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Health Care Law Bulletin

## *What Does the Recently Enacted HIPAA “Delay” Really Mean?*

Holland & Hart’s December 2001 *Health Care Law Bulletin* referred to legislation pending in Congress that would delay the effective date of complying with healthcare billing transaction and code sets standards. Shortly after that publication was released, the Administrative Simplification Compliance Act passed the House and Senate and was signed into law by the President. However, the Act does not really allow for a delay in its truest sense. Covered entities—providers, health plans, and clearinghouses—should continue their efforts to attain compliance with the standards or face exclusion from Medicare participation.

An essential element of the drive toward healthcare billing administrative simplification is the use of standardized transaction and code sets. For the most part, covered entities were expected to fully convert to standardized electronic claims transmissions by October 16, 2002, for the following transactions:

- 1) Healthcare claims or equivalent encounter information transactions;
- 2) Healthcare payment and remittance advice transactions;
- 3) Coordination of benefits transactions;
- 4) Healthcare claim status transactions;
- 5) Health plan enrollment and disenrollment transactions;
- 6) Health plan eligibility transactions;
- 7) Health plan premium payments transactions; and
- 8) Referral certification and authorization transactions.

Congress recognized that some covered entities could not meet these requirements by October 2002 and, thus, needed more time. However, simply delaying the effective date might not

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encourage these entities to continue to work toward compliance.

The new law pushes these entities along. Any covered entity that cannot meet the October 16, 2002, deadline must submit a compliance plan to the Department of Health and Human Services (HHS) outlining how it intends to be in compliance by October 16, 2003. The entity must begin testing its plan by April 16, 2003. Entities that cannot meet the October 16, 2002, deadline for submitting transactions in the standardized format, but fail to submit a compliance plan by that date could be excluded from Medicare participation. In other words, begin to use the standardized transactions or submit a compliance plan or face exclusion.

### *What Does “Compliance Plan” Mean?*

The Congressional sponsors of this Act were very careful. Rather than leave ambiguities, Congress mandated HHS to provide a model compliance plan by March 2002 with certain elements. Specifically, the plan must include:

- 1) An analysis detailing the entity’s inability to achieve compliance, including the reason for this inability;
- 2) A budget, schedule, work plan, and implementation strategy for achieving compliance;
- 3) An indication of whether the entity plans to use or might use a contractor or other vendor to assist in achieving compliance; and
- 4) A time frame, beginning no later than April 16, 2003, for testing the entity’s implementation.

Interestingly, the law does not require HHS to specifically approve a covered entity’s plan. Submission of a plan is the law’s essential requirement.

### *What the Law Does NOT Affect*

The law does not affect small health plans — those with annual receipts of \$5 million or less. Since the deadline for these plans had been April 16, 2003 all along, the compliance requirements are not applicable.

It is also *vital* to keep in mind that this law makes absolutely no changes to the April 14, 2003, effective date for the federal privacy standards. That date is still April 14, 2003, for healthcare providers and most health plans. Health plans with less than \$5 million in annual receipts will have until April 14, 2004, to comply.

### *Speaking of the Privacy Standards*

Expect clarification of some of the final standards that were published in late 2000 in the near future. Among the

issues expected to be addressed will be easing the process by which physicians with hospital privilege can access patient medical records. Currently, compliance with the standard would require each physician to obtain a signed consent form from each patient. Alternatively, the physician could agree to a joint privacy notice with the hospital under the terms of an organized healthcare arrangement. Otherwise, the physician would not be able to access the patient’s medical record.

## *Beneficiary Awareness May Increase Number of Potential Whistle Blowers!*

Beneficiary understanding of the elements of Medicare fraud has increased by 15 percent since 1998, according to a November 2001 study by the HHS Office of Inspector General (OIG).

However, the number of complaints to the OIG, itself, has decreased. Instead, beneficiaries are more likely to contact their healthcare provider if they note a discrepancy on their bill. Alternatively, they may contact the Medicare program or their insurer. Calling the OIG Fraud Hotline appears to be last on the list, according to the OIG study.

What does this mean to healthcare providers? It means that there is one more group scrutinizing your business. It means one more method exists by which any “kinks” in your billing procedures will come to light. Moreover, it increases the importance of creating and maintaining an active compliance program.

An effective compliance program should have, as an essential element, a method by which employees can report suspected fraudulent or erroneous billing patterns. These reports *must* be followed up!

It has also been long advised that healthcare employers interview any employee leaving the facility’s employ. Within that interview should be pointed questions about the employee’s knowledge of any possible fraudulent or erroneous billing practices. Again, these comments *must* be followed up!

Now, add to all of this yet another potential area of reporting and necessary follow up: the beneficiary! If a beneficiary questions any part of a bill, *do not* dismiss the beneficiary with comments such as “you didn’t have to pay for it,” as noted in the OIG report.

*All* reports should be taken seriously. A facility cannot afford to ignore *any* indications that fraudulent activity is occurring.

Here’s what can happen if a report *is* discounted. Nothing will make someone run to the government faster than if his or her concerns are not validated. An employee, former employee, or beneficiary can file a report with Medicare, the OIG, or the local United States Attorney. This opens the facility up to close scrutiny regardless of whether the report is accurate. No facility needs this headache!

### *Responding to Employee Reports*

As stated before, do not discount employee reports. By the same token, be very careful as to how you address the employee’s report. Conduct a thorough investigation. Keep the employee informed of the investigation and its outcome.

In most instances, dismissing an employee for reporting billing anomalies is *not* a good idea. Take, for example, a 7th Circuit Court of Appeals case decided January 18, 2002. In this case, an anesthesiologist employed by a group practice in Illinois noted billing irregularities and tried, on several occasions, to bring these issues to the attention of his employers. All attempts at changing their billing practices were ignored. In fact, the group summarily discharged him and threatened to make it difficult for him to find future

employment. The anesthesiologist filed suit, charging the group practice with retaliatory discharge under Illinois law. Overlooking the various procedural issues the 7th Circuit was asked to resolve in compliance, the essential issue is that the group violated, among other things, the state’s statutory policy against public benefits fraud. Therefore, the group was guilty of retaliatory discharge. The court noted that the Federal False Claims Act (FCA) had its own anti-retaliation provision; however, since the anesthesiologist had not filed—nor even threatened to file until after he was discharged—a claim under the FCA, the relevant statutory authority was the state’s.

The anesthesiologist was originally awarded more than \$2 million for lost earnings, pain and suffering, and emotional distress. The award was overturned. The 7th Circuit reversed this action, reinstating the jury’s award, but sent it back to a lower court for a jury trial to determine punitive damages.

### *Moral of the story*

There are many avenues by which a spurned employee can seek remedies. You cannot simply “wish” a problem to go away; you have to fix it appropriately, ethically, and legally.

## *It May Be Time to Revisit Your By-Laws*

Lately, compliance plans and programs have been the focus of much attention in the healthcare community. This may have occurred to the detriment of other important documents, namely hospital and medical staff by-laws. These documents set the core of the relationship between physicians and hospitals. While changes in these documents are more difficult to make, it remains important that all by-laws be reviewed periodically to make sure they reflect the current healthcare policy environment.

### *Areas That May Need Updating*

For example, if by-laws were written more than five years ago and have not been amended, there is probably no provision for the removal of a physician who has been excluded from federal program participation, such as Medicare or Medicaid. A physician who has been excluded cannot continue to have full medical staff privileges. Yet, a conflict will develop if the by-laws do not provide for removal under these circumstances.

The new federal privacy standards that become effective April 14, 2003, may also need to be addressed through by-laws. Unless the standard is amended, healthcare entities will need a mechanism so that physicians with staff privileges will be able to share health information, not just for treatment purposes, but also for other operational purposes, such as utilization review. The entity and its physicians can hold themselves out as an "organized health care arrangement" (OHCA) whereby the entity and the physicians adhere to one joint notice of privacy practices. Under this arrangement, a patient will only need to sign one consent form that would cover all members of the OHCA. The by-laws should stipulate that all parties will agree to adhere to the joint notice of privacy practices.

### *Do By-Laws Establish a Contract Between the Hospital and Physician?*

Notwithstanding the need to update and maintain by-laws, there should be cautious reliance on this document. A California appellate case, decided December 20, 2001, found that by-laws did not constitute a contract between a physician and a hospital. Therefore, remedies under contract law were not available. However, that case was decided based on state law and the elements of the by-laws. Specifically, the by-laws incorporated only the elements required by state regulation. Therefore, the issuance and acceptance of the by-laws by the hospital and physician, respectively, were pursuant to state law and, thus, did not constitute a contract. Had there been provisions in the by-laws that were in addition to the state requirements, the court might have ruled otherwise.

The court's decision does not rule out the possibility of lawsuits concerning by-laws. As pointed out in the California case, an aggrieved party can still take actions to stop the other party from disregarding the terms of the by-laws. The question becomes whether the action can be based on a "breach of contract." The answer to that question depends upon the actual by-laws and relevant state law.

### *Action Required?*

It is probably time to "dust off" your by-laws. While reviewing the by-laws, consider the following general questions:

- Do they contain all of the provisions required by state law?
- Do they go beyond those provisions?
- Do they facilitate a smooth operation?
- Are there adequate protections to ensure that there is recourse in the event a party does not live up to the by-laws or other statutory requirements?

This analysis will ensure adequate protections not only for the hospital and medical staff, but also for the patients being served.

*Tidbits*

\*\*\*The October 2001 edition of *Health Care Law Bulletin* included a web site for information on the Centers for Disease Control's (CDC's) suggested protocols in the event of a bioterrorism attack. As a result of the increased public interest in bioterrorism, the CDC launched a new separate web site for this topic.

According to the CDC, [t]he site at [www.bt.cdc.gov](http://www.bt.cdc.gov) addresses the need for up-to-date and accurate information on health threats arising from exposure to biological, chemical, or radiological agents. ... [It] is the official federal site for medical, laboratory, and public health professionals to

reference when providing information to the public, and for updates on protocols related to health threats such as anthrax.

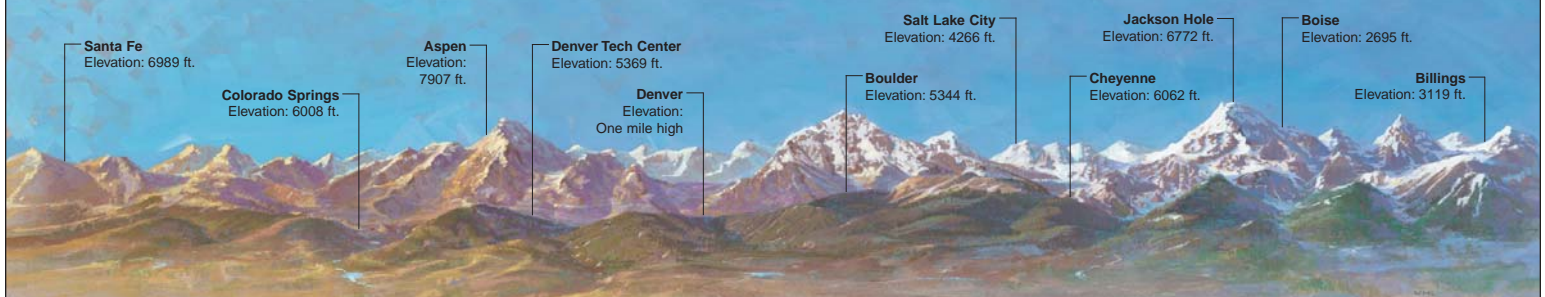
\*\*\*The Occupational Safety and Health Administration (OSHA) updated its Fact Sheet on Workplace Violence. While the fact sheet does not contain any new directives, and is for informational purposes only, it is an excellent reference for all employers. In addition, healthcare workers are specifically identified as a group that is at increased risk for workplace violence. The fact sheet also serves as a reminder to all employers that failure to "take reasonable steps to

prevent or abate a recognized violence hazard in the workplace" can result in an OSHA citation. The Fact Sheet is available from OSHA's web site, at [http://www.osha-slc.gov/OshDoc/data\\_General\\_Facts/factsheet-workplace-violence.pdf](http://www.osha-slc.gov/OshDoc/data_General_Facts/factsheet-workplace-violence.pdf)

\*\*\*Regulations implementing the Physician Referral Prohibition became effective January 4, 2002. Remember, however, that the provision addressing percentage compensation arrangements is not effective at this time. Refer to the December 2001 edition of *Health Care Law Bulletin* for a full explanation of this issue.

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