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WORKERS' COMPENSATION DISCOUNTING: WHAT'S A PROVIDER TO DO?

In a recent decision, the Nebraska Workers' Compensation Court rejected a hospital's charge of \$117,656 for surgical implants, and allowed payment of only \$46,072.00. (*Kothe v. Don Hager & Sons, Inc., Doc. 203, No. 1646, 6/3/05*). The Court's disallowance of over \$71,000 of the hospital's charges raises difficult issues for all health care providers seeking appropriate payment for the treatment and care of patients who have been injured on the job.

In *Kothe*, the worker was an over-the-road trucker. While tarping a load and reaching for a broken strap, he slipped and fell about thirteen feet to the ground. As a result of the fall, the worker sustained injury to his right knee and lower back. The injury to the lower back led to surgery, during which the physician surgically implanted hardware. The hospital providing the hardware for the surgery submitted a bill for \$117,656 to the workers' compensation insurance carrier, which was disallowed. The insurance carrier took the position that invoice cost (\$38,594) plus 20% was a proper reimbursement.

The injured employee's case proceeded to trial. During trial, the insurance carrier again objected to the hospital's original bill. The Compensation Court agreed with the insurance carrier and made several findings:

1. The Court ruled that the Court has the "obligation" to determine if the "cost for medical care is fair, reasonable, and whether any such charge exceeds the regular charge made for such service in similar cases."
2. The Court ruled that the Court's own hospital fee schedule (allowing for payment based on hospital charge less 7.5%), sets the *maximum* amount of payment. The Court held that it could determine the reasonableness of charges without regard to the fee schedule.
3. The Court was persuaded by the reports submitted at trial by the insurance

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carrier from “entities with expertise in medical bill review” that invoice cost plus 20% is the “usual and customary charge” for surgical implants. Significantly, all the “entities” that provided reports were managed care or preferred provider organizations, with an obvious interest in having hospital charges reduced. From the written opinion of the Court, it appears that the employee’s attorney did not offer any evidence to rebut the defense reports.

There are several lessons from the *Kothe* decision. First, a provider should be alert to any challenges to its charges or bills, and be prepared to respond quickly, completely, and professionally to inquiries from insurance companies. Defense counsel in the *Kothe* case indicated that the insurance company took a strong position that the hospital’s charges were unreasonable. Indeed, it appears the insurance company took this position without affording the hospital the opportunity to explain its charges thoroughly. Such an adversarial position raises an issue of whether the carrier was interested in learning the facts that the hospital could have presented in support of its charges.

Second, a provider should be prepared to justify all of its billings. Time should be taken to explain *all* circumstances justifying charges. This is especially true when the hospital is furnishing special surgical hardware on an infrequent basis.

Third, providers should be aware when workers’ compensation cases are going to trial and inform the employee’s attorney that the provider will be pleased to provide documentation and other information that could be useful to support the charges. Unfortunately, health care providers are not parties in workers’ compensation cases, and thus it may be necessary to seek out and make contact with the employee’s attorney.

Fourth, in certain instances, providers should consider retaining counsel to handle negotiations with insurance carriers. This would be especially true in cases involving very expensive procedures where the insurance carrier has indicated an unwillingness to accept the charges.

Finally, providers should consider utilizing the informal dispute resolution procedures of the Workers’ Compensation Court. Under the Court’s Rule 48, a supplier of medical, surgical, or hospital

services may ask the Court to conduct informal or formal mediation to resolve contested matters. This procedure, which can be used with or without counsel, may furnish a basis for a speedier and, hopefully, more profitable resolution of contested billing issues.

Kirk S. Blecha

EMTALA and the Born Alive Infants Protection Act of 2002

On April 22, 2005, CMS issued guidance on the “Interaction of the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002.”

The Born-Alive Infants Protection Act of 2002 defined the term “individual,” “person,” and federal statutory references to “human beings” as including “every infant member of the species homo sapiens who is born alive at any stage of development.” “Born alive” is defined as including any human being whom after being expelled or extracted from his or her mother “breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section or induced abortion.” These definitions are relevant under the EMTALA statute and regulations which are designed to protect “individuals.”

The impact of CMS’s guidance is that any infant born alive must be provided a medical screening examination and any necessary stabilizing treatment. CMS points out three likely scenarios, which we describe below with our additional comments:

1. Most labor and delivery departments will be considered DEDs. Hospital emergency departments are invariably considered DEDs. In DEDs, the obligation to provide screening and any necessary stabilizing treatment arises if a prudent layperson observer would believe that the individual (infant born alive) required examination or treatment for a *medical condition*. Any infant “born alive,” but in distress, would appear to a prudent lay person observer to require

examination or treatment for a medical condition. Accordingly, any infant born alive in an ED or a labor and delivery department must be provided screening and necessary stabilization. This obviously presents issues for any scheduled or spontaneous abortion which might occur in a DED.

2. On the hospital campus outside a DED, the obligation to provide screening and any necessary stabilizing treatment arises if a prudent layperson observer would believe that the individual (infant born alive) required examination or treatment for an *emergency medical condition*. Any infant born alive as a result of a scheduled or spontaneous abortion would presumably exhibit signs of distress which a prudent layperson would interpret as requiring examination or treatment for an emergency medical condition. Accordingly, such individuals should be provided screening and necessary stabilizing treatment.

3. An infant born alive might also be admitted as an inpatient. EMTALA does not apply to inpatients, as long as they are admitted in good faith. However, Medicare Conditions of Participation apply to inpatients, and contain separate requirements for emergency services and discharge planning. Accordingly, CMS considers inpatients to be adequately protected without application of EMTALA.

A court decision from the mid-nineties highlights the practical effect of CMS's guidance. In *In re Baby "K"*, 16 F.3d 590 (4th Cir. 1994), a hospital sought a declaratory judgment that it was not required by EMTALA to provide treatment other than warmth, nutrition and hydration to Baby K, an anencephalic infant. The family was encouraged by the health professionals to institute a DNR order. The family insisted that the baby be supported with mechanical breathing assistance whenever the infant experienced difficulties. The court construed EMTALA to leave little latitude in determining the breadth of medical response. The court gave weight to the regulatory definition of "stabilizing treatment:" that "necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." The court concluded that EMTALA required nothing less than stabilizing treatment. Essentially all efforts had to be made to

sustain the life of the child. The court rejected the argument that the requested treatment exceeded the standard of care.

The application of the decision in *In re Baby K* to a hypothetical hospital case involving an aborted fetus meeting the definition of an infant "born alive" suggests a similar obligation. The important variable in *In re Baby K*, however, is parental consent. CMS's guidance does not address issues of parental consent, and EMTALA does not change the common law requirement for consent to treatment. EMTALA consistently provides that the individual or a representative acting on behalf of the individual may refuse examination, treatment or transfer, and that refusal relieves the hospital and physicians of further obligations under EMTALA. Any parental refusal of life-sustaining treatment for an infant born alive should be documented on an EMTALA-compliant Refusal of Exam/Treatment form.

Barbara E. Person

Legislative Update: Advance Nursing Practice in Nebraska

At the last session of the Nebraska Unicameral for 2005, the State of Nebraska adopted Legislative Bill 256 ("LB 256"). This bill contained provisions regulating the licensing procedure for Advanced Practice Registered Nurses ("APRN") as well as Clinical Nurse Specialists ("CNS"). LB 256 also modified the scope of practice for Nurse Practitioners, Certified Respiratory Nurse Anesthetists, and Midwives. LB 256 was approved by the Governor on June 2, 2005, and the sections mentioned in this article will become effective on July 1, 2007.

Clinical Nurse Specialist Practice Act

Sections 1 to 14 of LB 256 adopt the Clinical Nurse Specialist Practice Act. A Clinical Nurse Specialist is a type of advance practice nurse (and may use the title "CNS"), but this individual cannot practice as an Advanced Practice Registered Nurse or use the title "APRN" unless he/she has fulfilled the requirements

of the Advanced Practice Registered Nurse Act. The new law states that the Clinical Nurse Specialist's job includes "health promotion, health supervision, illness prevention, and disease management including assessing patients, synthesizing and analyzing data, and applying advanced nursing practice." In order to be licensed as a CNS, an applicant needs: (1) a completed application accompanied by the fee, a master's or doctoral degree in a nursing clinical specialty or a master's in nursing along with a completed graduate-level clinical nurse program, and (2) a passing score on a board-approved examination issued by an approved certifying body. If an individual is practicing as a CNS under the Nurse Practice Act on July 1, 2007, and applies under the Clinical Nurse Specialist Practice Act before September 2007, he/she does not need to prove passage of the board exam.

The Clinical Nurse Specialist certificate expires on October 31 of every even-numbered year. A person who practices as a CNS without such a certificate is guilty of a Class IV felony.

Advanced Practice Registered Nurse Act

Sections 36 to 46 of LB 256 adopt the Advanced Practice Registered Nurse Act. These provisions state that an applicant for initial licensure as an advanced practice registered nurse needs to: (1) be licensed as a registered nurse or have authority under the Nurse Licensure Compact to practice as a registered nurse, (2) complete a graduate level program in a clinical specialty area of certified registered nurse anesthetist, clinical nurse specialist, certified nurse midwife, or nurse practitioner, (3) be certified as a certified registered nurse anesthetist, a clinical nurse specialist, a certified nurse midwife, or a nurse practitioner, (4) submit a completed application with fee, (5) provide evidence as required by any rules and regulations adopted by the board, and (6) commit no acts or omissions which are grounds for disciplinary actions in another jurisdiction, or which would be grounds for discipline under the Nurse Practice Act.

There are two alternative ways to attain an Advanced Practice Registered Nurse license according to these sections. An individual who was licensed in another jurisdiction can be licensed under the Act if the jurisdiction's requirements meet or exceed those of

the Act. In addition, an individual who is licensed as an advanced practice registered nurse or certified as a registered nurse anesthetist or a certified midwife in Nebraska on the effective date of the provisions, the individual will be issued a license as an advanced practice registered nurse on that date.

Changes in Oversight

Under this new law, the oversight of all advanced practice registered nurses and advanced nursing practice specialties will be placed under the Board of Advanced Practice Registered Nurses. This legislative change provides oversight from a single board as opposed to the previous practice of joint oversight by both the Board of Medicine and Surgery and the Board of Nursing.

Nurse Practitioner Act

LB 256 also makes amendments to the Nurse Practitioner Act which determine the scope of practice of a nurse practitioner ("NP"). Nurse practitioner practice means health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and chronic conditions including assessing patients, ordering diagnostic tests and therapeutic treatments, synthesizing and analyzing data, and applying advanced nurse principles. The advanced nurse principles include: dispensing (incident to practice only) sample medications provided by the manufacturer at no charge to the patient, and prescribing therapeutic measures and medications except Schedule II controlled substances. The Schedule II substances can only be prescribed for pain control for a maximum 72-hour supply. It is interesting that LB 256 retained this limitation. The prescriptive authority for physician assistants was recently amended by LB 175 and no longer limits physician assistants in prescribing controlled substances for pain for a maximum of 72 hours. Any limitation is now strictly subject to the PA's scope of practice agreement with his or her supervising physician. LB 256 also makes conforming amendments to the Certified Registered Nurse Anesthetist Act and the Certified Nurse Midwifery Act so that these acts conform with the new scope of practice.

Vickie J. Brady

DIRECT DEPOSIT IN IOWA

Iowa Workforce Development (the State of Iowa's labor authority) has long ruled that employers may not require employees, as a condition of employment, to authorize the automatic deposit of their wages into a financial institution—employees must have a choice to receive payment by check. In recent legislation, SF 342, the Iowa legislature seemingly overruled the state regulators, by amending Iowa Code Section 91A.3. Effective July 1, 2005, the law allows an employer to require a "new employee," as a condition of employment, to have his or her wages directly deposited into a financial institution as long as (i) the cost to the employee of establishing and maintaining an account for purposes of direct deposit would not effectively reduce the employee's wages below minimum wage, (ii) the employee would not incur fees charged to the employee's account as a result of the direct deposit, and (iii) there is no collective bargaining agreement prohibiting the employer from doing so. However, a notice which has since been posted on Iowa Workforce Development's Web site takes the position that once someone is hired, they immediately cease to be a "new employee" and become a "current employee," and can then immediately opt out and go back to a paper paycheck. If the Labor Commissioner's interpretation is correct, the changes to Iowa Code Section 91A.3 provide little relief to employers seeking to improve efficiencies in their payroll systems.

Jonathan R. Breuning

UPCOMING BAIRD HOLM SPEAKING ENGAGEMENTS

September 8

"Workers' Compensation Discounting and HIPAA Update"

-Vickie J. Brady

AAHAM Fall Conference, Grand Island, NE

October 5

"Doing Business as a Public Hospital"

-Alex M. (Kelly) Clarke & John R. Holdenried

Iowa Hospital Association

October 11

"Appealing Claim Denials & Challenging Medicare Local and National Coverage Determinations with the Potential of Winning"

-Barbara E. Person

PFS Lunch-n-Learn Webinar Series

October 14

"OIG Work Plan and Other Hot Topics in Compliance"

-Julie A. Knutson

Midwest Region of Medical Audit Specialists

October 21

"Key Legal Issues in Health Care Hiring"

-Jonathan R. Breuning & Scott S. Moore

Nebraska Hospital Association

October 24-25

"Physician Recruitment: Are the Rules Finally Clear?"

-John R. Holdenried

Tax Issues for Healthcare Organizations sponsored by the American Health Lawyers Association, Arlington, VA

November 18

Save the date for the Baird Holm Health Law Forum

BAIRD HOLM

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