income Taxes, an Interpretation of FASB Statement No. 109*, or other accounting standards to reserve an amount. In the context of for-profit entities, FIN 48 requires consideration of material tax positions and a determination of the position's degree of certainty. A quantitative assessment

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is made, based on the likelihood of prevailing on a tax position, and a reserve may be required to "hold" a tax benefit required under FIN 48.[2] Other generally accepted accounting standards, such as International Financial Reporting Standards, may have similar requirements. The IRS intends that the proposed schedule will require (i) a *concise description of each uncertain tax position* for which the taxpayer or a related entity has recorded a reserve in its financial statements, and (ii) *the maximum amount of potential federal tax liability* attributable to each uncertain tax position (determined without regard to the taxpayer's risk analysis regarding its likelihood of prevailing on the merits).

(2) Any positions related to the determination of any United States federal income tax liability for which a taxpayer or a related entity has not recorded a tax reserve because (i) *the taxpayer expects to litigate the position*, or (ii) the taxpayer has determined that *the IRS has a general administrative practice not to examine the tax position*.

Common examples of tax positions may include ordinary versus capital loss classification, valuation or basis issues, tax credits and carryforwards, employee versus independent contractor positions, non-taxable corporate reorganizations, dividend versus return of capital treatment, and distribution of capital versus disguised compensation. In the context of tax-exempt organizations, classification of income as unrelated business taxable income, transactions potentially subject to intermediate sanctions, private benefit/private inurement issues, and even tax-exempt classification itself may all create uncertain tax positions.

Specific disclosure requirements. Once the above collective "uncertain tax positions" are established, the IRS will require a concise description of each position in sufficient detail so that the IRS can determine the nature of the issue. Generally, at a minimum, the IRS expects: (1) the actual Internal Revenue Code (Code) provisions at issue; (2) the taxable year or years to which the uncertain tax position relates; (3) a statement that the uncertain tax position involves an item of income, gain, loss, deduction, or credit against tax; (4) a statement that the uncertain tax position involves a permanent inclusion or exclusion of any item, the timing of that item, or both; (5) a statement whether the uncertain tax position involves a determination of value; (6) a statement as to whether the uncertain tax position involves a computation of basis; and (7) a specification, for each uncertain tax position, of the entire amount of federal income tax that would be due if the position were disallowed entirely upon audit.

Admittedly these requirements, although phrased as "restrained" by the IRS, are quite onerous and mark a significant burden on large corporate organizations. While the Announcement takes care to note that the IRS will not request, in the tax return schedule, the taxpayer's assessment of risk or actual reserve amounts, such restraint provides little comfort. To provide teeth, the IRS expects to publish regulations requiring the schedule, as well as penalty provisions for failure to file the schedule or make adequate disclosures.

Potential impact. The Announcement marks a fundamental change in the philosophy of tax compliance - the IRS has never before required substantial disclosures with respect to decision-making processes in tax departments. It will put *pressure on tax departments, small and large, to expend additional efforts in drafting schedule responses to sensitive matters. Tax counsel may need to be employed to assist in reviewing issues* for which outside return preparers and internal staff cannot adequately assess and disclose exposure or a sufficient legal basis for a position. *Tax-exempt organizations will need to monitor this Announcement* to see if it adds an additional complication to an already burdensome revised Form 990, which requires disclosure of only FIN 48-related footnotes.

This development is not unexpected. Technological advancements and IRS focus on its internal information technology[3] have accelerated to the point where the mathematical and data compilation aspects of tax compliance will eventually be so efficient,[4] the healthcare organization can expect future IRS efforts to be far more focused on legal issues as opposed to calculation problems and/or recordkeeping. ■

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1 *Available at http://www.irs.gov/irb/.*

2 *See* "IRS FIN 48 Implications - LMSB Field Examiners' Guide," *available at* http://www.irs.gov/businesses/corporations/article/0,,id=171859,00.html.

3 *See* "IRS 2009-2013 Strategic Plan," p. 28, Apr. 2009, *available at* http://www.irs.gov/pub/irs-pdf/p3744.pdf.

4 *See* Randall Stross, "Why Can't the I.R.S. Fill in the Blanks," N.Y. Times, Jan. 23, 2010, *available at* http://www.nytimes.com/2010/01/24/business/24digi.html.

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Medical transport company's conviction for aggravated identity theft upheld

An owner of a medical transportation company was properly convicted of health care fraud under 18 U.S.C. §1347 and aggravated identity theft under 18 U.S.C. §1028A(a)(1) for using Medicaid patients' identifying information to submit fraudulent billing claims to a health maintenance organization (HMO). The district court's two-level enhancement of the owner's sentence was also proper due to the owner's abuse of his position of trust.

The transportation company contracted with the HMO to provide medical transportation services to Medicaid patients. Typically, the HMO would send the transportation company a daily trip log, which included patients' identifying information such as their Medicaid identification numbers. The transportation company would then submit claims to the HMO and the HMO would compensate the transportation company based on factors such as mileage and driver's wait time. It was discovered that the owner of the transportation company submitted claims with substantially inflated mileage amounts and also claims for trips that did not occur, enabling the owner to collect at least $303,329 in fraudulent payments.

"Without lawful authority." To establish aggravated identity theft under 18 U.S.C. §1028A(a)(1), the government had to prove that the owner used Medicaid patients' identifying information "without lawful authority" to commit a felony. On appeal, the owner argued that, to use the identification of another without lawful authority, an individual must misappropriate or misrepresent someone's identity or identifying information. In his case, the owner did not steal nor otherwise unlawfully obtain Medicaid patients' identification, or misrepresent his own or some other person's identity; in fact, the HMO specifically furnished him with patients' identifying information for billing purposes. He reasoned that he did have the "lawful authority" to use the identification of another and therefore could not be found guilty of aggravated identity theft.

The Court of Appeals for the Fourth Circuit noted, however, that there were other ways an individual could possess or use another person's identification, yet not have the "lawful authority" to do so. While the owner did have the "lawful authority" to use the identifying information for proper billing purposes, he did not have the lawful authority to use Medicaid patients' identifying information to submit fraudulent billing claims.

Moreover, if Congress had wished to include a misappropriation element in the aggravated identity theft statute, it would have included language in the statute similar to language used in another statute of the same section. The broader phrase, "without lawful authority," was intended to prohibit a wider range of activities than just theft. For these and other reasons, the owner's argument that he acted with lawful authority was rejected.

Sentence enhancement. Section 3B1.3 of the U.S. Sentencing Guidelines provides that an individual's offense level should be increased by two levels if the individual abused a position of trust that significantly contributed to the commission of the offense. The owner asserted that he had no relationship with Medicaid and was given no discretion by the HMO; therefore, the position of trust enhancement was inapplicable.

Application Note 2(B) to §3B1.3 of the U.S. Sentencing Guidelines states, however, that an abuse-of-trust enhancement applies when an individual exceeds or abuses the authority of his position to obtain unlawfully or use without authority any means of identification. The Fourth Circuit found that the owner abused the authority of his position by misusing the Medicaid patients' identification information to file fraudulent claims for payment. His arguments regarding lack of discretion and fiduciary relationship with Medicaid were irrelevant. The owner enjoyed a position of trust in regard to patients' identifying information and abused it.

Moreover, his abuse of trust facilitated the commission of aggravated identity theft because it granted him access to patients' identifying information, which was necessary to file fraudulent claims. Therefore, the two-level, offense-level enhancement of the owner's sentence for abuse of trust was proper because he abused the authority of his position to use Medicaid patients' identification information unlawfully. ■

U.S. v. Abdelshafi, 4th Cir., Jan. 25, 2010, Health Care Compliance Reporter, ¶800,826

The National Practitioner Data Bank Revisited

by Fay A. Rozovsky, JD, MPH, DFASHRM

On January 28, 2010, the Department of Health and Human Services (HHS) published long-anticipated changes to the National Practitioner Data Bank.[1] Commonly referred to by the acronym "NPDB," reporting to and retrieving information from the data bank has long been a source of discussion among many physicians and eligible healthcare entities under the terms of the Health Care Quality Improvement Act of 1986.[2]

The discussion was not restricted to the healthcare field. Congress entered the arena with legislative changes that sparked the need for regulatory change. With a focus on Section 1921 of the Social Security Act,[3] the regulatory change was first proposed in the *Federal Register* in March 2006. Now final, the new requirements become effective on March 1, 2010.

What is the current scope of the NPDB requirements? How does NPDB differ from the Healthcare Integrity and Protection Data Bank (HIPDB) created by the Health Insurance Portability and Accountability Act (HIPAA) in 1996? What is the context for the recent regulatory changes to NPDB? Are there major modifications to the existing regulatory requirements under NPDB? Will there be more information available in the care provider credentialing process? The answers to these questions are important in dealing with what might be considered "NPDB 2.0." For healthcare risk management and medical staff credentialing professionals, there are some practical strategies to consider in meeting the revised regulatory requirements.

Current Scope of NPDB

The NPDB was the creation of the Health Care Quality Improvement Act of 1986 (HCQIA) and includes reports about adverse licensure action taken against physicians and dentists. Such reports include revocations, suspensions, reprimands, censures, surrenders and probations with respect to quality of care. It also includes:

- adverse clinical privilege actions;
- adverse professional society membership actions;
- Drug Enforcement Administration (DEA) adverse actions;
- HHS-Office of the Inspector General (OIG) Medicare and Medicaid exclusions; and
- medical malpractice payments made for the benefit of any health care practitioner.[4]

The number of those obliged to make NPDB reports is limited. It includes:

- medical malpractice payers;
- state medical boards;
- state dental boards;
- DEA;
- HHS-OIG;
- professional societies with formal peer review; and
- hospitals and other health care entities.[5]

Those who have access to NPDB information include:

- hospitals and other health care entities that conduct peer review and provide health care services;
- state medical boards;
- state dental boards; and
- other health care practitioner state boards.[6]

In addition, NPDB provides for self-queries by individual practitioners.[7]

How NPDB Differs from HIPDB

Sometimes known as Section 1128E reporting under the Social Security Act, HIPDB focuses on reporting final adverse actions involving fraud and abuse. Although the data is collected in a separate data base from NPDB, it is administered by the same federal agency, the Health Resources and Services Administration (HRSA).[8]

The final adverse actions reported to HIPDB involve those against healthcare providers, suppliers and practitioners. HIPDB includes final adverse action data taken on or after August 21, 1996.[9] Reports are made by federal and state governmental agencies and health plans. Those who may query HIPDB differ from NPDB and include federal and state governmental agencies, health plans, and researchers for statistical data. Additionally, self-queries may be made by health care practitioners, providers and suppliers.[10] A notable difference is that hospitals are precluded from reporting and querying HIPDB.[11]

Context for Recent NPDB Changes

The *Final rule* makes clear that the driving force behind the regulatory change can be found in Section 1921 of the Social Security Act as amended by Medicare and Medicaid Patient and Program Protection Act of 1987 (MMPPPA) and Omnibus Budget Reconciliation Act of 1990 (OBRA). It expands the scope of NPDB, obligating all states to adopt a reporting system to the Secretary of HHS for certain types of adverse licensure actions taken against:

> "...health care practitioners and health care entities by any authority of the State responsible for the licensing of such practitioners or entities. It also requires each State to report any negative action or finding that a State licensing authority, a peer review organization, or *a private accreditation entity has finalized against a health care practitioner or entity.*"[12]

In a fact sheet, HRSA suggested that the rationale for the change was:

> "to provide protection from unfit health care practitioners to beneficiaries participating in the Social Security Act's health care programs and to improve the anti-fraud provisions of these programs."[13]

The Modifications to NPDB

In the *Final rule*, HRSA provided a chart that highlights the expanded scope of NPDB reporting and querying responsibilities.[14] A key area of change involves expanding the obligation of state reporting of licensure actions taken against doctors and dentists to match similar obligations under HIPDB. In other words, the reporting obligation of state medical and dental licensing authorities will no longer be limited to:

> "adverse actions related to professional competence or professional conduct, but these authorities must report all actions to the HIPDB. The change will make the reporting of adverse actions by all State licensure and certification authorities nearly identical for both the NPDB and HIPDB. No current NPDB reporting requirements will be changed for hospitals, other health care entities, professional societies, DEA, HHS-OIG, or medical malpractice payers."[15]

A thorough reading of the preamble to the *Final rule* identifies not only the rationale for implementing the Section 1921 changes, but also what it will mean for hospitals and other healthcare entities, care providers, and private accreditation organizations. Highlights include:

- The expanded NPDB will include reporting *all* licensure actions taken against *all* health care practitioners. This point is amplified in a fact sheet made available on the HRSA website that was published in March 2009. It provides that:
  > "adverse licensing actions taken against all licensed health care practitioners since January 1, 1992 will be included in the NPDB. Examples of licensed practitioners that are subject to Section 1921 reporting requirements by the State licensing board are: chiropractors, podiatrists, pharmacists, physician assistants, optometrists, professional and paraprofessional nurses, physical therapists, respiratory therapists, and social workers."[16]
- Government health care programs and law enforcement agencies that access NPDB through Section 1921 eligibility will only have access to information reported under Section 1921. They will not have access to information reported under the HCQIA.
- Under Section 1921, private-sector hospitals will now have access to all licensure actions taken against health care practitioners, including physicians and dentists. That is, the query will not be limited to queries regarding professional competence or conduct.
- Only health care practitioners, physicians, and dentists will be the subjects of peer review organization reports – not professional societies.
- A peer review organization for purposes of the *Final rule* is a stand-alone entity separate and apart from a hospital or other health care entity. As such, it does not include internal peer review committees of hospitals, professional societies, or other health care entities.
- The *Final rule* does not have a specific exclusion for patient safety organizations (PSOs) from the definition of peer review organizations because HRSA perceived Patient Safety Organizations as having specific and separate responsibilities under the Patient Safety Act.
- Only those actions taken by a private accreditation body against a "health care entity" are reportable. As such, purely educational programs would not constitute a health care entity for this purpose.
- A private accreditation entity may have a reporting obligation with other government agencies. However, making such reports does not relieve private accreditation entities from their reporting obligations under Section 1921.
- Voluntary surrender of a license after notification of an investigation is reportable and applies to state licensing actions under Section 1921. However, as long as there is no investigation underway, a voluntary surrender of license due to retirement, non-payment of license renewal fees, or a change to inactive status is not reportable.
- The Section 1921 information that the Secretary of HHS may release to authorized law enforcement and regulatory authorities does not include data on professional review actions or medical malpractice information found in NPDB.[17]

Observations on the *Final Rule*

The *Final rule* imposes new requirements on the states. For example, in the preamble, HRSA responded to concerns about the burden on state licensing boards that would have to report data going back 15 years. There was concern raised too about the accuracy of such information.

Recognizing that this could be a daunting task, HRSA offered two possible solutions:

> "[W]ith the States' permission, for HRSA to provide copies to the NPDB of all actions previously reported to the HIPDB that fall under the section 1921 require-

ments. The second option is for the State agencies to resubmit all legacy HIPDB reports (August 21, 1996, forward) to the NPDB under section 1921."[18]

The burden on state licensing agencies aside, there is much to absorb in terms of changes in the *Final rule*. The revised NPDB is really a "2.0" version. Extending reporting obligations to encompass healthcare entities and all licensure actions taken against all health care practitioners – not just physicians and dentists – is a significant change.

To be certain, there are some restrictions on accessing only Section 1921 data. Public sector hospitals will now have access to information that heretofore was blocked to them under the terms of HIPDB. To be clear, there are ways in which one can dispute information and provisions are in place to address confidentiality. Nonetheless, the revisions taking effect on March 1, 2010 will mark a major change for many healthcare practitioners and entities.

The *Final rule* has a few themes that are evident in the preamble discussion. One is that NPDB is a "national repository" and a "flagging system" that is:

> "... intended to be used as a resource to assist authorized queriers in conducting an extensive independent investigation of the qualifications of a health care practitioner or entity."[19]

The other important themes found in the expanded NPDB involve patient safety and controlling fraud and abuse. In the preamble discussion of "voluntary surrender" following notification of an investigation, HRSA spoke to the importance of such information:

> "... reporting voluntary surrenders after notification of investigation eliminates a loophole in which a health care practitioner, physician, or dentist surrenders his or her license to avoid possible disciplinary proceedings and a subsequent report to the Data Banks. If these voluntary surrenders are not reported to the NPDB, health care practitioners, with potentially questionable histories, would be able to move from state-to-state without detection."[20]

No doubt, there will be a learning curve for reporting entities, state licensing boards, peer review organizations, and private accrediting bodies. Similarly, those involved in administering "NPDB 2.0" will face their own challenges. It will be worthwhile to watch for new guidance from HRSA on the implementation and interpretation of the new rule. Disputes can be anticipated for which the Secretary of HHS will need to respond through the mechanisms found in the *Final rule*.

Strategies for Managing the Revised NPDB Requirements

There are a number of practical strategies to consider in gearing up for the revisions found in the *Final rule* on NPDB. With a deadline of March 1, 2010, emphasis should be on a practical approach. Some changes may be needed in the way in which reporting entities operate in order to meet the *Final rule*. Some strategies to consider are:

1. **Complete an NPDB gap analysis.** Review the requirements found in the *Final rule* and determine if the policies, procedures, and practice routines of the hospital and other healthcare entities are consistent with the new reporting requirements. Identify any variances or "gaps" with a view to developing a practical approach to align internal practices with the regulation.
2. **Work with legal counsel to address possible state law complications.** Ask legal counsel to help resolve potential state law - federal regulatory differences that may arise in meeting the revised NPDB reporting obligations. Should redundancies or inconsistencies be identified, be poised to make this information known to HRSA or the Secretary of HHS as such challenges may necessitate modifications to the reporting requirements. Be prepared that in some instances, a legal challenge may be necessary to resolve unresolved situations between state and federal requirements.
3. **Make certain the internal reporting structure is comprehensive.** Recognize that adverse data on "health care practitioners" will now be part of the information captured under NPDB. Determine if current systems need to be revised to accommodate required reporting obligations. Think about who collects information and how it can be assembled in a manner that meets the timeframes for reporting under the revised NPDB obligations. Note that this applies to all who will now have an obligation to report adverse information.
4. **Provide educational forums for key individuals.** Make certain that timely, focused educational programs are provided to those responsible for meeting the NPDB data gathering and reporting obligations. Recognize that such education is as important for state boards as it is for peer review organization personnel and hospital board members.
5. **Make necessary changes to the credentialing and employment process.** Evaluate current credentialing practices to determine how expanded information in NPDB will be used in evaluating physicians, dentists and other independent healthcare practitioners. Think about a similar approach for other healthcare practitioners who are prospective employees of a hospital or healthcare entity.
6. **Use the resources of the NPDB.** Anticipate updates, frequently asked questions (FAQs), and a revised Guidebook from NPDB. Track such information on a regular basis through the NPDB website. Do not hesitate to pose questions to HRSA when there is confusion or uncertainty based on the application of the *Final rule* requirements.

Conclusion

Many in the healthcare field have anticipated a major change in the NPDB. The *Final rule* is certain not to disappoint them. The *Final rule* harnesses much information. It will take time for the field and HRSA to put into place the necessary processes to "operationalize" the new requirements. Refinements may be needed in future. For now, there is much to do to maximize the idea of the revised NPDB to serve as a vehicle for enhanced patient safety and a tool in anti-fraud and abuse measures. ■

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[1] "National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners: Reporting on Adverse and Negative Actions; Final Rule," 75 FR 4656-4682 (Jan. 28, 2010).

[2] 42 USC §11101 et seq. as amended.

[3] See §5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (MMPPPA) and the Omnibus Budget Reconciliation Act of 1990 (OBRA).

[4] 75 FR 4656, 4656 (Jan. 28, 2010).

[5] *Id.*

[6] *Id.*

[7] *Id.*

[8] http://npdb-hipdb.hrsa.gov

[9] 75 FR 4656, 4656-4657 (Jan. 28, 2010).

[10] *Id.* at 4658.

[11] *Id.*

[12] 75 FR 4656, 4656 (Jan. 28, 2010) (emphasis added).

[13] "Fact Sheet on Section 1921," Mar. 2009, *available at* http://www.npdb-hipdb.hrsa.gov/pubs/fs/Fact_Sheet-Section_1921.pdf.

[14] 75 FR 4656, 4659 (Jan. 28, 2010).

[15] *Id.* at 4657.

[16] "Fact Sheet on Section 1921," Mar. 2009, *available at* http://www.npdb-hipdb.hrsa.gov/pubs/fs/Fact_Sheet-Section_1921.pdf.

[17] 75 FR 4656, 4660-73 (Jan. 28, 2010).

[18] *Id.* at 4671.

[19] *Id.* at 4662.

[20] *Id.* at 4667.

Fraud and Abuse

Power wheelchair supplier convicted of fraud

The owner of a durable medical equipment (DME) supplier was properly convicted and sentenced for health care fraud because she submitted false prescriptions for power wheelchairs on behalf of Medicare beneficiaries, provided those beneficiaries with power scooters which were less expensive than power wheelchairs, and pocketed the substantial cost difference between the two.

Venue. On appeal, the owner challenged the district court's denial of her motion to transfer venue. While the scheme did occur in several other districts, including the district in which the owner submitted the claims, there was evidence that the owner received patient information about Medicare beneficiaries who resided in the federal district in which the district court resided, directed her scheme to those persons, and then delivered power scooters to those persons.

Further, the district court had considered, among other things, the location or residence of the owner, the location of possible witnesses, and the location of events likely to be in issue. Given that these factors were either neutral or cut against transferring the action, and that the motion appeared to be a delay tactic, the district court's denial of the motion to transfer venue was permissible.

Sufficient evidence. The owner next contended with the denial of her motion for judgment of acquittal based on insufficient evidence. The evidence, however, was sufficient to support the jury's finding of guilt; there was, among other things, evidence that the owner paid Medicare suppliers for beneficiary information; testimony that she approached some of these Medicare beneficiaries and applied for power scooters for them by submitting Certificates of Medical Necessity from physicians who had not treated the beneficiaries; and evidence that she provided power scooters to these beneficiaries, but charged Medicare for power wheelchairs, and pocketed the $5,800 cost difference between the two.

Racial composition of jury. The owner, who was black, also challenged the racial composition of the jury. Specifically, the owner asserted that the district court erred when it denied her challenges to the government's striking of two black individuals. However, the government offered race-neutral reasons for striking the two jurors that were found to be plausible and not pretextual.

In addition, the owner asserted that the jury was not drawn from a fair cross-section of the relevant federal district because it contained more whites than blacks. However, she failed to offer any evidence that the selection process systematically excluded blacks.

Calculation of loss. The owner next argued that the district court's sentence was based on an improper calculation of the government's loss. The calculated amount was drawn from the owner's presentence report and derived from an investigation of business records that showed the amount the supplier had billed Medicare for power wheelchairs. A presentence report generally bears indicia of reliability sufficient to permit reliance on it at sentencing, and an individual must present countervailing evidence that the information in these reports is unreliable, which the owner failed to do.

Restitution amount. Finally, the owner disputed the restitution amount because it exceeded the amount proved at trial. The owner failed to prove, however, that the information used at sentencing was materially untrue. ■

U.S. v. Ubak-Offiong, 5th Cir., Feb. 2, 2010, Health Care Compliance Reporter, ¶800,833

HIPAA

HIPAA not a bar to medical records in medical malpractice action

Court orders authorizing the disclosure of medical information requested by two physicians were granted to the extent the information related to a patient's medical malpractice suit against the physicians for allegedly failing to remove the patient's cancerous mass that had been identified in a CT scan and biopsy. The patient asserted that, as a result of the physicians' negligence, she was forced to undergo additional surgery and was denied a substantial chance for better recovery.

The order authorizing the patient's healthcare providers to disclose her medical and mental health records under the Health Insurance Portability and Accountability Act (HIPAA) and 45 C.F.R. §164.512(e) was granted because the patient placed her physical and mental condition at issue and asserted no physician-patient privilege to preclude discovery of her medical and healthcare information.

The physicians' request to authorize the patient's healthcare providers to disclose HIV/AIDS information and drug, alcohol and mental health records was granted only with respect to the diagnosis and treatment of any mental, alcoholic, drug dependency and emotional condition, given that the patient made her mental and emotional condition an issue in her suit.

The order allowing the physicians' counsel to have informal *ex parte* communications with the patient's treating physicians was granted for the same reason and also because *ex parte* interviews were less expensive and less time-consuming than more formal discovery processes.

Contrary to the patient's argument, HIPAA did not prohibit *ex parte* interviews with healthcare providers if the party seeking the interview complies with HIPAA requirements for securing protected health information. ■

Pratt v. Petelin, D. Kan., Feb. 4, 2010, Health Care Compliance Reporter, ¶800,835

In the News

HHS and DOL announce $1 billion for health IT

HHS Secretary Kathleen Sebelius and Department of Labor (DOL) Secretary Hilda Solis announced the award of nearly $1 billion in funds pursuant to the American Recovery and Reinvestment Act of 2009 (PubLNo 111-5) to help health care providers advance the adoption and meaningful use of health information technology (IT) and train workers for the health care jobs of the future. The $750 million in HHS grant awards are part of a federal initiative to build capacity to enable widespread meaningful use of health IT, thus facilitating health care providers' efforts to adopt and use electronic health records in a meaningful manner that has the potential to improve the quality and efficiency of health care. The $225 million in DOL grant awards will be used to train 15,000 people in job skills needed to access careers in health care, IT and other high growth fields. The recipients of these grants have already identified roughly 10,000 job openings for skilled workers that likely will become available in the next two years in areas like nursing, pharmacy technology and IT.

HHS Press Release, Feb. 12, 2010

$17.4 million award for electronic medical records

Fifteen healthcare providers and networks received $17.4 million in contract awards to provide electronic medical records (EMR) to the Social Security Administration. The EMR will be sent through the Nationwide Health Information Network (NHIN), will significantly shorten the time it takes to make a disability decision, and will improve the speed, accuracy, and efficiency of the disability program. The contract awards, which are funded through the American Recovery and Reinvestment Act (PubLNo 111-5), require awardees, with a patient's authorization, to send Social Security EMR through the NHIN. The NHIN, a safe and secure method for receiving access to EMR over the Internet, is an initiative of the Department of Health and Human Services supported by multiple government agencies and private sector entities. "Using health information technology will improve our disability programs and provide better service to the public," said Michael J. Astrue, Commissioner of Social Security. "The use of health IT will dramatically improve the speed, accuracy, and efficiency of this process, reducing the cost of making a disability decision for both the medical community and the American taxpayer."

Soc. Sec. Admin. Press Release, Feb. 1, 2010

HHS awards $1.19 million to improve public health

The Department of Health and Human Services (HHS) awarded over $1.19 million to all 50 states, the District of Columbia, Puerto Rico and six Pacific territories to support public health efforts to reduce obesity, increase physical activity, improve nutrition, and decrease smoking. The funds will focus on efforts to help communities and schools support healthy choices through a variety of methods, including using the media to support healthy food and beverage choices and increased physical activity, and increasing access to healthy choices and safe places to be active. "Our goal through these statewide projects is to help make healthy choices the easier choices for all Americans, no matter where they live," said HHS Secretary Kathleen Sebelius. "When we improve obesity-related and tobacco policies, we make it that much easier for people to eat right, to get more physical activity, and to avoid or stop smoking."

HHS Press Release, Feb. 5, 2010