

Health Law ADVISORY

Current legal insights for health care executives

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Julie A. Knutson, Editor

RAC SERIES: Key Steps to Prepare for RAC Audits

This article is the second in the series on RAC Audits. Last month we covered the basic facts about the RAC program. In this article, we highlight key areas where providers should target their preparation efforts. Future articles in this series will go further in depth into key areas and make recommendations for best practices and important legal considerations as you prepare for RAC audits.

1. Get To Know Your Recovery Audit Contractor. Health Data Insights (“HDI”) is the audit contractor for Region D, which includes the Midwest states of Nebraska, Kansas, Iowa, Illinois, North Dakota, and South Dakota, along with a few northwestern states. The bid protests that were filed in November 2008 by contractors not awarded contracts have been withdrawn. The protesting contractors will now serve as subcontractors for the selected contractors. Part of the reason the protesting contractors were not selected originally by CMS was the numerous complaints received about them during the demonstration

phase. PRG-Schultz will serve as a subcontractor to HDI in Region D. PRG-Schultz touts on its website that, during the demonstration project, it identified over \$330 million in improper payments. It is unknown at this time what role PRG-Schultz will play in the audit process.

Speaking to the audience of the recent RAC Summit in Washington, D.C., the CEO of HDI, Andrea Benko, expressed her company’s absolute openness to customer service inquiries from providers; even offering that providers may speak directly with the RAC Medical Director. Each contractor is required to designate one contact person to receive records and correspondence from providers. Watch for announcements of this designated contact person from HDI. From the provider’s perspective, it may be necessary to make several requests to ensure that all correspondence from the RAC comes to one designated person in your facility. HDI indicates it has a “customization of address”

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form available, but is waiting for approval from CMS to gather that information through its website. HDI has indicated that it will generally send correspondence to the provider's compliance officer, but did not indicate how that contact information was obtained.

HDI will not begin reviews until it has been in the state conducting outreach education with providers. Be sure to attend these provider education meetings and be prepared to ask questions. Watch the RAC website as the RAC contractors are required to post new issues that the RAC will monitor, along with the common errors it is finding. Announcements of the date of reviews will also be posted on the website. Currently, HDI has no RAC information posted on its website.

Once you begin interacting with HDI and asking questions, be clear and detailed in documenting the advice, and also be cautious in relying on it. In a panel presentation in which all recovery audit contractors participated, Ms. Benko described HDI's "notice process" explaining that providers will receive an "informational letter" (CMS calls it a "demand letter") that starts a "discussion period" (this was previously referred to as a "rebuttal period" but CMS and the contractors are trying to move away from this term). Ms. Benko stated that after the discussion/rebuttal period ends, HDI will make its claim decision. Later Ms. Benko suggested that the appeal period begins to run once HDI makes its claim decision. This is inconsistent with other information published by CMS stating that the time period for appeal begins to run on the date of the demand letter.

When questioned further, panelists could not address the discrepancy. This time period is very important, as is discussed below. Be cautious about relying on advice provided by HDI, particularly regarding appeal issues. It is not in HDI's best interest for providers to appeal its denials. If the decision is overturned, HDI must return its contingency fee of 9.49%.

2. Medical Staff/Provider Education.

Begin to educate physicians and other practitioners on the RAC program. It is important that practitioners understand the impact of the RAC program on hospitals and practitioners. During the demonstration project, when a hospital claim was denied, the RACs did not correlate the Part A denial with the related claims for professional services on the Part B side. Each RAC has publicly announced that it will make that correlation under the permanent program. HDI specifically stated that, when an inpatient admission is denied for lack of medical necessity, it will correlate those denials and likewise deny any claims for related professional services under Part B. HDI also stated that it will be looking at 100% of claims data – SNE, Home Health, DME, Hospital and practitioner claims. The assistance of practitioners will be critical to both avoiding a claim denial, and in responding to a denied claim. Complete medical record dictation will greatly enhance the success of challenges to the denial during the appeals process. Practitioners need to be sure that the medical record accurately reflects the patient's condition and the medical need for services.

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3. Ramp Up the Utilization Review

Process. For most hospitals, the utilization review process at the time of admission is the best prevention of a RAC denial. Eighty-five percent of claim denials during the demonstration involved inpatient hospital claims; of those, 41.5% were “wrong setting” denials. Many of the appeals of denials during the demonstration project are based on the RAC’s inappropriate use of InterQual and Milliman USA criteria as bases for denial. The argument is that InterQual and Milliman USA criteria are not consistent with Medicare policy. HDI has stated that it will use both InterQual and Milliman USA criteria as bases for its review. If the claim fails those criteria, HDI states that it will send the claim to a physician reviewer to evaluate. Due to expected high volumes of claims, it is generally believed to be unlikely that the claims will be sent to a physician for review. InterQual and Milliman USA or similar criteria can be helpful in conducting required utilization review for RAC purposes and for the purpose of meeting the requirements in the conditions of participation for both critical access and PPS hospitals. Establishing the process and open lines of communication for utilization review staff to consult with practitioners when questions arise is critical in carrying out an effective utilization review process. Even if the claim is denied, having documentation of the utilization review process provides an advantage in arguing both the merits of the admission and establishing audit defenses.

4. Understand the Difference Between Automated Reviews and Complex Reviews.

Not all RAC reviews follow

the same process. Automated reviews will rely on data sent to the RAC by CMS to determine improper payments. This type of review does not involve a review of medical records. You may not even be aware that this type of review has occurred unless you are notified of overpayments. This type of review consumes fewer resources than a complex review and is conducted more frequently. A complex review occurs when data analysis is insufficient and the medical records are necessary for full analysis. The RAC will seek to identify discrepancies between the medical records and the claim. Some of the confusion surrounding informational letters and demand letters arises because of the different types of reviews. All letters from the RAC that indicate any action proposed to be taken by the RAC regarding that claim should be carefully evaluated to determine whether or not an appeal deadline has been triggered.

5. Medical Record Management, Communication and Tracking.

A key to RAC success is management of the information that flows through the RAC process. From the first request for medical record copies, to the last level of appeal, coordination of the process externally and internally is critical. As noted, it is important to diligently work with the RAC to establish a single point of contact for all communication from the RAC. All incoming mail from the RAC and all documentation provided to the RAC in response should flow through a designated coordinator. The coordinator can ensure that critical deadlines are not missed and verify which documentation has been previously submitted to the RAC. Hospital staff must be educated to

All letters from the RAC that indicate any action proposed to be taken by the RAC regarding that claim should be carefully evaluated to determine whether or not an appeal deadline has been triggered.

identify mail from the RAC that may be sent to them contrary to instructions given to the RAC (common problem for demonstration hospitals) and route all correspondence from the RAC through to the designated coordinator. Once a request for medical records has been received, there must be a system in place to ensure timely review, copying and submission of the requested records. It is important that the system avoids the need to access paper documentation multiple times. Retain a hard copy or electronic images of documents sent in response to the request to facilitate efficient and informed responses to follow up with the RAC. Include a cover letter with each submission that identifies the records included in the response. Many facilities are evaluating tracking software for use in managing all correspondence and the status of the claim in the review process. Whether you plan to use an internally developed spreadsheet or proprietary software, it is critical that you are able to track deadlines so that important appeal dates are not missed.

6. Prepare for Appeals. Future articles will be devoted to the RAC appeals process and strategies for effectively managing appeals. There are key areas you should be aware of now as begin to plan for your RAC appeals. First, know the appeal deadlines.

a. Redetermination. The first level of appeal is the request for redetermination filed with the Medicare Administrative Contractor (MAC). Do not be confused by the statement that the redetermination must be filed within 120 calendar days of the date on the demand letter. This is true;

however, in order to avoid recoupment, the appeal must be filed within 30 days of the date on the demand letter (not the date of receipt). Recoupment begins on day 41 if no appeal has been filed at this level. There is a catch, however. If you are not successful on appeal, the claim must be repaid with interest accruing from the date of the demand letter at the rate of approximately 11% (rate fluctuates). If you do not file for a redetermination, there is automatic recoupment. Payment for current claims will be withheld until the full debt is satisfied or payment arrangements are made. The MAC must render a decision within 60 days of receipt. Most providers in the demonstration project reported limited success upon appeal at the redetermination level.

b. Reconsideration. The second level of appeal is a request for reconsideration filed with the Qualified Independent Consultant (QIC). While you have 180 days to file the appeal at the reconsideration level, you must do so within 60 days if you want to hold on to the money. This is a review “on the record” meaning that there is no in-person meeting held. The review consists of a review of the initial determination, the redetermination and all issues related to the payment of the claim. It is very important that the record is complete at this stage – as no further evidence can be submitted at the next levels of appeal. At this level of review, the QIC is bound by national coverage decisions, CMS rulings and applicable laws and regulations. It is not bound by local coverage decisions, local medical review policies or CMS program guidance such as program memoranda and manual instructions.

Whether you plan to use an internally developed spreadsheet or proprietary software, it is critical that you are able to track deadlines so that important appeal dates are not missed.

It will be important to evaluate the denial and the basis for the denial at the prior stages so that all arguments can be set forth during the reconsideration. The QIC has 60 days to render its decision. It may extend the 60 days for an additional 14 days if the provider submits additional evidence at this level of appeal. A recent OIG report found that Part B QICs did not meet the 60 day timeframe 58% of the time.

c. Administrative Law Judge (ALJ). The third level of appeal is an ALJ hearing. The amount in controversy must be at least \$120, but claims of similar issues may be aggregated. You may request an in-person meeting if you go to the ALJ's office, however the rule requires hearings to be conducted by video teleconference if the technology is available. The ALJ has 90 days to act, or the provider may automatically escalate the appeal to the Medicare Appeals Council. The demonstration project providers had the greatest success at the ALJ level. Like the QIC, the ALJ is only bound by national coverage decisions, CMS rulings and applicable laws and regulations.

d. Medicare Appeals Council. The fourth level of appeal is the Medicare Appeals Council (Council). The provider has 60 days to file for Council review. There is no hearing in front of the Council and no further evidence may be submitted. The Council has 90 days to render its decision.

e. Federal District Court. The fifth level of appeal is the federal district court. A provider has 60 days to file. The regulations provide that, in a federal district court action, the findings of fact by the Secretary of HHS, if supported

by substantial evidence, are deemed conclusive.

Navigating the appeals process involves careful strategy and attention to timing as well as thorough development of documentation of the clinical merits of the case along with touchstone legal defenses. In future articles in this series as we discuss strategies for managing RAC appeals, a very, if not the most, critical phase of the RAC process.

Vickie Brady Ahlers

Iowa Hospitals And Nursing Homes Required to File Form 990 with IDPH and LSA

Effective July 1, 2008, Iowa hospitals and nursing homes are required to submit a copy of their IRS Form 990 to the Iowa Department of Public Health (IDPH) and the Legislative Services Agency of the Iowa General Assembly (LSA). Copies must be submitted within 90 days of the due date for filing the return.

The legislation requiring this submission provides that this includes Schedule J or other schedule that includes compensation information, along with revenues, expenses,

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surplus, and reserves.

Please note the following:

1. This requirement does not apply to hospital affiliates (e.g., parent companies, foundations, and clinics).
2. There is no Form 990 Schedule J for returns for fiscal periods ending prior to December 31, 2008.
3. We have been strongly advocating that all exempt organizations take steps to be prepared for the first filing of the new Form 990. This includes careful planning for the responses to the wide range of good governance questions and the process for determining and evaluating executive compensation. The requirement for submission of the Form 990 to the IDPH and the LSA provides one more reason for extra care in this planning for the new Form 990.
4. IRS rules provide that the names and addresses of contributors are not open to public inspection, but that all other information, including the amount of contributions, the description of noncash contributions, and any other information provided, will be open to public inspection unless it clearly identifies the contributor. The instructions to the IRS Form 990 provide that if an organization files a copy of Form 990 and attachments with any state, it should not include its Schedule B in the attachments for the state, unless a schedule of contributors is specifically required by the state. The instructions note that states that do not require the information might inadvertently make the schedule available for public inspection along with the rest of the Form 990. We share that concern here, as we believe that submitting the Form 990 with

Schedule B attached to the IDPH and the LSA would likely make these Schedules public under the Iowa public records law. Until advised otherwise by IDPH or the LSA, we recommend that hospitals and nursing homes redact names and addresses of contributors from Schedule B prior to submission to the IDPH and the LSA and reference such redaction in a cover memo submitted with the filing.

5. At this time, we are not aware of any plans of the IDPH or the LSA as to how they plan to use such documents or whether they plan to make them broadly available for public access.

John R. Holdenried

Until advised otherwise by IDPH or the LSA, we recommend that hospitals and nursing homes redact names and addresses of contributors from Schedule B prior to submission to the IDPH and the LSA and reference such redaction in a cover memo submitted with the filing.

Inspector General Announces Narrowing of Self-Disclosure Process

In a brief letter dated March 24, 2009, Daniel R. Levinson, Inspector General of the Department of Health and Human Services (DHHS) issued an Open Letter to Health Care Providers that significantly narrowed the scope of the self-disclosure process.

Attributing the changes to necessary prioritization “to fulfill DHHS’s mission and allocate resources,” Levinson limited the scope of the SDP to anti-kickback issues “intended to induce or reward a physician’s referrals.” The SDP will no longer be available for matters involving only liability under Stark Law. With respect to Stark, Levinson cautioned that providers should not “draw any inferences about the Government’s approach to enforcement of the physician self-referral law” as a result of this limitation of the SDP.

The second and final limitation is in connection with a new minimum settlement amount. The SDP will now only be available for matters involving a minimum \$50,000 settlement. The Inspector General explained that this minimum is consistent with the OIG’s statutory authority to impose a penalty of up to \$50,000 for each kickback violation and an assessment of up to three times the total remuneration. The Letter states that the OIG “will continue to analyze the facts and circumstances of each disclosure to determine the appropriate settlement amount consistent with [the OIG’s] practice, stated in the 2006 Open Letter, of generally resolving the matter near the lower end of the damages continuum, i.e., a multiplier of the value of the financial benefit conferred.”

These limitations foreclose the option of resolving matters involving only Stark Law and lower dollar matters under the SDP. Although the Open Letter did not set out procedural details, it follows that the initial disclosures by the provider and the acceptance process into the SDP will be used by the OIG, as before, to determine the appropriateness of the disclosure under the new parameters prior to acceptance. Under the refinements to the SDP outlined in the April 15, 2008 Open Letter, providers making disclosures were already required to estimate the amount of damages to Federal health care programs.

These changes will make it necessary to evaluate the possibility of other self-disclosure options other than the SDP in cases involving only Stark Law issues or amounts under the \$50,000 settlement minimum.

Julie A. Knutson

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Protecting Your Company’s Trademarks and Trade Names

Part I: Understanding the Basic Differences

For a business, its name is one of its most valuable assets. In fact, a company’s viability may hinge on the strength and value of its name. Yet, often companies do not recognize the benefits of available legal protections. No clear directives exist as to how to best select, use and protect a company’s name. The proper selection, use and protection of a name begins with a basic understanding of the differences between *Corporate Names*, *Trade Names* and *Trademarks*.

Corporate Names

A corporate name is the term used for the legal name of an entity, be it a corporate name, limited partnership name, partnership name or limited liability company name. Most states permit the registration of a corporate name if it is

merely distinguishable from the registered names of other entities, even if the name is confusingly similar to another. Registration generally only authorizes the applicant to use that exact corporate name in the state and does not necessarily grant ownership or ensure protection from infringement by another party. The standards for registering a corporate name are different from the standards constituting ownership or infringement of a trademark or a trade name. An applicant may have authority from the state to use a corporate name, but still may not own the name and may be sued as an infringer.

Trademarks and Service Marks

A trademark is any word, phrase, symbol, logo, group of letters or numbers, or combination thereof, that identifies the goods or services and distinguishes them from the goods or services of another. The primary purpose of trademark laws and protections is to prevent consumers from being confused about the source or origin of a product or service. Whereas trademarks apply to goods, service marks apply to services.

Trade Names

A trade name is any name used in the course of business that differs in any respect from the full legal corporate name. A trade name is the name that a business uses to identify itself – the name on its invoices, letterhead, and signage. Technically, a trade name is not considered a trademark or entitled to protection under trademark laws, unless it actually adorns a product or service. If a business does use its name to identify a product or service, the name will then be considered a trademark or service mark and could be entitled to protection (if it is distinctive enough). For instance, Apple Computer Corporation uses the trade name Apple as a trademark on its line of computer products.

A trade name that is not used on a product

or service may be given some protection under state and local laws (through a trade name or fictitious name registration) or be protected against a confusing use by a competitor under federal and state unfair competition laws.

How They Work Together

Corporate names, trademarks and trade names all have separate meanings, rights and registration requirements. For example, the *Corporate Name* of a company is Down Home Health Systems, Inc. Yet, when the company does business it generally uses the shorter Down Home, which is found on its letterhead and invoices. This use is considered a *Trade Name*. The slogan “We Do Healthcare Best,” used in advertising to promote its health care services, is considered to be a *Service Mark* of the company.

Each of these categories is a separate type of use, and registration and protection is different for each. A trademark could not be obtained on the name Baird Holm Health Systems, Inc. if it is only used as the corporate name. A trademark could not be obtained on Baird Holm unless it is actually used with the sale of goods or services. The mere registration with a state of a corporate name or trade name does not of itself confer trademark ownership or even necessarily the exclusive right of use in that state. A name must be used as a trademark in order to enjoy trademark protection.

The Registration Process and the Protections Granted

Next month, in Part II, we will summarize the registration process for corporate names, trademarks and trade names and outline the protections granted by each type of registration.

The mere registration with a state of a corporate name or trade name does not of itself confer trademark ownership or even necessarily the exclusive right of use in that state.

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Update Of EMTALA Interpretive Guidelines

The Centers for Medicare and Medicaid Services published, on March 6, 2009, revisions to the Interpretive Guidelines regarding the Emergency Medical Treatment and Labor Act (EMTALA), including updates to reflect the Inpatient Prospective Payment System 2009 Final Rule revisions to the EMTALA regulations.

1. On-Call Provisions.

a. Community Call Plans (CCPs).

The 2009 final rule added a provision allowing neighboring hospitals to adopt CCPs to share on-call responsibilities. The regulation lists specific requirements for a formal CCP:

- Clear delineation of on-call coverage responsibilities (when each participating hospital is responsible for coverage: by time period and by specialty).
- Description of geographic area governed by CCP.
- Signature by appropriate representative of each hospital in the CCP.
- Assurances that EMS system protocol formally includes information on the CCP.
- Acknowledgement that an individual's presentation at a hospital that is not on-call under the CCP will still provide a medical screening exam and stabilizing treatment within its capability and abide by the EMTALA regulations.

- An annual assessment of the CCP by the participating hospitals.

In addition to these new requirements, CMS advises that: (i) CCPs are not required to be approved in advance by CMS. (ii) Each hospital must have a "back up" plan for those times when the CCP is not in operation for any reason. (iii) On-call lists must now include any physicians covering under a CCP, including those physicians who are not on the medical staff of the participating hospital maintaining the on-call list.

b. On-Call Lists.

- The regulations have been revised to refer to CCPs and to anticipate that physicians providing emergency coverage pursuant to the CCP will be listed on the hospital's on-call list, even if they are not on that particular hospital's medical staff.
- Historically liberal language has been deleted from the Interpretive Guidelines. The deleted language gave hospitals broad flexibility to maintain on-call lists "in a manner that best meets the needs of the hospital's patients who are receiving services . . . [under EMTALA], in accordance with the resources available to the hospital, including the availability of on-call physicians." CMS explained that the deleted language had proven difficult to interpret and caused confusion; the new language more closely tracks the statute.
- Reflecting the deletion of the historically liberal language on on-call schedules, CMS emphasizes the need for on-call coverage for services provided at the hospital and the resources available, including specialists. As an example, CMS notes that if a hospital performs a

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significant number of interventional cardiac catheterizations and holds itself out to the public as a center of excellence in this specialty, it would be reasonable to expect on-call coverage by an interventional cardiologist for patients presenting to the DED or who may require transfer to that hospital for such a procedure. In an astoundingly naive statement overestimating the capabilities of CAHs, the revised Interpretive Guidelines state “it may not be reasonable to expect a CAH to have an interventional radiologist on call if that service is not routinely provided at the CAH or in the local vicinity of the CAH, unless the CAH participates in a community call plan that provides for this service.”

- CMS draws attention to the practice of allowing a physician to take selective emergency call, only for his private patients. Hospitals are cautioned to ensure that other patients have access to emergency services. Selective call responsibility for private patients only is no substitute for the on-call services required by the hospital’s Medicare provider agreement.

c. On-Call Physician Appearance Requirements.

- New language refers to a hospital’s ability to send a patient to a specialist’s office if it is a “hospital-based department of the hospital.” Appropriate personnel must accompany the patient to the specialist’s office. It is important to note that this will not allow transport of a patient from a CAH ED to the on-call physician’s office in a provider-based rural health clinic. The hospital-based department must be Medicare-certified under the same provider number as the hospital. RHCs are separately certified.
- On-call physicians may send a mid-

level practitioner, if that practice is allowed by the hospital, state law, and scope of licensure. However, if the treating physician is not satisfied by the appearance of the mid-level practitioner, the treating physician can require the on-call physician to appear personally.

- It is permissible to use telemedicine to obtain a specialist’s consultation on an emergency patient, with the understanding that the telespecialist is not on-call, and thus is not required to appear in person. However, if the telespecialist is on the on-call list, he will be considered on-call, subject to being called in by the treating physician or mid-level practitioner.
- Repeated reference is made to hospitals’ need for “fall back” or “back-up” plans in the event that emergency coverage fails due to the on-call physician being busy with another emergency, simultaneous call for another hospital or scheduled elective surgery. In practice, this may be a plan to transfer the patient to another hospital where the service needed by the patient can be provided more promptly.

2. **Emergency Waiver Regulation**

Technical Changes. CMS has refined procedures for hospitals to obtain an EMTALA waiver, based on several weather-related disasters in FY2008. Clearly, among those disasters, CMS is referring to the flooding in Cedar Rapids, Iowa last year. Hospitals will be required to notify their State Agency when they activate their disaster plans, and when utilizing EMTALA waivers pursuant to Survey and Certification Letter 08-05.

- Sanctions will not be imposed for inappropriate transfer of patients who have not been stabilized, or for direction or relocation of an individual to receive a medical

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screening examination at an alternate location pursuant to a state emergency preparedness or pandemic plan.

- The hospital seeking waiver must be located in an “emergency area” during an “emergency period.” This means that there is an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and a public health emergency has been declared by the Secretary pursuant to section 319 of the Public Health Service Act.
 - The CMS Central Office will notify the Regional Offices when EMTALA waivers are permitted and whether they will take effect retroactively.
 - The RO will remind hospitals that in order to invoke the waiver, the hospital must activate its disaster protocol and the state must have activated an emergency or pandemic preparedness plan.
 - Interestingly, the circumstances which would require a receiving hospital to accept a lateral transfer (one between two hospitals with the same capabilities) have been expanded to include “loss of power or significant flooding.”
- 3. EMTALA Obligations for Hospitals with Specialized Capabilities.** This update of the Interpretive Guidelines reflects amendments to the EMTALA regulations implemented in the FY2009 IPPS Final Rule. In the 2003 regulatory amendments, CMS clarified that EMTALA does not apply to inpatients. Along the same vein, CMS has now clarified that a receiving hospital’s obligation to accept a patient requiring specialized services not available at the transferring hospital does not apply to a patient who has been admitted as an inpatient at the transferring hospital. CMS

notes that patients admitted for observation are outpatients, not inpatients, so a receiving hospital will have an obligation to accept transfer of an observation patient who requires specialized services available at the receiving hospital, but not at the transferring hospital.

- 4. Patient Transfers/Physician Certification that Benefits Outweigh Risks.** The physician certification must state the reason(s) for transfer, specific to the patient’s condition. The rationale must be included on the certification form or in the medical record. Hospitals that do not provide obstetrical services must still provide screening, stabilizing treatment and meet transfer requirements. However, the benefits of transfer to a hospital with an obstetrical service may outweigh the risks.

Barbara E. Person

Upcoming Speaking Engagements

Vickie Brady Ahlers and Alex (Kelly) M. Clarke will speak at the Omaha Health Information Management Association - Spring Workshop 2008. This event will be held on April 4, 2009 at the Nebraska Methodist Hospital in Omaha, Nebraska.

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