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Telemedicine Update: Now Playing in New Jersey

By Meghan V. Hoppe, Esq.

As anticipated in our January edition of the *Health Law Dispatch,* New Jersey Governor Chris Christie signed Senate bill S291 into law (P.L.2017, c.117. codified at N.J.S.A. 45:1-61, *et seq.*), authorizing health care providers to engage in telemedicine and telehealth. Among other things, the law describes the technologies that may be utilized to provide telemedicine and telehealth services, stipulates the requirements for establishing a proper provider-patient relationship, and imposes registration and reporting obligations on telemedicine and telehealth providers.

The law defines "telemedicine" as the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site. Telemedicine is provided using interactive, real-time, two-way audio and video technologies to communicate and treat the patient; however, asynchronous store-and-forward technology may be used in situations where the provider determines, after reviewing the patient's medical records, that he/she is able to meet the same standard of care as if the services were being provided in person. Specifically, telemedicine does not include the use, in isolation, of audio-only telephone conversations, electronic mail, instant messaging, phone text or facsimile transmission.

On the other hand, a provider may engage in "telehealth" by using information and communications technologies, including telephones, remote patient monitoring devices or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration and other services. A health care provider may engage in telehealth as may be necessary to support and facilitate the provision of health care services to patients.

A health care provider engaging in telemedicine or telehealth may establish the provider-patient relationship by (i) properly identifying the provider and patient, (ii) performing a review of the patient's medical history and available medical records prior to an initial encounter with the patient, and (iii) prior to each encounter, determining that he/she will be able to meet the same standard of care for the patient using telemedicine or telehealth services as would be provided if the services were conducted in person.

Each telemedicine or telehealth organization operating in New Jersey must annually register with the New Jersey Department of Health ("DOH") and file annual reports to the DOH, which reports must include de-identified encounter data, including: the total number of telemedicine and telehealth encounters conducted; the type of technology utilized to provide services using telemedicine or telehealth; the category of medical condition for which services were sought; the geographic region of the patient and the provider; the patient's age and sex; and any prescriptions issued. A telemedicine or telehealth organization that fails to register with the DOH or that fails to submit an annual report will be subject to disciplinary action.

Importantly, the law also requires that a carrier (e.g. insurance company, health maintenance organization, etc.) offering a health benefits plan in New Jersey provide coverage and payment for services delivered through telemedicine or telehealth on the same basis as services delivered in-person and at a reimbursement rate that does not exceed the in-person provider reimbursement rate. Likewise, the State Medicaid and NJ FamilyCare

programs, the State Health Benefits Commission and the School Employees Health Benefits Commission must ensure that their hospital and medical expense benefits plans provide equivalent coverage and payment for telemedicine and telehealth services.

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New Expansion of New Jersey's Physical Therapy Licensing Act

By Sharmila D. Jaipersaud, Esq.

This summer, Governor Chris Christie signed into law Senate bill S1315, which revised the "Physical Therapist Licensing Act of 1983," codified at N.J.S.A. 45:9-37.11, *et seq.* (the "Law"). See P.L.2017, c.121. Effective January 17, 2018, the Law will provide numerous expansions to the scope of practice for physical therapists to include: identification of balance disorders; utilization review; screening, examination, evaluation, and application of interventions for the promotion, improvement, and maintenance of fitness, health, wellness and prevention services in populations of all ages exclusively related to physical therapy practice.

The Law also allows for physical therapists to provide wound debridement and care to promote healing, provided it is done with a physician or podiatric physician. Additional changes included the supervision of physical therapist assistants, which may now be provided by general supervision, as opposed to direct supervision. Under the Law, "general supervision means supervision by a physical therapist in which: the physical therapist shall be available at all times by telecommunications but is not required to be on-site for direction and supervision; and the supervising physical therapist assesses on an ongoing basis the ability of the physical therapist assistant to perform the selected interventions as directed." N.J.S.A. 45:9-37.13 [Effective Jan. 17, 2018]. Furthermore, the Law provides that within 180 days following its enactment, the State Board of Physical Therapy Examiners shall establish guidelines concerning the general supervision of physical therapist assistants, including, but not limited to: (1) on-site review of the plan of care with appropriate revision or termination, completed during a regular physical therapist visit; and (2) evaluation of the need for, and a recommendation regarding, utilization of outside resources.

A new section was added to the Law which provides that a person shall be guilty of a third degree crime if he knowingly does not possess a license to practice physical therapy, or knowingly has had such license suspended, revoked or otherwise limited by an order entered by the State Board of Physical Therapy, and: (1) engages in the practice of physical therapy; (2) exceeds the scope of practice permitted by the board order; (3) holds himself out to the public, or any person as being eligible to engage in the practice of physical therapy; (4) engages in any activity for which a license to practice physical therapy is a necessary prerequisite; or, (5) practices physical therapy under a false or assumed name or falsely impersonates another person licensed by the board. The criminal provisions do not apply to a person practicing physical therapy without a license if that person's activities are permitted under an exception to the licensing requirement, pursuant to N.J.S.A. 45:9-37.19.

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Aetna Breach Results in Disclosure of HIV-Related Information

By Deborah A. Cmielewski, Esq.

Andrew Beckett, a pseudonym, on behalf of himself and others similarly situated, has filed a class action lawsuit against Aetna in the United States District Court for the Eastern District of Pennsylvania for improperly disclosing HIV-related information of as many as 12,000 insureds living in 23 states. The plaintiffs seek monetary damages, confirmation that Aetna has modified its mailing practices and reimbursement for their legal fees and costs.

By way of background, on July 28, 2017, Aetna's third party vendor mailed letters that explained changes to the insurer's policies regarding pharmacy benefits and access to HIV medications. The letters were sent to patients who

had taken those medications. While some of the insureds were HIV positive, others required the medications as a prophylactic measure following exposure to the disease. Shortly after the mailing was sent, Aetna learned that due to a technical error, the letters had been misplaced inside their envelopes, revealing the phrase "filling prescriptions for HIV" through the transparent window. The visible portion of the window revealed that Aetna had sent the letters; it also included the patients' names and addresses, claim numbers and other identifying information.

Interestingly, the letters came on the heels of two lawsuits filed in 2014 and 2015, after Aetna required its insureds to receive HIV medications through the mail. The plaintiffs in those lawsuits alleged that the mail order requirement could result in a breach of their privacy. The 2014 and 2015 lawsuits were settled and as a condition of the settlement, Aetna wrote to advise patients of the changes to its medication protocol.

Aetna mailed breach notification letters to the affected patients and apologized for its unacceptable conduct. It acknowledged that the envelope at issue had in some cases revealed elements of protected health information. Aetna claims to be reviewing its processes to ensure that such conduct is not repeated in the future.

The 2017 lawsuit alleges that Aetna's reckless and negligent actions have caused numerous insureds to sustain serious and irreparable harm. Some patients claim that they have lost housing and others have been shunned by their loved ones after becoming aware of their HIV status. Despite the passage of time since the HIV crisis began, the disease continues to carry with it a significant stigma in social and personal circles.

The Aetna lawsuit highlights the need for HIPAA covered entities to be ever-vigilant about monitoring their policies and procedures, staff training and vendor relationships. What may seem like a straightforward issue can result in catastrophic outcomes. SPSK is available to assist entities in their compliance reviews.

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Hospital Physician Incentive Plan Exception to Codey Law

By Divya Srivastav-Seth, Esq.

On May 1, 2017, and effective immediately, Governor Christie signed into law P.L.2017 c.46, which exempts from the New Jersey prohibition against physician self-referrals, N.J.S.A. 45:9-22.5, *et. seq.*, also known as the "Codey Law", qualified hospital physician incentive plans registered with the Department of Health ("DOH") prior to their implementation. Subject to certain exceptions, the Codey Law prohibits referrals of a patient by a practitioner for healthcare services in which the practitioner or the practitioner's family has a significant beneficial interest. The new law expressly exempts qualified hospital physician incentive plans from the Codey Law's definition of a "significant beneficial interest" and allows for direct payments of incentives from a licensed acute care hospital to physicians or physicians groups if such payments are calculated using a fixed incentive payment methodology based on the physician's performance in meeting the hospital's institutional and specialty specific goals as established by the incentive program.

The law requires that the hospital establish a steering committee charged with establishing and formulating the incentive based payment methodology according to objective, uniform, performance and quality based measures. The plan will generally be applicable to all inpatient costs related to admissions in a given program and must ensure that no payments are made based on the reduction or limitation of medical care. Any patient subject to such a compensation arrangement must be advised of the existence of the plan prior to admission. The law also requires that the hospital engage an independent third party to administer the plan, apply the methodology and calculate the direct payments. The DOH will have the authority to review, approve and terminate any plan if it determines that it is not in compliance with state or federal law or if there is a decrease in the quality of care provided.

Providers interested in participation in this type of compensation arrangement must also evaluate the risk of non-compliance under the federal prohibition against

physician self-referral, 42 U.S.C. 1395nn, also known as the Stark law ("Stark") and the Anti-kickback statute. See 42 U.S.C. 1320a-7b ("AKS"). Stark generally prohibits a physician from referring a Medicare patient for designated health services to an entity with which the physician, or a member of the physician's immediate family, has a financial relationship unless an exception applies. The AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. Both Stark and the AKS have statutory exceptions and/or regulatory safe harbors which protect certain arrangements from liability and the proposed hospital physician incentive plan should be analyzed to see if it meets an exception.

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IRS Revokes Hospital's IRC 501(c)(3) Status for Failure to Comply with Requirements Imposed Under IRC 501(r)

By Farah N. Ansari, Esq.

The Internal Revenue Code ("IRC") 501(c)(3) tax-exempt status of a hospital was recently revoked by the Internal Revenue Service ("IRS") for failing to comply with requirements imposed under IRC 501(r). If a hospital with IRC 501(c)(3) status fails to comply with the requirements imposed under IRC 501(r), then the hospital may be subject to excise taxes, taxation on certain income, and finally, the IRS may revoke the 501(c)(3) status of the hospital. The hospital in this ruling had tax-exempt status on the dual basis of its IRC 501(c)(3) classification and it being a governmental unit. As a result, the hospital did not find it necessary, for its purposes, to maintain its IRC 501(c)(3) tax-exemption. Hospitals that have IRC 501(c)(3) status should be aware that the IRS is conducting audits to ensure compliance with 501(r). A detailed discussion of the private letter ruling can be found here.

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