

# Health Law ADVISORY

*Current legal insights for health care executives*

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## *Nebraska LB 403: Action Needed by October!*

We have reported on the implementation of Nebraska Legislative Bill 403 (“LB 403”) in past issues of the *Health Law Advisory* and the *Labor and Employment Update* (See April 2009 editions). The effective date is tomorrow, October 1, 2009. On that date, LB 403 requires the verification of lawful presence in the United States for recipients of certain public benefits and verification of employment eligibility for certain “public” employers. Although the effective date has arrived, there is still confusion and unanswered questions about many details. No regulations have been issued and the guidance from state agencies is limited. We will continue to supplement the information in this article as additional guidance becomes available.

### **Public Benefits**

LB 403 requires state agencies and political subdivisions to verify the lawful presence in the United States of each person applying for public benefits. “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.”

There are limited exceptions in LB 403 for certain benefits including “assistance for healthcare 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 severe pain, such that 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 functions, 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 diseases, whether or not such symptoms are caused by a communicable disease.”

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## Public Contractors

If a public or private hospital functions as a “public contractor,” the hospital is required to verify the lawful presence of applicants for public benefits. Under LB 403, “public contractor” includes “any contractor or ... subcontractor who is awarded a contract by a public employer for the physical performance of services within the State of Nebraska.”

The Governor’s Policy Research Office has stated that certain arrangements do not require verification of a recipient’s lawful presence. Health care providers are not required to verify the lawful presence of Medicare and Medicaid recipients. The explanation is that the burden of verifying the Medicare or Medicaid beneficiary’s lawful presence is on the federal or state government. Contracts between providers and the Regional Behavioral Health Authorities are considered to be contracts with the state, rather than the provider, thereby carving out contracts with the Regions from the scope of LB 403.

There is a question about this carve-out for mental health contracts with the regions. We understand that the regions have advised their contracting agencies that they are including contract language stating the requirement to verify the immigration status of their program applicants. Less clear, but also a possibility, is the resulting status of the agency as a public contractor or subcontractor, which would then also be required to use E-Verify to confirm the status of their employees as well. Inquiries are being pursued regarding the apparent change or conflict in advice. Affected organizations should contact their legal counsel for analysis and advice regarding this contract term.

## Verification of Applicants for Public Benefits

An applicant for public benefits must sign

an affidavit attesting to the fact that he or she is a United States citizen or 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. If the applicant indicates he or she is an alien, verification is completed by using the Systematic Alien Verification for Entitlements (SAVE) Program operated by the United States Department of Homeland Security. Agencies must apply to the United States Department of Homeland Security in order to use the SAVE program. An attestation form is available through the Nebraska Administrative Services website at [http://www.das.state.ne.us/lb403/attestation\\_form.pdf](http://www.das.state.ne.us/lb403/attestation_form.pdf). Providers may rely on the applicant’s attestation until the verification is completed.

## Verification of New Employees

(See also the article by Amy Erlbacher-Anderson in the September issue of the *Labor and Employment Update*.)

LB 403 requires public employers and public contractors, including Nebraska public hospitals, to use the internet-based federal immigration verification system (E-Verify) to determine the work eligibility status of new employees physically providing services within the state. In addition, *all* U.S. employers must continue to complete Employment Eligibility Verification forms (Forms I-9) for all new employees, including U.S. citizens, by their first day of employment. This means public employers and public contractors must complete the I-9 Form and submit a query through the federal E-Verify program for each new employee.

Public employers need to register for E-Verify on-line at <https://e-verify.uscis.gov/enroll/>. The registration process is free and includes signing a Memorandum of Understanding with the Department of Homeland Security (DHS) and the Social

## New Employee Verification Procedures

- *Prior to October 2009, employer must register on-line for E-Verify program*
- *For all new hires, complete the Form I-9*
- *After completing the Form I-9 and within 3 business days of the new hire’s start date employer must initiate an E-Verify query*

*DHS and SSA have published an E-Verify User Manual for employers available at [http://www.uscis.gov/files/natedocuments/E-Verify\\_Manual.pdf](http://www.uscis.gov/files/natedocuments/E-Verify_Manual.pdf). The manual provides a comprehensive overview of the E-Verify registration process and verification procedures.*

Security Administration (SSA) that provides the terms of the agreement between the employer and the DHS and SSA.

Once registered for the federal E-Verify program, employers must submit queries in E-Verify to confirm the legal status of new hires. The earliest the employer may initiate a query is after an individual accepts an offer of employment and after the employee and employer complete the Form I-9. The employer *must* initiate the query no later than three (3) business days after the new employee's actual start date.

**Julie A. Knutson**  
**Michael W. Chase**

# *Top 10 List for Winning Medicaid/ Medicare Appeal Hearings*

In our experience handling Medicare and Medicaid appeal hearings before administrative law judges and the courts, we have seen a pattern in the items that most persuade these judges. Providers should consider the following top 10 “must haves” in pursuing a successful appeal:

**1. Get a better expert than the reviewing physician.** Many times, the reviewing physician supporting the denial of benefits

is not an expert in the medical field at issue. Judges will accord appropriate weight to an expert who is specialized in that field. Using an expert in that particular field can be very persuasive.

**2. Use the treating physician.** In addition to or in lieu of an expert if one is not available, have your treating physician testify. The treating physician is often very convincing and passionate about the issue on appeal. Many judges seem to appreciate the opportunity to understand the treating physician's particular insight into the issue. As one Nebraska district court judge stated in a Medicaid appeal, “second-guessing the attending physician's judgment in effect gives the judgment of the reviewing physician presumptive validity” which is inappropriate since the attending physician is the only one with a firsthand view of the patient. If more than one doctor saw the patient, have them both testify or provide affidavits for the record.

**3. Challenge the reviewing physician(s) decision.** Often, the reviewing physician does not give sufficient detail to support the denial of benefits. Challenge those deficiencies. Another Nebraska court has concluded that peer reviewers should not overrule a treating physician's decision without giving a detailed basis for their denial.

**4. Tell the patient's story.** During the review process, provide a complete, detailed description of why the patient needs the service, supplies, or benefits at issue. Describe all of the patient's symptoms in addition to the patient's medical history and personal situation, if relevant.

**5. Explain the risk to the patient.** In telling the beneficiaries' story, emphasize the risks to the patient if the service/benefit at issue is denied.

**6. Have a complete record.** Make the record as complete as possible. Make sure

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all relevant medical documentation is included in the record for review. Where the medical records lack some necessary detail, getting a short addendum to the record from the treating physician has worked in some cases.

**7. Make sure the exhibits match.** In a Medicare appeal hearing in particular, the judge's office provides a list of numbered exhibits already placed in the record. Make sure you have your exhibits labeled in exactly the same manner so that you can refer to them by the same exhibit numbers as well as the page number within each document. Judges do not like to hunt through the record to see if you are all on the same page during a hearing.

**8. Cite legal authority.** Be able to describe and show exactly in the record how the legal elements of the regulation at issue have been satisfied. This is a key point. Counsel can be especially helpful in this aspect because you must be able to convince the judge that you have complied with the legal prerequisites for coverage.

**9. Pre-hearing brief.** You may want to consider a short pre-hearing brief (2-3 pages) to concisely outline the arguments and points in the record before the hearing so the judge will be familiar with the case beforehand. The judge will appreciate having that written outline to follow along.

**10. Practice!** Administrative law judges and appeal officers usually have a tremendous load of cases. Keep them as happy as possible by having all of your "ducks in a row." Cover your arguments and each relevant point in the record as quickly as possible. Anticipate questions the judge will have and be ready with concise answers.

**Heidi A. Guttau-Fox**  
**Labor, Employment and Employee**  
**Benefits Section**

## *EMTALA Risk Management May Depend on Who's Asking*

Allegations of EMTALA violations in federal court are often dealt with perfunctorily and dismissively. The federal courts resist being burdened with what look like run of the mill medical malpractice cases. In contrast, the U.S. District Court for the Northern District of Iowa was presented a defense that a transferring hospital bore no liability under EMTALA for the stillbirth of an infant, because the transferring physician had certified that the benefits of transferring the mother outweighed the risks of transfer. The hospital argued that it had to rely upon medical staff for medical judgment and, that institutionally, it was not in a position to preclude transfer once the physician recommended and certified it.

In *Heimlicher v. Steele*<sup>1</sup>, the court considered the case of an obstetrical patient at 34 weeks of gestation, who experienced vaginal bleeding in her home on February 11, 2004. She called 911 and was taken to the emergency room of Dickinson County Memorial Hospital in Spirit Lake, Iowa. The ED physician (EDP) performed a vaginal exam and ordered an ultrasound. The technician was not qualified to interpret the ultrasound, but she described what she saw to the EDP, who documented that the test had ruled out the possibility of a placental abruption. The EDP testified that he knew an ultrasound could not rule out a placental abruption. The ultrasound images were transmitted to a radiologist in Minnesota. The tech and radiologist discussed his diagnosis

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<sup>1</sup> 615 F. Supp.2d 884 (N.D.IA 2009).

by phone. The radiologist died prior to trial, but the tech testified that he had told her that his diagnosis was “mass vs. hemorrhage vs. fibroid.” The tech said she documented and relayed this information to the EDP, but he did not recall receiving it. The EDP testified that if he had received the radiologist’s diagnosis, he would have ordered a caesarean section immediately. That surgical capability was available at the hospital.

Instead, the EDP consulted with an obstetrician in Sioux Falls, South Dakota, and it was agreed that the patient would be transferred to Sioux Valley Hospital, about 100 miles away. It was reported to the obstetrician that the patient’s condition was stable, her placenta was not abrupting, and her uterus was not ruptured. Medication was provided to slow her contractions. Weather prevented use of an air ambulance, so the plaintiff was transferred by ground ambulance. A hospital nurse with obstetrical experience accompanied the patient. Almost immediately upon leaving the first hospital, the plaintiff began experiencing too-rapid contractions, profuse vaginal bleeding and severe pain in her abdomen. The fetal monitor showed the baby was in distress. Nevertheless, the nurse did not report the symptoms to the EDP or anyone else, and the ambulance proceeded to Sioux Falls, passing a number of hospitals where a c-section could have been performed.

Upon arrival in Sioux Falls, a c-section was performed, but the baby was stillborn. It was undisputed that the baby could have been delivered by c-section without complication at the first hospital.

A trial was held March 2, 2009, and both the EDP and the hospital were found negligent. The total amount of damages awarded was \$1,710,000, with 30% allocated to the EDP and 70% to the hospital.

The transferring hospital’s defense in this

case relied heavily upon the EMTALA transfer form. The EDP had checked the box indicating that the patient had been in an emergency medical condition, but was stable at the time of transfer; “within a reasonable degree of medical certainty, no material deterioration of this patient’s condition is likely to result from or occur during transfer.” The EDP did not check the box indicating that the patient remained in an unstable emergency medical condition. The court doubted the EDP’s finding of stability, however, based on the fact that he proceeded to complete the physician certification (that the benefits of transfer outweighed the risks). The court noted that this certification was only required if the physician believed that the patient was unstable.

This finding by the court is worrisome, since most hospitals require transferring physicians to complete the certification even if the patient is stable. This is a common risk management approach based on common experience of having patients’ stability questioned in retrospective peer review. The court’s negative inference from the EDP’s completion of the physician certification might logically prompt hospitals to reconsider that risk management practice, except for the court’s subsequent, and more influential finding.

The court found the EDP’s documentation of the risks and benefits of transfer to be poorly reasoned, and unbelievable: “Based on the expected **benefits** of delivery on C-section of premature fetus 34 weeks and foreseeable **risks** of more bleeding, painful contractions to this patient, and based upon the information available to me at the time of this patient’s transfer, I believe the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the patient’s (and/or fetus’) medical condition from effecting transfer.” (Emphasis added.)

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The testimony at trial established that under the circumstances, these were not the true potential benefits and risks of transfer, and the EDP was aware of this fact. The court noted that Congress had intended for transferring physicians to truly deliberate on the medical risks and benefits, not just sign a paper stating that the benefits outweigh the risks. The court found that the EDP had signed the transfer form without actually deliberating and weighing the medical risks and benefits of transfer, and he gave improper consideration to significant factors in the certification decision. For this reason, and based on a finding that the EDP, staffing the ED through a professional staffing agreement, was an agent of the hospital, the physician certification defense failed.

Although the court did not address this, it is important to note that CMS describes this as a process of informed consent. In order to obtain informed consent, the patient must be made aware of those risks and benefits. So not only should the physician fully deliberate the medical risks and benefits of transfer, he/she must communicate them to the patient in order to obtain informed consent.

This case is a significant departure from the perspective of state agencies and CMS regional offices as they perform EMTALA complaint surveys. These agencies would have been interested in the transfer form and medical record documentation of the risks and the benefits of transfer, but that would not have been the entire focus of the survey. These agencies would have been more concerned about what appeared to be a “lateral transfer;” one in which the patient was transferred for services which could have been performed in the first hospital, and the fact that the diagnostics were not completed prior to transfer to accurately determine the patient’s status.

Teaching points from *Heimlicher v. Steele* include:

1. Transferring physicians must personally consider the risks and benefits of transfer, so it is obviously safest for the physician to document those risks and benefits rather than relying upon nursing personnel to do so.
2. The transferring physician must fully deliberate and document the true risks and benefits of transfer in the physician certification.
3. In hospitals where mid-level practitioners perform the medical screening exam (or other qualified medical personnel) and the physician certifies the transfer by phone, the physician should take a strong interest in how the risks and benefits are being documented. That is the certifying physician’s responsibility.
4. It is important to accurately document whether the patient is stable or unstable on the transfer form. This goes to credibility in cases with bad outcomes, and if the patients are unstable, the accuracy of the physician certification becomes more important.
5. While the physician’s clinical goal may be to stabilize a patient prior to transfer, he/she must not let that goal influence documentation of the patient’s status for this legal purpose. It is perfectly permissible to transfer a patient in an unstable condition (provided that the patient is provided stabilizing treatment to reduce the risks during transfer), as long as the benefits of transfer outweigh the risks.
6. The transferring physician (or other qualified medical personnel) must explain the risks and benefits of transfer to the patient or family members, in order to obtain informed consent to transfer of a patient in an unstable emergency medical condition.

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7. Think twice before effecting a “lateral transfer;” making sure that there is a patient request for the transfer or a medical explanation for it.
8. If diagnostic testing capabilities are available to rule out a possible diagnosis prior to transfer, those tests should generally be performed and interpreted prior to transfer, unless there is a solid medical rationale for immediate transfer to a higher level of care.

The decision in *Heimlicher v. Steele* does not call for any particular update to EMTALA policies and procedures, but it does call for periodic quality assurance review of transfer forms and related medical records to verify the proper documentation of the risks and benefits of transfer.

**Barbara E. Person**

## Upcoming Speaking Engagements:

**October 8:** Barbara Person and Vickie Ahlers, Nebraska Hospital Association Webinar – RAC Appeals

**October 8:** Kelly Clarke with Mark Bowden of the Iowa Board of Medicine and Kevin Elsberry, Mercy Medical Center, Iowa Hospital Association Annual Meeting – Methods for Dealing with Disruptive Physicians.

**October 12/13:** John Holdenried, American Health Lawyers Association, Tax Issues for Healthcare Organizations with Jim Lloyd of Pershing Yoakley & Associates – Hospital-Physician Economic Relationships: Assessing Their Fair Market Value and Commercial Reasonableness.

**October 15:** Vickie Ahlers and Jim O’Connor, NHA Annual Meeting – Preparing for Data Breach Notifications and Other Privacy and Security Issues

**October 16:** Julie Knutson with Pat Connell of Boystown National Research Hospital, Nebraska Association of Behavioral Healthcare Organizations – Behavioral Health Compliance

**November 4:** Barbara Person, Iowa Hospital Association – EMTALA: From All the Angles

### Save the Date!

The 21st Annual Health Law Forum will be held on Friday, November 20, 2009 at the Marriott Regency in Omaha, Nebraska.

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