

Voluntary Refunds and Internal Investigations: Tips, Tricks and Tripwires

By David Glaser and Katie Ilten

June 2015

Fredrikson
& BYRON, P.A.

Preparation: What can you do to prevent a audit?

- A trick question.
- Get an “Anomalies happen” bumper sticker.
- Goal: Know that you can defend yourself if you are audit.
- Means: investigate like an auditor.

Question

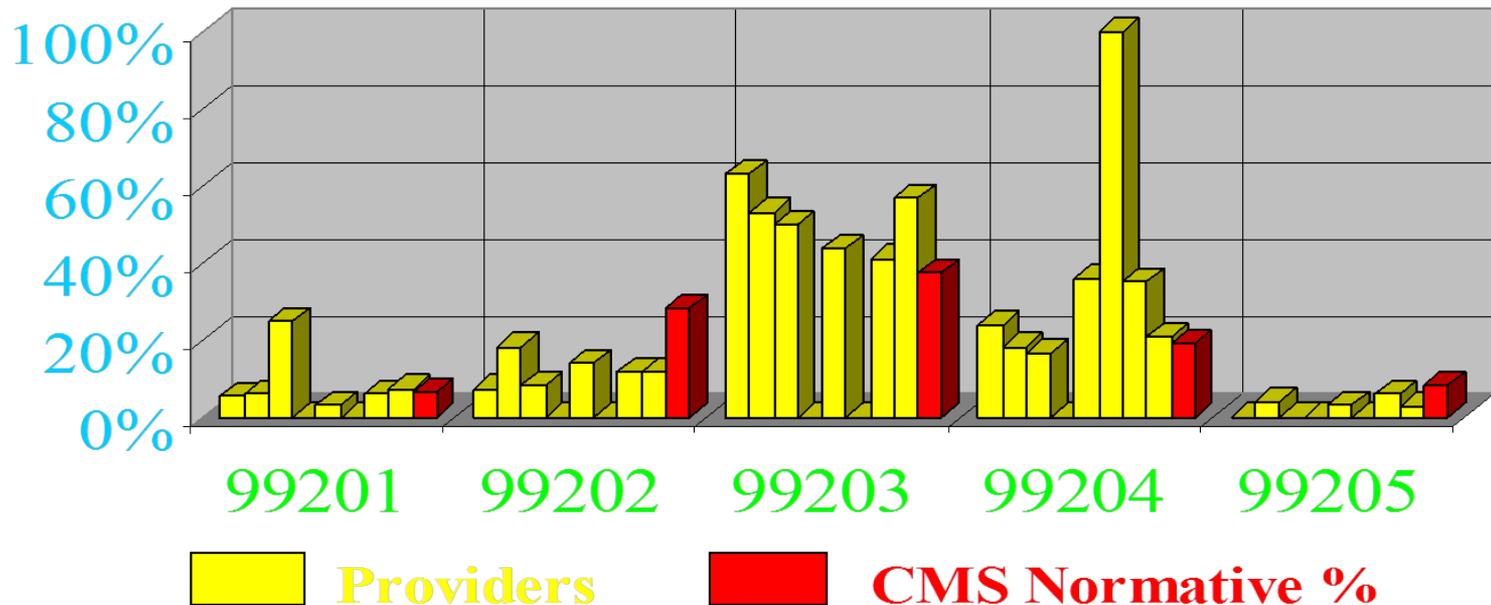
- If you could only have one piece of data as part of your compliance review, what would you choose?

What do you look for?

- Documentation.
- Code Distribution Patterns.
 - Variation from the norm.
 - Changes.
- Total Production.
- Diagnosis coding.
- Nervous employees.
- Credit Balances.

ABC Company

Comparison to CMS Norms – New Patient Visits Variance by Specialty – Family Practice



Compliance Plan Put to the Test

- The OIG wants to know about reviews, training, and your process for digging up dirt.
- How's your hotline?
- Record your refunds.
- Annual (semi?) employee certification.
- See our 10/9/13 webinar.

Who should do internal investigations?

- Attorney/compliance officer/other?
 - Who will people be most honest with?
 - Who will “ask the next question?”
 - There should be two people; one might be a witness.
 - Cost.
 - Privilege.

What is Privileged?

- Attorney-client privilege:
 - Oral and written communications.
 - Communications from the client as well as advice from the attorney and retained agents.
 - Key issue: whether the communication was in furtherance of obtaining legal advice?
- Work product privilege:
 - Materials prepared or assembled at the direction of counsel.
 - Must be in anticipation of potential litigation.

What is Privileged?

- Exceptions to privilege:
 - Presence of unauthorized third party.
 - Overbroad dissemination of privileged information.
 - Waiver.
 - Business versus legal advice.
 - Crime/fraud exception.
- Labelling isn't required, but sure helps.

Investigation Tips

- Make people comfortable.
- Let them talk!
- Educate your witness.
- No need to be conventional.
- Phone interviews can be great when documents aren't important.

Hiring Consultants

- Consider using work product privilege.
- Discuss the consultant's role; is s/he an advocate or a cop?
- Get references. There are some horror stories.

“If we refund, will it raise a red flag?”



“Now stay calm...Let’s hear what they said to Bill.”

The 60 Day Rule

- Federal law **REQUIRES** reporting and returning any Medicare/Medicaid overpayment within 60 days of “identification” of the overpayment.
- What is an overpayment?
- What is identification?

SSA § 1128J

- GENERAL.—If a person has received an overpayment, the person shall—
 - (A) **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and
 - (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

Identification

- Not defined.
- House bill required reporting when you “know of an overpayment.”
- “Identification” seems to require quantification. Otherwise, how could you return the payment?
- Proposed Rule 2/16/12. Not finalized, recently “delayed.”

Continuum Qui Tam Case

- Qui tam False Claims Act case pending in New York federal court.
- First case to litigate 60-day rule.
- Government intervened in June 2014.
- Hospitals were paid Medicaid secondary payer claims in error. Whistleblower sent email to management with list of improperly billed claims. Hospital took two years to refund.

Continuum Qui Tam Case

- Pending Motion to Dismiss filed by the hospitals in December 2014.
- Issue: was the overpayment “identified” when the relator sent the email with a spreadsheet of 900 claims with a comment that further analysis was needed?
- Stay tuned

Overpayment

- “Any funds that a person receives or retains under title [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled under such title.”
- Many things are NOT overpayments.
 - Poor documentation (More soon).
 - Violations of COP.
 - Reassignment problems.

Is There An Overpayment?

- Contractors, consultants, clients and counselors are often guilty of mistakenly believing some policy or conventional wisdom is based in law.
- Sometimes they'll use interesting techniques to make the point.



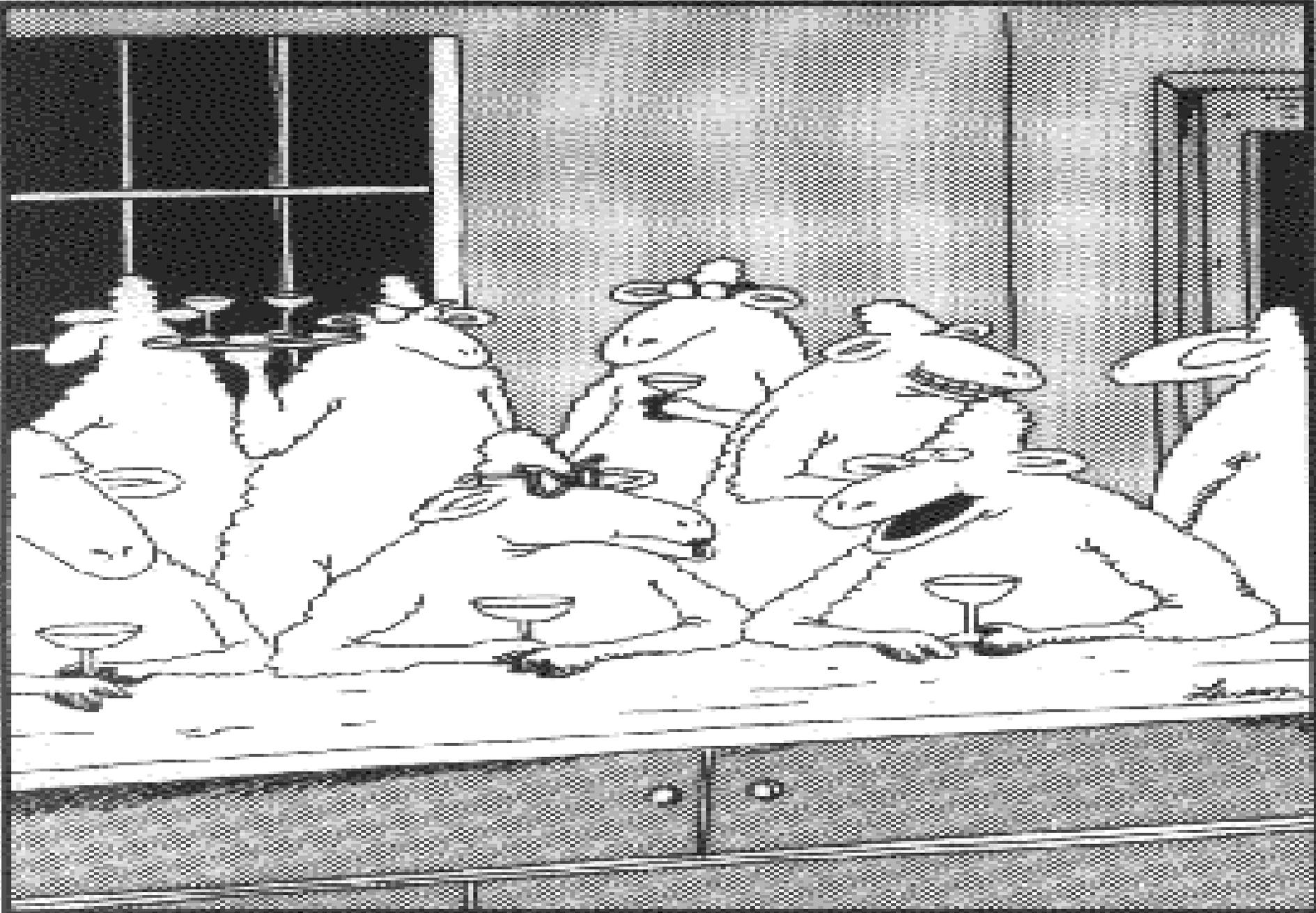
“Uh-oh, Danny. Sounds like the monster in the basement has heard you crying again.... Let’s be reaaaal quiet and hope he goes away.”

Question Authority

- Is it a requirement or a guideline?
- Medicare—ask if it is in the statute, regulations or Medicare Manuals.
- Get a copy of the rule in writing.
- Determine if the rule was properly promulgated.
- Ask your lawyer/consultant to explain all arguments supporting and refuting their position.
- Just because they sound smart doesn't mean they're right.

Core Principle: Be Fair

- You should get paid for services you actually provided unless there is a clear, valid rule prohibiting what you did.
- If you have been paid for something you have not done, or did something that was not medically necessary, or violated a clear, valid rule, you should refund the money.
- Be a salmon, not a sheep.



"Well, what d'ya know! ... I'm a follower, too!"

Short Stays: Pre 10/1/13 Guidance

Medicare Benefit Policy Manual (CMS Pub. 100-02)

§ 10 - Covered Inpatient Hospital Services Covered Under Part A

An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. **Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight** and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

Pre 10/1/13 Guidance

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors,**

Pre 10/1/13 Guidance

including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;

E&M Issues

An internal documentation review finds....

Audit Results

	Under-coded	Correctly-coded	Over-coded
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
Dr. D	0	19	81
Dr. E	33	33	33

What is the Relevant Law?

- “If it isn’t written, it wasn’t done,” right?
- Good advice, but not the law.
- Medicare payment is determined by the content of the service, not the content of the medical record.
- For more, see:
<http://www.slideshare.net/FredriksonLaw/why-documentation-deficiencies-do-not-automatically-create-an-overpayment> , our 8/12 webinar.
- The documentation guidelines are just that: guidelines (although the Medicare contractor won’t believe that).

Role of Documentation: The Law

“No payment shall be made to any provider of services or other person under this part **unless there has been furnished such information** as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.”

Social Security Act § 1833(e)

Role of Documentation: Guidance from CPT and CMS

- The CPT Assistant explains: “it is important to note that these are *Guidelines*, not a law or rule. Physicians need not modify their record keeping practices at all.”

CPT Assistant Vol. 5, Issue 1, Winter 1995

- Then HCFA, now CMS, publicly stated that physicians are not required to use the Documentation Guidelines.

Role of Documentation: Guidance from CMS/HCFA

Documentation Guidelines for Evaluation and Management Services Questions and Answers

These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1. Are these guidelines required?

No. Physicians are not required to use these guidelines in documenting their services.

Guidance from CMS/HCFA

However, it is important to note that all physicians are potentially subject to post payment review. **In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered.** Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g. SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible.”

Guidance from CMS/HCFA

“6. How will the guidelines be utilized if I am reviewed by the carrier?”

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information.”

Audit Results

	Under-coded	Correctly-coded	Over-coded
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
Dr. D	0	19	81
Dr. E	33	33	33

Audit Review Results

What Do They Mean?

	Documentation Exceeds Code Under coded	Documentation Supports Code Correctly coded	Documentation Does Not Support Code Over coded
Dr. A	13%	76%	11%
Dr. B	50	30	20
Dr. C	15	50	35
Dr. D	0	19	81
Dr.	33	33	3

How Do We Figure Out If the Service Was Done?

- Ask.
 - The physicians.
 - Others (nurses, receptionists).
 - Secret shopper/shadowing.
- Schedules/time based billing.
- Patient complaints.
- Production data.

What If:

- Physician D is a very hard worker, is at the 75th percentile for RVUs.
- Physician C is a hard worker, is at twice the 90th percentile for RVUs.

Preliminary Conclusions

- Dr. D is ok. Educate, don't refund.
- Dr. C: Need more development. Begin interviews, etc.
- If you conclude the work wasn't done, how do you calculate the amount?
 - Sample?
 - Calculation?
 - Focus on intellectual consistency!

Scenario 2: Conditions of Participation

A hospital discovers many unsigned medical records, a violation of the conditions of participation. Must they refund all of the services?

42 CFR § 488.18 & 488.24

- If a supplier does not meet a condition for coverage, the state agency may:
 - find that the supplier is in compliance, but with deficiencies not adversely affecting patient health safety; or
 - If deficiencies “are of such character as to substantially limit the provider’s or supplier’s capacity to furnish adequate care or which adversely affect the health and safety of patients” conclude that the supplier is out of compliance.

Program Integrity Manual

§ 3.1 - Introduction

Contractors must analyze provider compliance with Medicare coverage and coding rules and take appropriate corrective action when providers are found to be non-compliant. MR staff should not expend resources analyzing provider compliance with other Medicare rules (such as claims processing rules conditions of participation, etc.).

Program Integrity Manual

§ 3.1 - Introduction

If during a review it is determined that a provider does not comply with conditions of participation, do not deny payment solely for this reason. Refer to the applicable state survey agency. The overall goal of taking administrative action should be to correct the behavior in need of change, to collect overpayments once identified, and deny payment when payment should not be made.

Program Integrity Manual

§ 3.1 - Introduction

For repeated infractions, or infractions showing potential fraud or pattern of abuse, more severe administrative action should be initiated. In every instance, the contractor's priority is to minimize the potential or actual loss to the Medicare Trust Funds while using resources efficiently and treating providers and beneficiaries fairly.

Key Points

- Regulations and Manual provisions contemplate that providers/suppliers will be paid through (and in some cases after) the date of termination. State Operations Manual, Ch, 3, § § 3008-3008.1.
- There is no instruction for CMS to attempt to recoup payments made when a supplier was not in compliance with a condition for coverage.
- Violations of the COP are not an overpayment. See U.S ex. rel. Hobbs v. MedQuest Assoc., April 1, 2013 (6th Cir.)

The Part B Side

The rules will vary based on the payor, but Medicare doesn't require a signature.

“11. Is the physician's signature required on each page of the documentation?”

No. The guidelines only state that the identity of the observer be legibly recorded.”

Program Integrity Manual, CMS Pub 100-08 § 3.3.2.4, *Signature Requirements*

- *If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received).*
- *If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.*

Manuals Are NOT a Basis For an Overpayment

- “Thus, if government manuals go counter to governing statutes and regulations of the highest or higher dignity, a person ‘relies on them at his peril.’ Government Brief in Saint Mary’s Hospital v. Leavitt.
- “[The Manual] embodies a policy that itself is not even binding in agency adjudications.... Manual provisions concerning investigational devices also ‘do not have the force and effect of law and are not accorded that weight in the adjudicatory process.’ ” Gov’t brief in Cedars-Sinai Medical Center v. Shalala.

Manuals/Guidance Can't Limit Coverage

- 42 USC § 1395hh(a)(1) says nothing other than an NCD may change benefits unless promulgated as a regulation.

Hard Questions About Internal Reviews

- If an internal review identifies an error, when do you just refund on the claims reviewed and when do you project to a larger universe?
- If a review of ten claims finds three identical errors, does that trigger the duty?
- What if there are three errors, but each one is different?

Hard Questions About Internal Reviews

- If you have identified a problem, how large a sample should you select?
- Do you use the same approach used by Medicare, and use the lower bound of the 95 percent confidence interval?
- How much effort do you put into developing a statistically valid sample?
- Do you use the same approach for all payors?

How Far Back Do You Go? Did the Answer Change In 2013?

- Section 1870 of the SSA limits recovery of overpayments. A provision limiting recovery of overpayments “subsequent to the third year following the year in which notice of such payment” was made was changed to the fifth year.

How does § 1870 work?

- Focus only on the YEAR payment is made.
- Payment made 1/4/13. Can recover 5 years after 2013, so count: 2014, 15, 16, 17, 18. Recovery possible through 12/31/18.
- Payment made 12/31/12. If new provision applies, 2013, 14, 15, 16, 17. Recovery until 12/31/17.
- Note that references to “five years” are very misleading. Simplicity trumps accuracy.

How Far Back Do You Go?

- False Claims Act says 6 years, or up to 10 if the government was not aware of a situation, BUT....
- Most billing errors are not false claims.

How Far Back Do You Go?

- Manuals indicate that claims may only be reopened after 48 months when there is evidence of “fraud or similar fault.”
- “Fraud or similar fault” would seem to require some intentional wrongdoing.

What Does This Mean?

- The statute is nearly incomprehensible, at least to us.
- Important to remember the legal hierarchy: statute, regulation, manual.
- CMS and the court's application of the law varies from the actual language.
- Big questions: How do we apply the statutory change today? Will the statutory change result in regulatory/interpretive change? Does that matter?

Legal Framework

- Two statutory provisions limit recovery of overpayments: 1870 and 1879. Neither use the word “reopening.”
- 1870 focuses on “without fault” and includes a time frame, 1879 uses “did not and should not” have known, no timeframe.
- Regulations limit reopening, are silent on recovery.
- Manuals both limit reopening and recovery.

Social Security Act § 1870

(c) There shall be no adjustment as provided in subsection (b)(nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is **without fault** or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience.

Social Security Act § 1870

Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience **if** (A) **the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) section 1862(a)** ***and*** (B) **if the Secretary's determination that such payment was incorrect was made subsequent to the third [FIFTH] year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-[FIVE] year period to not less than one year if he finds such reduction is consistent with the objectives of this title.**

Can You “Blame” Someone Else?

- Hospitals with an independent medical staff may try the “without fault” defense.
- Any service dependent on physician orders (lab/ambulance/PT) should consider using it.
- Outside consultant’s advice?

Social Security Act § 1879

(a) Where -- (1) a determination is made that, **by reason of section 1862(a)(1) or (9)** or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and (2) both such individual and such provider of services or such other person, as the case may be, **did not know, and could not reasonably have been expected to know**, that payment would not be made for such items or services under such part A or part B, then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a)(1) and section 1862(a)(9) did not apply and as though the coverage denial described in subsection (g) had not occurred.

Social Security Act § 1879

... Any provider or other person furnishing items or services for which payment may not be made by reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g) shall be deemed to have knowledge that payment cannot be made for such items or services if the claim relating to such items or services involves a case, provider or other person furnishing services, procedure, or test, with respect to which such provider or other person has been notified by the Secretary (including notification by a quality improvement organization) that a pattern of inappropriate utilization has occurred in the past, and such provider or other person has been allowed a reasonable time to correct such inappropriate utilization.

42 C.F.R. § 405.980

(b) A contractor may reopen an initial determination or redetermination on its own motion—

(1) Within 1 year from the date of the initial determination or redetermination for any reason.

(2) **Within 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986.**

(3) **At any time if there exists reliable evidence as defined in § 405.902 that the initial determination was procured by fraud or similar fault as defined in § 405.902.**

(4) At anytime if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

(5) At any time to effectuate a decision issued under the coverage appeals process.

§ 405.986 Good Cause for Reopening

(a) Establishing good cause. Good cause may be established when—

(1) There is new and material evidence that—

(i) Was not available or known at the time of the determination or decision; and

(ii) May result in a different conclusion; or

(2) The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

§ 405.986 Good Cause for Reopening

(b) Change in substantive law or interpretative policy. A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, or a change in legal interpretation or policy by SSA in a regulation, SSA ruling, or SSA general instruction in entitlement appeals, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or hearing decision under this section. This provision does not preclude contractors from conducting reopenings to effectuate coverage decisions issued under the authority granted by section 1869(f) of the Act.

(c) Third party payer error. A request to reopen a claim based upon a third party payer's error in making a primary payment determination when Medicare processed the claim in accordance with the information in its system of records or on the claim form does not constitute good cause for reopening.

42 C.F.R. § 405.902

- “Similar fault” means “to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim”
- 42 CFR § 411.21 defines a “proper claim” as a “claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or Insurer.”

Financial Management Manual § 70

Examples of § 1870 determinations

A – Overpaid Provider or Physician Not Liable Because It Was Without Fault (§ 1870(b) of the Act.)

If the provider was without fault with respect to an overpayment it received **(or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the third calendar year after the year of payment)** it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. The FI or carrier makes these determinations.

Financial Management Manual § 170

The Carrier shall not attempt recovery action on individual overpayments if:

B – The Carrier Has Not Taken Action to Reopen the Payment Decision Within Four Years (48 Months) after the Date of the Initial Payment Determination

Unless Fraud or similar fault is present, a payment determination may not be reopened where the Carrier has not taken some action (which can be documented) questioning the correctness of the determination within 4 years (48 months) after the date the initial determination was approved. (See Medicare Claims Processing, Chapter 30, Correspondence and Appeals for policies governing the reopening and revision of decisions to allow or disallow a claim.)

Financial Management Manual,

Chapter 3, § 90

A provider is liable for overpayments it received unless it is found to be **without fault**. The FI or carrier, as applicable, makes this determination.

The FI or carrier considers a provider **without fault**, if it exercised reasonable care in billing for, and accepting, the payment, i.e.,

It made full disclosure of all material facts; **and**

- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier's attention.
- Normally, it will be clear from the circumstances whether the provider was without fault in causing the overpayment. Where it is not clear, the FI or carrier shall develop the issue.

Issues

- Are you deemed to be without fault after the passage of time?
- Can a MAC ask for records from January 10, 2011 right now? Limit on reopening should prevent it, unless there is “fraud or similar fault.” But is asking for records a “reopening?” Perhaps they can ask for records, but not recoup money?
- Can the MAC point to the new law as “trumping” the regulation?
 - Law does not ALLOW recovery, it limits it.
 - Law allows Secretary to be more lenient.

Issues

- A MAC requested records from 1/11, but hasn't issued an overpayment notice yet. Can they recoup an overpayment?
 - Does the amendment apply? Good question. Presumption against retroactive application of laws absent explicit statement.
 - There may be a difference between “reopening” and “recoupment/recovery.”
 - What constitutes “reopening?”

Reopening: 42 CFR 405.980(a)(1)

- A reopening is a remedial action taken to **change** a binding determination or decision that resulted in either an overpayment or underpayment, even though the binding determination or decision may have been correct at the time it was made based on the evidence of record. That action may be taken by-
 - **(i)** A contractor to revise the initial determination or redetermination;
 - **(ii)** A QIC to revise the reconsideration;
 - **(iii)** An ALJ to revise the hearing decision; or
 - **(iv)** The MAC to revise the hearing or review decision.

RACs

- A whole different ballgame. Governed by a different statute and a statement of work.
- Statute is four FISCAL years (10/1) after the year of payment.
- Statement of work is three years. (Three years from the date of payment.)
- Statement of work should carry the day.

Bringing It Home

- You discover an overpayment today. How far back must you go?
 - PPACA requires you to “report and return” an overpayment within 60 days of “identification.”
 - An “overpayment” is “Any funds that a person receives or retains under title [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled under such title.”
 - If the MAC can’t reopen, it shouldn’t be an overpayment.

Self-Disclosure Options

- Contractor Refund
- CMS Self-Referral Disclosure Protocol (Stark)
- OIG Self Disclosure Protocol (Fraud)
- State Medicaid agencies
- DOJ
- Why pay a multiplier in a refund?

The Refund Letter

- Do you ever send a “placeholder” letter?
- Who is it from?
- Who is it to?
- How much detail do you provide?
- What about small issues where cost of investigation exceeds overpayment?
- What don't you say?

Dr. C's Letter

We **recently** discovered that one of our physicians **was committing billing fraud**. She was **not documenting services properly**. We **inadvertently** billed for these services. We did a **statistically valid sample**. We **have corrected the problem**.

The Refund Letter

- “As part of our ongoing compliance process.”
- “More appropriate” is a great phrase.
- “Possible issues.”
- Reserve the right to recant.
- “Level we are confident defending...”
- Beware of “our attorney has told us”
- “Refund” vs. “overpayment.”
- “Steps to improve....”

What Do You Do With Copayments?

- Law is less clear.
- Size matters. (Would you bill the patient if they owed you the same amount?)
- State law.

Do You Rebill or Refund?

- Rebilling generates timely filing issues.
- Refunding leaves bad claims data in the insurer's system.
- For private payors, beware of your contract.
- Refund is the way to go.

How Do Refunds Affect RACs?

- If you have sampled, no one claim has been “refunded.”
- This will be something to watch.
- Note this is an issue even if the audit is on a different problem.
- In any overpayment situation, always look at prior refunds/audits on the same issue.
- (Note tie-in to rebill/refund issue!)

What About Private Payors?

- Contract (and manual??) control.
- Refund requirement is gov. only, but “health fraud” is a federal crime.
- State statute of limitations apply.
- State insurance law.
- Is Medicare Advantage a private payor?

Questions?

David Glaser
Fredrikson & Byron
dglaser@fredlaw.com
(612) 492.7143

Katie Ilten
Fredrikson & Byron
kilten@fredlaw.com
(612) 492.7428