

# Health Law ADVISORY

*Current legal insights for health care executives*

April 30, 2009  
Julie A. Knutson, Editor

## *Effects of Nebraska LB 403 on Health Care Providers*

*Editor's Note: LB 403 also affects certain employers. The April Edition (Volume 18, No. 4) of the Labor & Employment Law Update describes the requirements for employers.*

### **Provisions of the Act – Public Benefits and Public Contractors**

LB 403 was signed by Governor Heineman to be effective October 1, 2009. With respect to health care providers, the Act requires verification of lawful presence for purposes of “public benefits” unless an exemption is applicable. Put another way, “unless exempted, no state agency or political subdivision may provide public benefits to a person not lawfully present in the United States.”

Compliance requires verification by state agencies and political subdivisions that each person applying for public benefits is lawfully present in the United States. “Public benefits” means “any grant, contract, loan, professional license, commercial license, welfare benefit, health payment or financial assistance benefit, disability benefit, public or assisted housing benefit, postsecondary education benefit involving direct payment of financial assistance, food assistance benefit, or

unemployment benefit or any other similar benefit provided by or for which payments or assistance are provided to an individual, a household, or to a family eligibility unit by an agency of the United States, the State of Nebraska, or a political subdivision of the State of Nebraska

Verification for public benefits purposes requires that applicant attest to United States citizenship; or that he or she is a qualified alien under the federal Immigration and Nationality Act, 8. U.S.C 1101 *et seq.*, as such act existed on January 1, 2009 and is lawfully present in the United States. When the applicant is not a U.S. citizen and alternatively attests to lawful presence under the Immigration and Nationality Act, the verification shall be accomplished using the Systematic Alien Verification for Entitlements Program operated by the United States Department of Homeland Security or an equivalent program designated by the Department, (currently E-Verify). Providers may rely on the attestation by the applicant until the verification is completed.

**Health Care Exemptions.** Verification of lawful presence is not required (in regard to health care) for “assistance for

### ALSO IN THIS ISSUE

Nebraska Medical Assistance Program (NMAP) Adopts “Never Event” Policy

2

RAC SERIES: Strategies for Defending RAC Audits

3

Protecting Your Company's Trademarks and Trade Names Part II: Protections Your Business Will Receive Through Registration

6

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

8

**Find back issues of our newsletters at: [www.bairdholm.com/news-updates-newsletters.html](http://www.bairdholm.com/news-updates-newsletters.html)**

health care services and products, not related to an organ transplant procedure, that are necessary for the treatment of an emergency medical condition, including emergency labor and delivery, manifesting itself by acute symptoms of sufficient severity, including sever pain, such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the patient's health in serious jeopardy, (b) serious impairment to bodily function, or (c) serious dysfunction of any bodily organ or part; or  
...

Public health assistance for immunizations with respect to diseases and for testing and treatment of symptoms of communicable disease, whether or not such symptoms are caused by a communicable disease.

In certain circumstances, health care providers could be considered "public contractors" under LB 403. A "public contractor" is any contractor (along with subcontractors), who is awarded a contract by a public employer for the performance of physical services within the State of Nebraska." Both public employers and public contractors are required to register with and use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the state of Nebraska.

#### *Practical Applications.*

All public hospitals in Nebraska will be impacted as public employers required to verify the lawful presence of new employees. Both public hospitals and private hospitals are required to verify the lawful presence of applicants for public benefits when functioning as a "public contractor." The broad language of LB 403 raises many questions about when a health care provider is acting as a public contractor. Bruce Rieker, Vice President for Advocacy for the Nebraska Hospital Association has been active in discussions with the Governor's

Policy Research Office for the purpose of determining the scope of the definition of public contractor for this purpose. Although many questions remain, the following arrangements (in addition to the exemptions) do not appear to trigger "public contractor" status and verification requirements:

- Providing services to Medicaid beneficiaries, as the lawful presence of such beneficiaries would have been determined in the enrollment process;
- Providing services under contracts with the Mental Health Regions as the regions are considered to hold the contracts with the state.

There has been no announcement about whether or not there will be regulations issued in connection with LB 403 provisions.

**Julie A. Knutson**

## *Nebraska Medical Assistance Program (NMAP) Adopts "Never Event" Policy*

Effective April 15, 2009, NMAP added the following regulation (471 NAC 10-010.03C) that parallels the federal "Never Event" policy:

"Non-Payment for Hospital Acquired

*Both public hospitals and private hospitals are required to verify the lawful presence of applicants for public benefits when functioning as a "public contractor."*

Conditions: NMAP will not make payment for those claims which are identified as non-payable by Medicare as a result of a hospital acquired condition. This provision applies only to those claims in which Medicaid is a secondary payor to Medicare.”

## *RAC SERIES: Strategies for Defending RAC Audits*

This article is the third in the series on Recovery Audit Contractor (RAC) Audits. In the first parts of this series, we covered the basic facts and history of the RAC program, and the key steps in preparing for RAC audits. This article identifies strategies for making a record at the Reconsideration level and legal defenses which may be raised in the various levels of appeal.

1. Dig in on the Merits of the Claim. Of the Medicare denials reported during the RAC Demonstration Program, the RACs had alleged that :

- 40% did not meet Medicare’s medical necessity criteria.
- 35% arose from incorrect coding.
- 17% were denied for “other” reasons such as payment being made on outdated fee schedules, duplicate claims, etc.
- 8% did not have sufficient documentation (the RAC requested information but it did not arrive timely or was incomplete).

The last of the four categories (insufficient documentation) signals administrative problems which should be addressed systematically by the Hospital. However, the first three rationales for denial call for case-by-case evaluation of whether the denial is worthy of appeal. Each case should be reviewed to consider whether there is evidence to rebut the RAC’s conclusion that there was a lack of medical necessity, the wrong code was submitted on the claim, or that claims were duplicated or paid on the wrong fee schedule.

2. Reconsideration: Last Opportunity to Submit Evidence. As explained in the second article in this RAC Series, the last opportunity to submit evidence for inclusion in the appeal record is at the Reconsideration. This is only the second of five potential stages of appeal in the Medicare appeals process. As a practical matter, Medicare providers have historically handled internally most of their Redeterminations and Reconsiderations internally, without involving outside legal counsel. Depending upon the value of the claims denied and the number of denials based on the same or similar diagnoses or other facts, it may be worthwhile to consult legal counsel to assist in preparation of the evidence for submission at the Reconsideration. If there are multiple similar cases, legal counsel can assist in developing the necessary exhibits, which may then be duplicated or altered slightly for submission in all similar cases.

3. Evidence Gathering and Preparation. In many cases, a finding of lack of medical necessity results from scant documentation, or incomplete medical records. The original record should be reviewed for information which may have been missing from that sent to the RAC. Another possibility is that the RAC reviewer did not review the medical record thoroughly

*In many cases, a finding of lack of medical necessity results from scant documentation, or incomplete medical records.*

or misunderstood pivotal documentation. Qualified clinical personnel should perform internal review of the medical record to conclude whether the medical record is defensible in showing medical necessity. Consultation with the attending physician, and in some instances a physician consultant, may be invaluable. Depending upon the facts of each case and the basis for the RAC's denial, a position statement should be developed, and evidence gathered to support the validity of the provider's claim. Such evidence may include medical summaries, scholarly articles, medical summaries, anatomical drawings, charts analyzing the array of similar claims, etc.

In cases denied for incorrect coding, internal coding personnel should be advised of the RAC's findings, and industry coding authorities and guidance reviewed. If the original coding is justified by these authorities, appeal will be worthwhile. As indicated in last month's article, the Reconsideration's decision-maker, the Qualified Independent Consultant (QIC), is not bound by local coverage decisions, local medical review policies or CMS program memoranda and manual instructions. Only national coverage decisions, CMS rulings and applicable laws and regulations are binding.

4. Legal Defenses, Generally. In addition to arguments on the merits, there are a number of legal theories which may support a provider's appeal of a RAC denial. These arguments may be raised at any stage of the appeal. The following are five such defenses.

- Treating Physician Rule. This rule is based on the theory that the treating physician's opinion should be afforded deference or extra weight, as he or she was the professional who examined

the patient and is most familiar with the patient's condition and therefore is in the best position to have made a determination of medical necessity. Courts that have adopted this rule require a showing of substantial evidence contradicting the treating physician's conclusion in order to defeat this presumption. The fact that RACs rely heavily on nurse reviewers is a sound rationale for insisting upon deference to the treating physician in the absence of substantial evidence to the contrary.

- Waiver of Liability. This legal defense typically applies in the case of denials based on lack of medical necessity. Section 1879(a) of the Social Security Act provides for a waiver of liability on the part of the provider, even if the service provided has been finally determined to be not reasonable and necessary. Payment is still proper if the provider did not know and could not reasonably have been expected to know that payment would not be made. In order to determine what the provider did know or could reasonably have been expected to know, the appeal process examines all relevant Medicare MAC, Carrier and Fiscal Intermediary communications. One example of a positive set of circumstances is a provider who received an overpayment demand, if the provider had been previously subject to claim reviews or Medicare audit where similar claims were approved. Those favorable decisions can be offered to show that the provider did not have reason to know that similar claims would not be paid.
- Provider without Fault. Section 1870 of the Social Security Act states that

*Depending upon the facts of each case and the basis for the RAC's denial, a position statement should be developed, and evidence gathered to support the validity of the provider's claim.*

payment will be made if the provider was “without fault” with regard to billing for and accepting payment for disputed services. In support of this defense, the provider must show that it used reasonable care in billing for and accepting payment, complying with all pertinent regulations, the provider fully disclosed all material facts and on the basis of the information available, it was reasonable for the provider to assume the payment was correct. In addition to the MAC, Carrier and FI communications mentioned in the preceding paragraph, providers may benefit from their claims processing personnel keeping logs of their conversations and Q&A by telephone with provider support contacts at the MAC, Carrier and FI. If a provider’s coding personnel called a Medicare contractor with a specific question, the telephone log could be produced to show the answer given to the provider. The log should include the name of the MAC, Carrier or FI contact, the date of the conversation, and the specific question asked and the response provided. This documentation could demonstrate that the provider could not have been expected to know payment would not be made on a particular claim or an entire class of claims.

- Reopening Regulations. Medicare regulations limit reopening of claims in recognition of the equitable argument that providers must be able to rely upon coverage determinations. Generally, a Medicare contractor is permitted to reopen and revise its initial determination

- Within 1 year from the date of the initial determination for any reason.
- Within 4 years of the date of the initial determination for good cause, as defined.
- At any time if there is reliable evidence, as defined, that the initial determination was procured by fraud or similar fault, as defined.

“Good cause” for reopening within 4 years is shown when there is new and material evidence that was not available or known at the time of the determination, and may result in a different conclusion; or the evidence that was considered in making the determination clearly shows on its face that an obvious error was made at the time of the determination. Medicare contractors are precluded from recovering overpayment outside the parameters set out above.

This legal defense was fairly successful during the RAC demonstration program, but a recent decision by the Medicare Appeals Council held that ALJs and the MAC lack jurisdiction to consider challenges to reopenings.

- Statistical Challenges. A final legal defense which has proven successful in post-payment audits alleges a failure to follow Medicare guidelines for extrapolating overpayments to the universe of a provider’s claims. RACs are authorized to use extrapolation as long as it adheres to the applicable

*Providers are deemed to be without fault in the absence of evidence to the contrary if the overpayment was discovered subsequent to the third calendar year after the year of payment.*

Another “Provider without Fault” argument is based on timing of the denial. Providers are deemed to be without fault in the absence of evidence to the contrary if the overpayment was discovered subsequent to the third calendar year after the year of payment. The RAC demonstration program allowed reopening of claims up to four years following the date of initial payment. So there were some claim denials which fell within the four year period, but outside the three calendar year period.

statute and manual provisions. The applicable statute limits the use of extrapolation to circumstances where the Secretary has determined that there is a sustained or high level of payment error, or documented educational intervention has failed to correct the payment error. If RAC denials are based in any way on such extrapolations, it may be valuable to review the calculation against the CMS guidelines for statistical extrapolations in the Medicare Program Integrity Manual at Chapter 3, sections 3.10.1 through 3.10.11.2.

**Barbara E. Person**

of an entity. Most states permit registration of a corporate name if the corporate name is not the same as, does not conflict with, and is not confusingly similar to any other corporate name registered in that state. An entity typically registers its corporate name when filing the incorporation/organization documents with the Secretary of State's office. However, if a prospective business is not ready to file the incorporation/organization documents, but would like to reserve the corporate name, both Nebraska and Iowa allow prospective businesses to reserve a corporate name by filing a reservation form with the Secretary of State's office along with a filing fee (\$25 in Nebraska and \$10 in Iowa). The reservation is good for 120 days in both states.

Registration generally only authorizes a company to use that exact corporate name in that state and does not necessarily grant ownership or ensure protection from infringement by another. There is a common misconception that when a state allows incorporation under, or reservation of, a corporate name, that name is free and clear from claims of infringement or ownership rights. When states allow for the registration of a corporate name, the states do not consider whether the name violates any federal or common law trademark rights. Therefore, it is important that a prospective business search not only the corporate name records, but also all available trademark databases.

### **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. Registration of a trade name is accomplished in each state (there is no federal registration), and, in most cases, is a relatively simple process. In Nebraska, a business need only file an Application for Registration of Trade Name with the Secretary of State, listing the name under which the company will do business in

*An entity typically registers its corporate name when filing the incorporation/organization documents with the Secretary of State's office.*

# *Protecting Your Trademarks and Trade Names*

## *Part II: Protections Your Business Will Receive Through Registration*

Last month, we looked at the basic differences among *Corporate Names*, *Trade Names* and *Trademarks*, and the role that each plays in protecting a company's name. This article summarizes the registration process for each of these and briefly discusses the protection that each provides.

### **Corporate Names**

"Corporate name" refers to the legal name

Nebraska, along with a \$100 filing fee, and file proof of publication (in a newspaper of general circulation in the city or county where the business is located) of the trade name registration with the Secretary of State within 30 days of the registration.

In Iowa, the process depends on the type of entity. All corporations, limited partnerships, limited liability companies, professional companies, nonprofit corporations, cooperatives and cooperative associations file a Fictitious Name Resolution with the Secretary of State's office, along with a \$5 filing fee. All other entities, including governmental entities, file a Verified Statement with the County Recorder's Office in the county in which the business is conducted. The fee for Verified Statement filing is set by each county.

The registration of a trade name does not necessarily confer ownership and does not necessarily provide protection from the use of the name by others. As with corporate names, it is important that a prospective business search not only the state trade name records, but also all available trademark databases.

### **Trademarks and Service Marks**

A trademark is any word, phrase, symbol, logo, group of letters or numbers, or combination thereof, that identifies a company's goods or services and distinguishes them from the goods or services of another. Trademark rights are conferred in one of three ways:

Common Law. Trademark rights in the U.S. are obtained through the actual use of a mark in connection with the offering of goods or services. The first person to adopt a mark and use it in commerce has a right to prevent others from using a similar mark in a manner that is likely to confuse consumers, regardless of whether or not the mark has been registered on

a state or federal level. These rights are known as common law rights – rights that arise through use of a mark in commerce, and not through statutory or regulatory authority.

Federal Registration. If a mark is used in more than one state, then federal registration with the United States Patent and Trademark Office is appropriate. Registration at the federal level creates a presumption in favor of the registrant's exclusive rights nationwide, constructive notice of the registrant's rights to any subsequent user, and procedural benefits including a right to attorney's fees and the right to use a ® symbol with the mark to designate its status as a federally registered trademark. A federal registration may also become incontestable on all but a few narrow grounds after five years.

The application process at the federal level typically is as follows:

1. The trademark application is filed electronically.
2. Several months later (generally five to six), the Trademark Office assigns the application to an Examining Attorney for review. The Examining Attorney may approve the application as filed or may issue an Office Action to seek amendments or declare that registration is refused.
3. If approved, the trademark will be published for opposition in the Trademark Gazette. Upon publication, anyone may object within 30 days.
4. If there are no objections, a Certificate of Registration is issued.

If there are no Office Actions issued or no oppositions filed, it generally takes about a year for the Trademark Office to issue a Certificate of Registration. If there are objections to the filing, additional time will

*There is a common misconception that when a state allows incorporation under, or reservation of, a corporate name, that name is free and clear from claims of infringement or ownership rights.*

be added to the registration process and may lead to a withdrawal of the application.

State Registrations. If a mark will only be used within one state, then a state trademark registration is appropriate. State registrations are much simpler, much less expensive and can generally be completed within a week. And like a federal registration, a state registration provides constructive notice to others that a mark is being used and that your company is claiming ownership to that mark within the state.

Regardless of whether a trademark is used at the state or federal level, due diligence in selecting and clearing a trademark prior to actual use can significantly reduce the risk of infringement, damage claims, and wasted time and marketing expenses. A trademark search should be conducted to provide needed information to make a decision on whether to proceed with use.

**Grayson J. Derrick**  
**Technology and Intellectual Property**  
**Practice Group**

## *Update: Iowa Hospitals And Nursing Homes Required to File Form 990 with IDPH and LSA*

Last month, we discussed the Iowa legislation that 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).

We understand that some public hospitals have asked about their obligations under this law, because public hospitals are not required to prepare or file a Form 990 with the IRS.

We understand that the Iowa Department of Public Health has been informing public hospitals that in lieu of submitting Form 990, they should submit a copy of their audited financial statements. Consistent with the legislation, we believe that copies should be submitted within 90 days after the Board's acceptance of the audit. We further believe that this requirement does not extend to management letters or other matters related to the audit.

**John R. Holdenried**

**BAIRD HOLM**<sup>LLP</sup>  
ATTORNEYS AT LAW

### HEALTH CARE GROUP

**Vickie Brady Ahlers**

402.636.8230  
vahlers@bairdholm.com

**Alex (Kelly) M. Clarke**

402.636.8204  
kclarke@bairdholm.com

**John R. Holdenried**

402.636.8201  
jholdenried@bairdholm.com

**Andrew D. Kloeckner**

402.636.8222  
akloeckner@bairdholm.com

**Julie A. Knutson**

402.636.8327  
jknutson@bairdholm.com

**Barbara E. Person**

402.636.8224  
bperson@bairdholm.com

*All attorneys are admitted to practice in Nebraska and Iowa.*

MEMBER  
**LEX MUNDI**  
THE WORLD'S LEADING ASSOCIATION OF INDEPENDENT LAW FIRMS

*Health Law Advisory* is intended for distribution to our clients and to others who have asked to be on our distribution list. If you wish to be removed from the distribution list, please notify [healthupdate@bairdholm.com](mailto:healthupdate@bairdholm.com).

**BAIRD HOLM LLP**  
1500 Woodmen Tower  
Omaha, NE 68102  
402.344.0500  
402.344.0588  
[www.bairdholm.com](http://www.bairdholm.com)

©2009 Baird Holm LLP