

Hot Topics in Health Law

2019 HCCA Charlotte Regional
Meeting January 18, 2019

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Hot Topics in Health Law

- EMTALA
- Telemedicine
- Federal Opioid Legislation
- Body Cameras

EMTALA

Recent-ish Developments in EMTALA

- Federal EMTALA law has not changed, nor have the regulations in a long time.
- The State Operations Manual has not been modified since 2010.
- So, why are we talking about EMTALA in a “Recent Developments” presentation?
- Because there have been developments in CMS interpretations of EMTALA, especially in Region IV
 - Region IV covers Alabama, Florida, Georgia, Kentucky, Mississippi, *North Carolina*, *South Carolina*, and Tennessee
 - And, lucky us, it is the most active region for penalties!

Why do strange things happen in South Carolina?

- Psychiatric resources are sorely lacking for patients in our area, resulting in individuals presenting to the ED for evaluation and, despite our best efforts, experiencing long waits before placement in a psychiatric facility.
- Can these patients be evaluated and managed during the “boarding” by an ED physician?
- Maybe not...
- This incident resulted in a fine to the hospital system of more than \$1M (*the largest ever!*)

Why do strange things happen in South Carolina?

- The United States is in an opioid crisis, costing thousands of lives every day.
- Can my hospital place a sign indicating that we do not provide narcotics to chronic pain patients or drug seekers in the ED?
 - Probably not... but there are other options.

Why do strange things happen in South Carolina?

- What does this mean for other signs or policies, such as:
 - Notices about what services are or are not available
 - ED wait time displays
 - Requirement for photo ID or other documentation
 - Listing of health insurance programs accepted
 - Do these rules also apply to your public website, and other marketing...

What we have seen during recent EMTALA surveys...

- CMS and state surveyors are heavily focusing on psychiatric patients
 - Evaluate your approach to keeping these individuals safe and in your hospital until admission or transfer
 - Staff should consider a suicidal patient in the same way as a patient with a STEMI (*both are emergency medical conditions under EMTALA*)
 - CMS does not care what state involuntary commitment statutes say, which can create problems... (e.g. patient consent for transfer)

What we have seen during recent EMTALA surveys...

- CMS and state surveyors are heavily focusing on psychiatric patients
 - CMS has raised questions about where these patients are transferred – residential vs. inpatient settings (e.g. *crisis centers*)
 - How are these patients best transported? (Ambulance, police, other)
 - Be aware of restraint rules, as well...
 - 280+ page public report and immediate jeopardy citation for NC hospital related to restraint for patient who was out of control and endangering self and others

What we have seen during recent EMTALA surveys...

- They are looking for signage in multiple languages and in odd places
 - Consider what languages are on your website, in other visible signs, and informed consent forms
 - Surveyors have indicated EMTALA signs need to be at entrances and waiting areas other than ED/L&D areas (which makes no sense)

What we have seen during recent EMTALA surveys...

- CMS and state surveyors are looking closely at risks/benefits on transfer forms
 - Most hospitals that I have worked with have boxes to check for possible MVA, deterioration of condition, delay in treatment, etc.
 - That has not satisfied surveyors, who want an individualized assessment documented in the chart (as the SOM states is needed)
 - If every form says the same thing, likely to be an issue...

What we have seen during recent EMTALA surveys...

- CMS has raised questions about what really is an EMTALA transfer
 - Many systems have multiple campuses and/or multiple hospitals
 - The rules are relatively clear on what is an EMTALA transfer (e.g. movement between campuses of the same CMS hospital is NOT)
 - But, surveyors have focused on language in chart (e.g. “transfer” to main campus) and whether an “EMTALA Transfer” form is used

What we have seen during recent EMTALA surveys...

- CMS remains focused on transfers and discharges
 - We have seen hospitals cited for telling a patient to get in his/her car and go to another hospital when transfer request was declined
- Consider whether to allow self-transport or transport by private vehicle
 - We have had some facilities contend those are inappropriate transfers under EMTALA, even where patient was offered, but *refused* ambulance transport
 - No practical way to force patient to accept transfer by ambulance

TELEMEDICINE

State Law Perspective

- “Practice of Medicine”: The performance of any act, within or without this State, described in this subdivision by use of any **electronic** or other means, including the **Internet** or **telephone**.
N.C.G.S. § 90-1.1(5)
 - Doctor can physically be located outside of North Carolina, but must be licensed to practice in NC
- Medical Board Position Statement

Federal Perspective

- Five conditions for Medicare coverage:
 1. Beneficiary is located in qualifying rural area;
 2. Beneficiary is located at a qualifying originating site;
 3. Services are provided by a qualifying distant site practitioner;
 4. Beneficiary and distant site practitioner communicate via an interactive AV telecommunications system that permits real-time communications; and
 5. CPT/HCPC code for the service is on Medicare’s list of covered telehealth services.

Federal Perspective

- Bipartisan Budget Act of 2018:
 - Expand stroke telehealth coverage
 - Improve access to telehealth-enabled home dialysis oversight
 - Enable provision of free at-home telehealth dialysis technology without violation of the CMP
 - Allow MA plans to include telehealth delivery in the plan's basic benefits
 - Enable ACOs to expand the use of telehealth services

Compliance Pitfalls

- Licensure/practice of medicine violations
- Prescribing violations
- Medical malpractice issues
- Corporate practice of medicine
- Practitioner credentialing
- HIPAA
- Payer requirements
- Fraud and abuse (Stark, Anti-Kickback, CMP, beneficiary inducement)

Compliance Pitfalls

- October 2018: HealthRight Telemedicine
 - DoJ unsealed 32 count indictment against 4 individuals and 7 companies in \$1 billion fraud scheme
 - Alleged HealthRight fraudulently solicited consumer’s insurance and prescription information and used compounding pharmacies in Florida and Texas to fill fraudulent prescriptions at a massive markup

Compliance Pitfalls

- November 2018: Choice MD
 - Defendants have pled guilty to bilking TRICARE of over \$65 million
 - Recruited Marines in San Diego through a telephone consult billed as a “telehealth visit”
 - Paid the Marines and their dependents to file prescriptions with pharmacies controlled by co-conspirators; prescriptions were signed by Choice MD doctors

FEDERAL OPIOID LEGISLATION

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- 72,000+ overdose deaths in the US in 2017, more than car accidents and gun violence combined
- Acronym for Substance Use-disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
- Bipartisan support in both houses of Congress
- Became Public Law No: 115-271 on October 24, 2018
- Not a significant increase in funding

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Makes changes to Medicare and Medicaid designed to limit the over-prescription of opioids
- Expands Medicare coverage for treatment programs that deliver medication assisted treatment (MAT)

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Expands types of providers who can prescribe or dispense MAT
- Makes permanent the prescribing authority for PAs and NPs
- Authorizes clinical nurse specialists, certified nurse midwives, and CRNAs to prescribe MAT, but only for 5 years

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Expands/supports telemedicine programs designed to combat opioid and heroin addiction and will:
 - Allow providers to prescribe controlled substances via telemedicine in legitimate emergency situations.
 - Provide guidance on telehealth services to address substance use disorders under Medicaid.
 - Expand Medicare coverage of telehealth services for treatment of substance use disorders and co-occurring mental health disorders.

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Authorizes SAMHSA to initiate grant program for entities to establish comprehensive opioid recovery centers that serve as community resources.
- Allows comprehensive opioid recovery centers to utilize the ECHO (Project Extension for Community Health Outcomes) model to enable care coordination and services delivery through technology.
- Requires various reports, evaluations, and assessments on the effectiveness of telemedicine services and technologies in substance use disorder treatment.

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Requires HHS to develop best practices for prominently displaying substance use disorder treatment information in EHRs when requested by the patient.
- Promotes the testing of incentive payments for behavioral health providers to adopt and use EHR technology.

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Seeks to reduce the number of unused controlled substances at risk of diversion or misuse in hospice programs
- Expands a grant program authorized by Comprehensive Addiction and Recovery Act allowing first responders to administer Naloxone (“Narcan”) to treat opioid overdoses.

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Permits Medicaid funding for beneficiaries aged 21-64 with substance use disorder to be treated in larger facilities (IMDs)
 - Up to 30 days of care in any 12 month period
 - Authority limited to 2019-2023 time period
 - State Medicaid programs have to meet certain requirements to benefit from this provision
 - States can still apply for Section 1115 demonstration waivers

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Provides educational resources for
 - Hospitals
 - Physicians
 - Medicare and Medicare Advantage beneficiaries
- Requires the HHS Secretary to develop a toolkit by July 1, 2019 on best practices for Medicare participating hospitals to reduce opioid use and to develop new quality measures related to opioids.

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

- Allows the National Institutes of Health to perform high impact cutting edge research on projects to respond to the opioid crisis
- Promotes research to find new, non-addictive drugs for pain management.

BODY CAMERAS

State Law

- N.C.G.S. § 132-1.4A
 - Establishes process for the use and release of police body camera recordings
 - Provides that in determining whether to release footage, should consider whether the recording “contains information that is otherwise confidential or exempt from disclosure or release under State or federal law”

State Law

- S.C. Code Ann. § 23-1-240
 - Requires all SC law enforcement agencies to implement body cameras
 - Enables law enforcement and the attorney general to release footage at their discretion

Body Cameras in the Hospital

- Can you tell police not to record?
 - Hospital photography/recording policies
 - HIPAA
 - State medical privacy laws
- War stories

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