

# Health Law ADVISORY

*Current legal insights for health care executives*

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Julie A. Knutson, Editor

## *How to Get the Most Out of a Compliance Effectiveness Review*

The Supplemental Compliance Program Guidance for Hospitals, issued by the OIG in January 2005, advocates regular review of compliance program effectiveness. But, how do you plan the process to get the maximum benefit?

Since this guidance was published, many hospitals have undertaken compliance reviews; some conducted by external consultants or attorneys, others through self-assessment. The OIG recommends a qualitative review of the compliance program as well as quantitative reviews:

“A common method of assessing compliance program effectiveness is measurement of various outcomes indicators (e.g., billing and coding error rates, identified overpayments and audit results). However, we have observed that exclusive reliance on these indicators may cause an organization to miss crucial underlying weaknesses. We

recommend that hospital examine program outcomes and assess the underlying structure and process of each compliance program element . . . Hospitals should consider these factors, as well as others, when developing the strategy for assessing their compliance programs.”

70 Fed. Reg. 4858, 4874 (January 31, 2005). The Guidance includes a list of detailed questions organized around each of the following basic elements of an effective compliance program: (i) designation of a compliance officer and compliance committee; (ii) development of compliance policies and procedures, including standards of conduct; (iii) development of open lines of communication; (iv) appropriate training and education; (v) response to detected offenses; (vi) internal monitoring and auditing; and (vii) enforcement of disciplinary standards. Consider these pointers to plan an effective compliance review.

### ALSO IN THIS ISSUE

Iowa Hospital Liens After the 2007 Amendments	4
Upcoming Speaking Engagements	7

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Internal or External Review. Internal self-assessments can be very useful. They are a good educational tool for the compliance officer and the compliance committee if conducted honestly. However, few organizations have the expertise, objectivity or time to rely exclusively on internal reviews. In many cases, it may be a false economy to avoid external reviews. Internal reviews are very time-consuming for staff and the quality and usefulness of the results will vary in direct proportion to the expertise of the reviewer. Also, deficiencies are sometimes more readily acknowledged when identified by a disinterested third party. However, a good value may be obtained by using external and internal reviews in combination. Here are some examples:

- Generally, use external reviewers for coding and documentation reviews. These reviews are labor-intensive and require specialized and up-to-date subject matter expertise. Always include an educational component so that providers and others receive immediate feedback and instruction. For these purposes, plan concurrent reviews on claims that have not yet been filed so that bills are submitted correctly the first time. Always engage your experts through legal counsel to obtain the benefit of available privileges (attorney-client, work product doctrine) over reports. Finally, be specific about the standard of review. Is it aspirational, that is, are the suggestions designed to promote the highest quality documentation? Or, is the standard of review to identify the minimal documentation requirements to support billing?

- Ask an expert to help plan your internal review. This will improve the quality of the review. You can go one step further and ask the expert to review your findings and conclusions.
- Engage an expert to conduct a baseline review which you then replicate internally in rotation with periodic external reviews in order to maintain quality.
- Combine an external review with an internal self-assessment to get the benefit of both internal and external perspectives.

Emphasize Education. The most useful reviews will reveal honest information which may then be used to set goals to improve the compliance program. This will not happen if the compliance officer, committee members or other hospital staff feel as though they are being inspected or interrogated. Your reviewer(s), whether internal or external, should be selected for their capabilities to be informative and non-threatening. Staff who will be interviewed or otherwise participate in compliance reviews should be informed in advance and encouraged to be straightforward. Reviewers should be instructed to provide consultation and on-the-spot training during the course of the review. In addition, schedule periods of formal training while the expert is on site. We recommend an education session with the compliance committee at minimum. It may be possible to schedule a compliance update for the Board and/or department managers as well. This will reduce cost and add value to the process, both for the organization and the individual

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participants, and can be an important source of compliance training.

Plan in Advance. Avoid selecting an external expert to conduct your compliance review and abdicating all things to him or her. The compliance committee should formulate its goals and expectations in advance and assist the compliance officer in planning the review. Many questions need to be answered: the scope of the review, identification of expert resources, time frames. The committee and the compliance officer should be clear and specific about the outcomes desired from the review, e.g., a written report, follow-up education, revised compliance materials, a substantive legal review of a particular topic such as physician contracts, help in developing an annual work plan for the compliance committee.

Share the Results and Use Them Right Away. Many reports of compliance reviews do not get enough attention. Once presented to the Board and compliance committee, they often hit the file cabinet forever. Promptly communicate results of process-type reviews (assessing the structure and effectiveness of compliance programs and structures) to department managers, staff members with key compliance roles, such as billing and coding staff, and all administrative personnel who are not members of the compliance committee. Pull key findings and recommendations into an annual work plan for the compliance committee soon after the report is available. Ask internal or external reviewers to consider the findings and goals from the prior year in the next year's review. Report progress toward goals at Board, compliance committee, and department managers meetings throughout the year. Reflect plans and goals in categories using the seven elements of an effective compliance program so nothing is overlooked.

Process v. Substance. The OIG's Supplemental Guidance envisions that compliance reviews will include assessment of both process (compliance structures and procedures) and substantive legal review of specific compliance topics. In addition to an annual review of compliance processes, the compliance committee and compliance officer should select one or two topics for a substantive legal review. The topics are best selected through the use of a risk assessment process as recommended by the Supplemental Guidance. The nature of the topics will determine the appropriate reviewer, for example—physician contracts and/or executive compensation should be reviewed by legal counsel, cost report compliance by an accounting firm, coding and documentation by a certified coding professional.

Undertake Document Upgrades. The original Compliance Program Guidance for Hospitals was published February 23, 1998. Many hospitals have not updated their compliance policies since then.

Embrace Improvements. The number one goal of the compliance effectiveness review should be to identify and implement positive improvements. It is not a review for the mere sake of doing it or a confirmation of the perfection of the program. The results of the compliance review may show that the compliance committee should be reconfigured, the meeting frequency increased, compliance documentation improved, or compliance education overhauled. The value of the most excellent and perceptive compliance review will be reduced to zero by the fundamental unwillingness to change. The compliance officer and the compliance committee must lead this effort and demonstrate their personal willingness to acknowledge the need for

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improvements as challenges, rather than criticisms.

We are happy to assist in planning and conducting compliance reviews from the legal perspective and to work with the engagement and reporting of results by external subject matter experts.

**Ed.**

## *“Liening” into a Stiff Wind: Iowa Hospital Liens After the 2007 Amendments*

Senate File 546, effective July 1, 2007, significantly amends Iowa’s hospital lien statute. These amendments are almost entirely designed to reduce hospitals’ lien rights. They are a stiff wind against hospitals seeking to collect patient debts through hospital liens. This article summarizes the most important amendments and suggests a basis for a hospital to determine whether to invoke lien rights in accident and other lien-type situations.

Iowa and Nebraska are among the many states with hospital lien statutes. The Nebraska statute includes physicians and nurses in addition to hospitals. The Iowa statute is limited to organizations that maintain an Iowa hospital. Liens benefit a hospital by paying all or a portion of the cost of care when a patient has a claim against another

legal person (whether individual or entity) for damages on account of the patient’s injuries. Hospital lien statutes can help to address the way attorneys for patients bargain with automobile insurers and non-health insurer payors. Patients’ attorneys often submit to such payors the hospital’s full billed charges, rather than some lesser amount that a health insurer might pay if billed directly by the hospital.

In recent years, however, hospitals have felt a gust of criticism by opponents who see liens as an attempt to collect more than a hospital would typically collect from a patient’s health plan. Senate File 546 (“S.F. 546”) promotes this view and accordingly reduces Iowa hospital lien rights.

One significant change in the new statute involves the interaction of hospital lien rights with “health plans.” S.F. 546 adopts the definition of “health plan” that is set out in the Health Insurance Portability and Accountability Act (“HIPAA”). Applying this definition, this aspect of S.F. 546 means:

- If a patient provides, within 30 days of the patient’s discharge from the hospital, proof of “insurance coverage under a health plan,” the hospital “shall submit all charges to the patient’s health plan prior to filing” a notice of hospital lien. This amendment apparently requires a hospital to bill health insurance before using hospital lien notification. Thus, even if a hospital has no managed care contract with the patient’s health insurer, or even if the hospital’s managed care contract with the pertinent insurer expressly allows or requires hospital liens to be used instead of health insurance in situations where liens (before S.F. 546) were

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available, S.F. 546 attempts to require the hospital to first bill health insurance. This requirement will reduce current choices available to hospitals under some circumstances. For example, hospital H may admit an emergency patient who has insurance with insurer X and so informs H. X may have such low payment rates for the pertinent services that H would never voluntarily sign a managed care contract with X and would never accept assignment of X's insurance if offered by a patient. S.F. 546 purports to eliminate H's ability to use a hospital lien unless H first submits all charges to X. To make sure that such submission limits H to X's pay rates, S.F. 546 goes on to state that H's hospital lien shall be limited to the amount H would have received from X if X covered the charges, plus "deductibles, co-payments, and coinsurance."

- Hospital lien opponents who wish to curtail a hospital's ability to assert a lien, may argue that this amendment requires a hospital to wait at least 30 days before filing any hospital lien notice. Under this argument, some patients will be able to settle with a payor or with the wrongdoer who injured them before a hospital can even file a lien. A rebuttal might be that a hospital lien arises even before a notice of it is filed. Another rebuttal is that a hospital should at least be able to file, before expiration of the 30-day period, a lien limited to the amount of deductibles, co-payments and coinsurance. The persuasiveness of this rebuttal is unclear and, especially in light of the anti-lien winds blowing in Iowa, legal advice is recommended on the entire 30-day issue if a hospital is establishing or revising lien procedures after S.F. 546.

- The patient's health plan "shall not deny payment for hospital services ... on the basis that a third party or other insurance carrier is responsible for the patient's injuries." This could speed payment to hospitals if a hospital resigns itself to receiving only the health plan's payment, which often will be less than full billed charges. But will health plans that purport not to do business in Iowa feel bound by this amendment?
- After a hospital files a notice of lien, if the hospital receives "health plan information regarding a patient, the hospital ... shall submit the hospital's charges to the health plan." This amendment can be dangerous to hospitals who file lien notices after the July 1, 2007, effective date. Return to the example of H and X above. Modify the example to assume H is neither told nor knowledgeable that X is the patient's health insurer. Assume the patient is solvent but feisty and H becomes aware of a reasonable automobile insurer for a driver who injured the patient. At least after 30 days post-discharge, H may wish to file a lien notice to increase H's chances of collecting from the automobile insurer. But this strategy could backfire for H under a strict view of S.F. 546, perhaps unintended by Iowa's legislature. A strict view could require H to bill X and thus accept assignment of X's unusually low pay rates. H in such situation may wish it had declined to use its lien rights, declined to bill X, and pursued the solvent patient for full billed charges. Possible rebuttals to the strict view exist. Legal advice pertinent to the circumstances is recommended.

S.F. 546 blew a second significant change into Iowa's hospital lien statute. This involves a

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hospital's responsibility for legal expense of the patient's attorney. S.F. 546 contains this provision:

"A hospital that recovers a judgment, verdict, or settlement pursuant to [Iowa's hospital lien statute] shall be responsible for the pro rata share of the legal and administrative expenses incurred in obtaining the judgment, verdict, or settlement."

This change contrasts with Nebraska's statute. Nebraska's statute expressly provides that, although the patient's attorney typically is to be paid first out of the gross settlement or judgment proceeds (assuming the patient's agreement with the attorney so allows), the hospital "shall not be liable for attorney's fees and costs incurred" by the patient in settling or litigating. This change does not purport to force an Iowa hospital to pay for a pro rata share of legal expense if the hospital declines all share of the judgment or settlement proceeds, declines to use a hospital lien, and instead pursues the patient directly. Such direct pursuit sometimes will be advisable, such as if the patient is wealthy and the hospital is not forced to accept assignment of any health insurance because the patient has an individual policy and the hospital uses no lien. Legal advice can help a hospital determine how long direct collection may take and whether a statutory delinquency charge might be available in the hospital's favor.

A third significant change allows a patient's attorney in Iowa to inject herself or himself into the payee process. S.F. 546 allows a patient's attorney to notify the payor (e.g., automobile insurer or slip-and-fall store liability insurer) that the patient's attorney will "assume responsibility for the satisfaction" of a hospital lien of which the payor has

received notice. The payor then is excused from including the hospital as a payee, at least as far as Iowa's hospital lien statute is considered. The attorney "shall pay" "the amount to which the hospital is entitled" from the payor's payment.

But S.F. 546 can foster disputes by this change. For example, there is no statutory deadline on when the attorney shall pay. For another example, the attorney is just assuming responsibility for "satisfaction" of the lien, not necessarily payment of the full billed charges.

This third change thus raises strategy topics for Iowa hospitals. Among them are:

- Should a large hospital that receives significant accident cases and has a critical mass of patients without managed care health insurance consider contracting with large automobile insurers? A pro-hospital reading of S.F. 546 does not require an automobile insurer to omit the hospital as a payee. But S.F. 546 contains other language that could affect this question. Legal analysis is recommended for hospitals interested in considering contracts with automobile insurers.
- The statute describes how much the attorney must "hold in trust" and appears to authorize the attorney to disburse "any other amounts to the patient, attorney, or other persons entitled to the funds." But the statute is silent about how delinquency charge concepts affect the amount that must be held in trust. Delinquency charges of 5% per year, for example, have been used in some hospital collections and arguably are authorized by a separate Iowa statute. In addition to the direct economic benefit of a delinquency charge, some hospitals feel that a legitimate claim for them speeds the entire collection process and thus

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provides legitimate indirect benefits beyond the 5% per year. In response to this topic, a hospital could ignore any possible delinquency charge or could consult its legal team about this opportunity.

If a hospital properly “perfects” a lien under Nebraska law, in contrast, an automobile insurer, slip-and-fall liability insurer, or similar payor may not escape liability to a hospital merely by paying a patient’s attorney who promises to be “responsible” for the hospital bill.

S.F. 546 has blown change into Iowa’s hospital lien statute. This, like many important legal changes over the years, will cause Iowa hospitals to distinguish themselves as either effective or ineffective in decisions about when and how to use hospital liens and related negotiations with insurers. Legal advice can brace a hospital to progress in its patient account management, even in such a stiff wind.

**Tom Ashby,**  
**Financial Transactions**

### *Save the Date!*

The Baird Holm Annual Health Law Forum has been scheduled for Friday, November 16, 2007 at the Marriott Regency Hotel in Omaha, Nebraska. Please mark your calendar now and plan to join us. More details are forthcoming.

## *Upcoming Speaking Engagements*

Jim O’Connor and Kelly Clarke are speaking at a June 7 Nebraska Hospital Association program in Kearney, Nebraska titled “Information System Selection Seminar” on the topic of “Contractual and Regulatory Considerations in Deploying EMR Systems.”

Kelly Clarke is speaking at the September 5 Fall Conference of the Nebraska Association of Homes and Services for Aging in Papillion on the topic of “Issues in Multi-Institutional Collaboration - Acquisitions, Partnerships and Mergers.”

### *Questions? Ideas?*

We welcome your questions, ideas and suggestions.

E-mail [jknutson@bairdholm.com](mailto:jknutson@bairdholm.com) and help make the Advisory interactive!

**BAIRD HOLM** LLP  
ATTORNEYS AT LAW

#### HEALTH CARE GROUP

**Vickie J. Brady**  
402.636.8230  
[vbrady@bairdholm.com](mailto:vbrady@bairdholm.com)

**Alex (Kelly) M. Clarke**  
402.636.8204  
[kclarke@bairdholm.com](mailto:kclarke@bairdholm.com)

**John R. Holdenried**  
402.636.8201  
[jholdenried@bairdholm.com](mailto:jholdenried@bairdholm.com)

**Andrew D. Kloeckner**  
40.636.8222  
[akloeckner@bairdholm.com](mailto:akloeckner@bairdholm.com)

**Julie A. Knutson**  
40.636.8327  
[jknutson@bairdholm.com](mailto:jknutson@bairdholm.com)

**Barbara E. Person**  
402.636.8224  
[bperson@bairdholm.com](mailto: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

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

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