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Who Truly Wins in the Battle between Paper and Electronic Medical Records?

By Alyssa Mason, Esq., Orlando, FL*

The healthcare field is undergoing some major changes – changes that will affect not only the way doctors and healthcare facilities practice medicine, but also the legal implications of those practices. One of the most significant and controversial changes in the healthcare field is the transition from paper medical records to electronic medical records (EMRs). EMR adoption could complicate an already complicated area of law, medical malpractice law, for both healthcare providers and healthcare facilities.[1]

It should come as no surprise that this transition has had and will continue to have lasting effects on both the medical and legal fields. The medical field is constantly changing, and its changes have always shaped the way the law views and handles the liabilities associated with the practice of medicine. The change to an electronic form, while it may not be a change in practice per se, will have vastly wide-ranging repercussions as EMR adoption unfolds. "System breaches. Modification allegations. E-discovery demands. These issues are becoming common courtroom themes as physicians transition from paper to EMRs…. Not only are EMRs becoming part of the medical negligence lawsuits, they are actually creating additional liability."[2] Doctors and healthcare facilities will continue to face an increase in potential liability due to the use of, or the failure to use, EMR systems.[3] Mistakes in the use of those systems, failure to utilize all of the information contained in those systems, and failure to consult those systems at all may lead to increased exposure to liability for practitioners and healthcare facilities alike.[4] Courts will struggle to define what parts of an EMR constitute the legal record, whether the standard of care of a physician should change based on the use of, or failure to use, an EMR system, and how to best allocate the potential increase in discovery costs associated with EMRs.[5] In short, the switch to EMR systems may have several unanticipated consequences in both the medical and legal fields.

While proponents boast improved documentation, automatic checks for medication errors and drug interactions, and failsafe measures to track test results and follow-up with patients as some of EMRs most promising benefits, the change to an electronic form is not without its pitfalls.[6] Opponents point to privacy and security threats from hackers as the biggest concern, not to mention the costs and hassles associated with transferring to such systems.[7] More specifically, EMRs open physicians and healthcare facilities to a greater risk of malpractice liability. For example, "[EMR] systems can increase malpractice risk in the areas of documentation of clinical findings, recording of test and imaging results, computerized physician order entry, and clinical decision support."[8]

This article focuses on two main concerns associated with EMRs as it relates to medical malpractice law: first, EMRs potential to expose healthcare providers and healthcare facilities to liabilities that did not exist before EMRs; and second, EMRs potential to increase the number of medical malpractice suits filed, and its potential to effectively and drastically change the course of medical malpractice litigation.

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Agency Disciplinary Action and The *Frank Wells* Trilogy

By Miriam R. Coles, Esquire and John D. Buchanan, Jr., Esquire, Tallahassee, FL*

The Frank Wells trilogy is an important set of cases for any health care facility, and particularly a nursing home, which is seeking redress from disciplinary action by the Agency for Health Care Administration (AHCA). These cases explain that facilities are entitled to meaningful administrative review even when the Agency levies seemingly small or insignificant citations which are unaccompanied by any monetary fine.

In September of 2006, AHCA conducted a complaint investigation of a patient transfer at W. Frank Wells Nursing Home (Frank Wells). Based on the investigation, AHCA concluded that Frank Wells violated emergency patient transfer requirements under the Baker Act, Chapter 394, Florida Statutes. As a result, AHCA cited Frank Wells with a "Tag N-509" violation, a Class III deficiency under Section 400.23(7)(d), Florida Statutes. This citation required Frank Wells to complete a plan of correction, but did not include any monetary penalty. AHCA denied Frank Wells' request for an administrative hearing to dispute the citation on the ground that AHCA's actions were investigatory in nature and did not qualify as final agency action subject to administrative review. AHCA also argued that Frank Wells did not attempt to allege any substantial injury caused by the citation, another basis for denying its hearing request.

On appeal, the First District Court held that this type of citation is agency action subject to review, not simply part of the preliminary investigation. The case was remanded to AHCA with instructions to allow Frank Wells to amend its petition to address the issue of cognizable injury. W. Frank Wells Nursing Home v. AHCA, 979 So. 2d 339, 342 (Fla. 1st DCA 2008).

Frank Wells amended its petition for hearing as instructed by the district court only to be denied a formal administrative hearing yet again. This time, AHCA held that Frank Wells' petition failed to allege a substantial injury sufficient to satisfy the standing test outlined in Agrico Chemical Co. v. Dept. of Environmental Regulation, 406 So. 2d 478 (Fla. 2d DCA 1981), and that its injuries were too "speculative" and "conclusory" to warrant a formal hearing under Section 120.57, Florida Statutes. Among its conclusions, AHCA asserted that Frank Wells had merely alleged injury to reputation, which is not cognizable, and that the minimal cost incurred by Frank Wells in creating a corrective action plan for this violation was simply the cost of doing business.

On appeal, the district court again reversed AHCA's ruling and held that the Agrico standing test only applies to third parties seeking to intervene in agency action, and does not apply to directly named parties seeking administrative review. The Court held that Frank Wells was a directly named party, thus the Agrico test was inapplicable and the citation constituted agency action, requiring AHCA to grant an administrative hearing. W. Frank Wells Nursing Home v. Agency for Health Care Administration, 27 So. 3d 73 (Fla. 1st DCA 2010). In so doing, the district court recognized that loose reference to Agrico over the years had resulted in confusing the third party intervention standard with the first party entitlement to a hearing.

As ordered by the district court, AHCA granted Frank Wells an administrative hearing. The administrative law judge determined that Frank Wells had in fact, transferred the patient in contravention of the Baker Act procedures and that the citation was valid. On appeal for a third time, the district court again sided with Frank Wells and held that the Agency's interpretation of Section 394.463, Florida Statutes was clearly erroneous, and remanded the matter to AHCA for removal of the citation from the Frank Wells' regulatory record. W. Frank Wells Nursing Home v. Agency for Health Care Administration, 75 So. 3d 328 (Fla. 1st DCA 2011). Frank Wells' persistence in appealing what it considered an unjust, but seemingly minor citation thus resulted not only in the vacation of the citation, but also an important clarification of the law governing entitlement to an evidentiary hearing before AHCA.

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Hospitalization Of Non-Resident Aliens: Current Issues Facing Hospitals

By Nancy S. Paikoff, Esq. and David R. Phillips, Esq., Clearwater, FL*

Consider the following real scenarios:

- A patient presents at the emergency room in a diabetic coma. The hospital provides treatment and stabilizes the patient pursuant to state and federal law. But the patient is in need of regular dialysis treatments which can be appropriately provided on an outpatient basis. However, the patient is uninsured and the hospital suspects that the patient is in the country illegally. Can the hospital discharge this patient?
- A Russian man frequently presents at the hospital with a pregnant woman in active labor. The woman speaks Russian and is not related to the man who brought her to the hospital. The hospital delivers the baby. The baby is born an American citizen. The hospital determines that the Russian man has been advertising online in Russia for pregnant women to come to Florida for child birth. The Russian man is paid a fee by the pregnant women. The hospital receives no reimbursement for the delivery of the baby though it can seek reimbursement from Medicaid for care provided to the baby. What can the hospital do about this?

If you are reading this article to learn the answer to these questions, then sorry to disappoint. There are no easy answers. The treatment and discharge of undocumented aliens is a problem facing hospitals today, especially in Florida where some experts estimate there may be between 700,000 to 850,000 undocumented aliens currently residing in the state. Care to undocumented aliens places financial pressures on an already overburdened emergency healthcare system. Oftentimes, hospitals are obligated to continue providing care to undocumented aliens after stabilization because without such measures, the patient faces a life threatening situation. Additionally, hospitals cannot legally or ethically discharge a person, regardless of immigration status, who clearly would not be stable — particularly when he or she has nowhere to go. Compounding the problem, there exists no requirement under current federal or Florida law for a rehabilitation facility or skilled nursing facility to accept these patients.

Under The Emergency Medical Treatment and Active Labor Act (EMTALA) at 42 U.S.C. § 1395dd, hospitals that receive Medicare funding and have emergency treatment facilities must treat all patients who have emergency medical conditions and who present themselves to the emergency department, regardless of insurance status or the ability to pay. EMTALA imposes the following duties on hospitals: (i) provide a medical screening examination to determine if an individual has an emergency medical condition within the capability and capacity of the hospital, and (ii) stabilize such an emergency condition. A woman in active labor is considered to have an emergency medical condition. Assuming the patient is a difficult to discharge undocumented alien, the Medicare Conditions of Participation for Hospitals mandate that a hospital must transfer or refer the patient for followup or ancillary care when he or she does not have the capacity for self care. *See* 42 C.F.R. 482.

A hospital may seek reimbursement from the federal government for emergency medical treatment rendered to an undocumented alien.[1] However, no payment source currently exists for the follow up or ancillary care that an undocumented alien may need.

Nursing homes and other long-term care facilities have recognized that Medicaid funding will not be available for undocumented aliens and generally refuse to accept them from hospitals. As a result, many hospitals are faced with patients who require long-term care and are in the country illegally such as the patient described in scenario one above. One alternative available to a hospital is to attempt to repatriate such patients to their home countries for further care and treatment. In order to accomplish a successful medical repatriation, without court intervention, the hospital should obtain the patient's consent and should work through the consulate of the home country. The hospital generally pays for the costs of transportation, including air ambulance flights in the most serious cases. However, without the consent of the patient, this process can be almost impossible.

There is one reported case in Florida where a hospital sought court approval to send a patient who required long-term care back to his home country, but it does not necessarily provide a precedent for other hospitals. In the case Martin Memorial Medical Center, Inc. v. Gaspar Montejo, No. 00-344-CP, slip op. 528 (Fla. Cir. Ct. Prob. Div. June 27, 2003), an undocumented alien was brought to the hospital after suffering a severe head injury in an automobile crash. The patient survived and was adjudicated incapacitated by the circuit court in Martin County and his cousin was appointed his guardian. The patient continued to improve and ultimately his condition stabilized to the point that he was ready for discharge. Unfortunately, his family would not allow him to be discharged home and there was no long-term facility willing to accept him due to his immigration status. The guardian initially agreed with the hospital that the patient should return to his native country of Guatemala. To the extent that the patient could understand, he also stated that he wanted to go home.

The hospital contacted the Guatemalan consulate in order to find the patient an appropriate receiving facility and to assist with arrangements for his return trip. When the guardian later tried to prevent the discharge and transport, the hospital sought a court order in the guardianship proceedings allowing them to transfer the patient home without the guardian's consent. After a lengthy hearing, the guardianship judge authorized the patient's transfer to Guatemala. Part of the court's order required the guardian to "refrain from frustrating the hospital's discharge plan to relocate (Jimenez) back to Guatemala under the authority and guarantee of the Guatemalan Ministry of Health." Ten days following the order, the hospital flew him to Guatemala and he was admitted to a rehabilitation facility.

The guardian appealed the order, arguing that the guardianship judge did not have the jurisdiction to deport a person; that deportation is the sole responsibility of the federal courts. The

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Will Accountable Care Organizations Create New Theories Of Accountability?

By Andrew S. Bolin, Esq., Tampa, FL*

Tucked away inside a mere seven pages of the massive Patient Protection and Affordable Care Act ("PPACA")[1], popularly known as "Obamacare," is a federally created model for delivering healthcare that has garnered attention from practitioners and hospitals throughout the United States. Accountable Care Organizations ("ACOs") are a network of healthcare providers and hospitals that share responsibility for managing all of the health care needs of a minimum of 5,000 Medicare beneficiaries[2] for at least three years.[3] The ACO has been touted by its proponents as a cost saving measure for Medicare that shifts the focus of healthcare providers away from the fee-for-service models, traditionally used in the billing for healthcare services, to a model that offers the providers, within the ACO, the ability to share in cost savings when providers meet quality benchmarks that are designed to focus on prevention and keeping patients "healthy" and out of hospitals. These financial incentive payments are to be determined by comparing the ACO member's annual incurred costs relative to national per capita Medicare expenditures for beneficiaries in the absence of the ACO.[4]

While the efficacy and practicality of creating and delivering such a system in an economy the size of the United States will no doubt be debated, one thing is now certain: Obamacare, and with it ACOs, are now a reality of healthcare in our country. With a projected $940,000,000.00 in cost savings to divide among ACOs in the next four years[5], it is easy to see why providers are eager to participate. A close examination of PPACA however, reveals a host of potential areas of exposure that ACO participants must consider in order to accurately balance the risks and benefits of accepting responsibility for the healthcare of more than 5,000 patients.

I. AS "FEE-FOR-SERVICE" SHIFTS TO "FEE-FOR-PERFORMANCE," PROVIDERS SHOULD EXPECT ALLEGATIONS BASED ON COST SAVINGS.

An ever-prevalent argument in many medical malpractice cases is currently that necessary diagnostic tests were not ordered, leading to harm to the patient. This argument seems counterintuitive given that a 2010 Gallup Poll of Florida physicians attributed 26% of the $132,000,000,000.00[6] spent in Florida in health care costs each year to the practice of defensive medicine. However, one can easily see this argument gaining additional traction when the provider who allegedly failed to order a test or diagnostic study is a member of an ACO that is paid to *save* money across a large patient population. Hospitals and practitioners alike should be prepared for plaintiffs to allege more frequently and fervently that the reason for the decision to withhold that expensive diagnostic study was an effort to save the ACO from the costs of that test, and thus push the organization closer to realizing the bonuses paid by The Centers for Medicare and Medicaid ("CMC") for shaving costs off the per capita average. In order to fairly respond to these charges, Florida ACO participants must place an even greater emphasis on explaining not only their plan of care, but also the thought process behind the plan of care, complete with the medical basis for choosing not to order an available test or study. Likewise, the reasons behind the timing of discharging a patient from the hospital and the choice not to order home health care services like additional therapy or nursing care will be more closely scrutinized. While sound medical explanations during a provider's deposition can be effective, nothing is more persuasive than seeing the more close to real time thought process of the practitioner that is offered by a detailed entry in the medical record. With the advent of the electronic medical record ("EMR"), charting in this way can sometimes be more easily completed. However, some EMR formats do not allow the space or the ability to reduce the non-financial reason for the plan of care to writing. Practitioners should seek out education and guidance from the managers of their EMR software so that they are aware of how to document the reasons behind their decision making as they move into the era of fee-for-performance healthcare delivery.

II. JUST HOW ACCOUNTABLE IS EACH MEMBER IN THIS "ACCOUNTABLE" CARE ORGANIZATION?

It is clear that each member of the ACO is accepting responsibility for the care provided to the patients that are assigned to the organization. What is less clear is who is responsible if one of those patients suffers from an adverse outcome or is allegedly injured by their healthcare provider.

a. Non-Delegable Duty:

The clear trend in medical malpractice litigation has been to attempt to hold hospitals responsible for everything that happens "under the hospital's roof." Currently, Florida District Courts of Appeal are split on whether to impose non-delegable duties on hospitals in the state, essentially eliminating the ability for hospitals to shift risk to the physicians caring for patients on its premises.[7] While plaintiffs and practitioners alike await for a Supreme Court confirmation on whether the theory of non-delegable duty is viable, all indications are that courts are seeking to move toward holding the hospitals responsible for all care provided at its facilities. Indeed, the well-respected Judge Altenbernd conveyed that very aspiration as Chief Judge, writing a specially concurring opinion in the case of *Roessler v. Novak*[8]. Judge Altenbernd stated that, in his view, the "twenty year experiment" of apparent agency as the doctrine for determining hospital liability for the negligence of independent contractors was a "complete failure" and that, in the context of medical negligence, a theory of non-delegable duty was preferred.[9] If this is in fact the leaning of our judiciary, the question of whether members of an ACO, who would be otherwise delegating the tasks of certain healthcare services to other members of the ACO, comes clearly into focus. To this point, a review of the language of the requirements set forth in §3022 of the PPACA contains some troubling statements regarding the responsibilities of its members. Among the responsibilities ascribed to the providers within the ACO is that,

"the ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it," that "the ACO shall include primary care

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ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO," "the ACO shall have in place a leadership and management structure that includes clinical and administrative systems," "the ACO must have a process for evaluating the health needs of the population it serves," and that "the ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies."

These responsibilities do not limit themselves to clearly defined practice groups or individuals, but rather spread the broad and sometimes unworkably vague responsibilities out to the entire organization. With those mandated responsibilities at a plaintiff's disposal it is not unreasonable to assume that allegations of failure of the ACO as an entity, and thus its individual members, to adequately carry out its duties will be a feature of complaints against providers who are involved in an ACO.

b. Joint Venture*:*

Anyone involved in the defense of hospitals and/or their independent contracting physicians has recognized the prevalence of plaintiffs' counsel beginning to include a count for "joint venture" in the complaint in an attempt to affix liability on the corporate defendants for the actions of the independent contractor provider. In order to establish a cause of action for joint venture in Florida, a plaintiff must be able to plead and prove four basic elements: (1) a contract exists between the parties establishing the joint venture relationship; (2) the intent to form a joint venture; (3) a joint "property" interest in the subject of the venture; (4) joint control over the activities of the venture; and (5) that the members of the joint venture have a right to share in the profits *and* a duty to share in the losses.[10] In many cases, these allegations fail at the trial court level because of the inability to adequately prove each required element, especially when physicians are paid a set salary or fee for service and it cannot be said that the parties shared in the profits and losses of the enterprise. The ACO model perhaps unwittingly fulfills the required elements of a joint venture by way of the very cost saving bonus program that makes ACOs so attractive to healthcare providers. Indeed, the requirements of §3022 specifically require the ACO to "have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers." What makes the joint venture allegations so troubling is that unlike other claims for vicarious responsibility where liability may be difficult to affix to unrelated treating physicians uninvolved in the alleged incident that makes up the basis of a claim, liability for a joint venture attaches to each and every member of the same joint venture.[11] Being permitted to pursue these claims against the ACO may also alter the rules relating to providing individual members of the ACO with pre-suit notice of a medical malpractice claim under Fla. Stat.§766.106.[12] In the case of *King v. Baptist Hospital of Miami, Inc.,*[13] handed down by the Third District Court of Appeal, the Court found that when no pre-suit notice had been served upon the hospital, that pre-suit notice supplied to a physician, *alleged* to have been in a joint venture with a hospital, served as notice to the hospital itself due to the legal relationship created by the alleged joint venture. Because ACOs may stretch across a large geographic area, and will necessarily involve radically diverse specialties, the potential exposure created by the ACO, and perhaps the inability to even be notified of a suit until after it is filed and underway is a disconcerting unintended consequence of this new law.

III. EXPOSURE TO CLAIMS FROM CENTERS FOR MEDICARE AND MEDICAID SERVICES

With continued skyrocketing federal spending and the inherent unsustainability of entitlement programs like Medicare, the Centers for Medicare & Medicaid Services ("CMS") has begun to take aggressive measures to recoup monies paid by CMS on behalf of beneficiaries. Under the Small Business Jobs Act of 2010[14], CMS developed the "Fraud Prevention System" ("FPS"). The FPS was designed using predictive analytics technology to identify and prevent the payment of improper claims by Medicare. Essentially, this program looks both retrospectively at payments made to providers by CMS as well as audits new claims being made by providers to identify claims CMS deems to be made improperly or as a result of "fraud and abuse." CMS, citing the FPS as the first time the government has used predictive technology on a large basis, has already touted the results it has seen in the first year of the program being implemented stating, "The FPS generated leads for 536 new fraud investigations, provided new information for 511 pre-existing investigations, and triggered thousands of provider and beneficiary interviews to verify legitimate items and services were provided to beneficiaries."[15] The empowerment of CMS under PPACA and the Small Business Jobs Act by the federal government may have an interesting interplay with the paradigm shift from fee-for-service to fee-for-performance ushered in by the ACO. As the ACO is required, under §3022, to report on the savings it has provided to CMS, it is altogether possible that the information provided by the practitioners in the group, when used in connection with a review of past claims for services may trigger a review of the past practices of members of the ACO to investigate whether "abuse" may have occurred. CMS has indicated that incidents of "abuse" may include payments to providers that did not "follow good medical practices," or incidents of alleged "over-use of services" including the providing of unnecessary tests.[16] Yet another area of identified "waste" refers to health care that is "not effective."[17] These extraordinarily broad and subjective areas of potential "abuse" by CMS could very well ensnare providers, who prior to joining the ACO are shown to have had a trend of ordering specific tests or therapies more often than after joining the ACO. While the change in practice may be easily explained by the greater efficiency of the network of the professionals due to the ACO, it would certainly not be surprising to the see the federal government attempt to use the very efficiency the ACO is designed to promote as a basis for a claim that pre-ACO activities were unwarranted and unnecessary. Even if CMS does not ultimately require a refund be paid as a result of such an investigation, having a client who is simply the subject of an investigation or even just one of the "thousands of interviews" CMS has cited above, creates exposure to significant losses in the form of time and the expense of representation. If CMS does move forward with an action to recoup funds, then any share of costs savings, realized as a member of the ACO, would almost certainly be negated.

IV. HOW MUCH MORE EFFICIENT CAN AN ACO BE YEAR AFTER YEAR?

One unanswered question that should be considered by any provider that is attempting to project potential benefits of joining an ACO is how benchmarks will

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be set and ultimately met in the years following the first year of implementation. While meeting the CMS benchmark in the first year is an aspiration that many ACOs may easily meet, it will certainly also trigger more stringent benchmarks by CMS seeking even more savings. If the ACO has stripped its operating costs and increased efficiency standards to optimal levels in order to meet year one benchmarks, how then will it continue to save more money for CMS year after year to take advantages of the bonuses paid for such savings? At some point, reason and medical necessity require that certain actions be taken to properly care for all patients and no further reduction of services and, therefore, cost is possible. Attempts to further reduce the cost per capita may only serve to further expose ACO members to the argument of improper care for the sake of savings pointed out at the outset of this article.

Accountable Care Organizations are exciting new creations in our healthcare system. They may offer great benefits to providers who join them, and even greater benefits to patients who will enjoy a more efficient and integrated network of practitioners. However, as with all new models of care, new challenges and new exposure to potential liability will also be created. For healthcare providers and the attorneys who represent them, how those new challenges are met will likely determine the future of the ACO.

Endnotes

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Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).

2 The Act also allows for larger ACOs to include homeless and uninsured in their patient populations. *See Miller, H.D. (2009). "How to Create Accountable Care Organizations." Center for Healthcare Quality and Payment Reform.*

3 *See § 3022 of the Patient Protection and Affordable Care Act.*

4 For a complete discussion on how these averages are set and updated by CMS, *See* McClellan M, McKethan AN, Lewis JL, Roski J, Fisher ES (2010). *A National Strategy to Put Accountable Care Into Practice.* 29. pp. 982-990.

5 Press Release, More Doctors, Hospitals Partner to Coordinate Care for People with Medicare (Jan. 10, 2013); *at_* http://www.hhs.gov/news/press/2013pres/01/20130110a.html.

6 U.S. Centers for Medicare and Medicaid Services (CMS).

7 *Compare*, *Tarpon Springs Hospital Foundation, Inc. v. Reth*, 40 So.3d 823 (Fla.2d DCA 2010) (Holding that applicable statutes and rules did not impose a non-delegable duty on a hospital to provide anesthesia services to surgical patients) *and Wax v Tenet Health Systems Hospitals, Inc.,* 955 So.2d 1 (Fla. 4th DCA 2007) (Holding that a direct theory of liability may be imposed on a hospital for the non-delegable duty of providing non-negligent surgical anesthesia care to patients).

8 858 So.2d 1158 (Fla. 2d DCA 2003).

9 *See id at* 1161.

10 *See Jackson–Shaw Co. v. Jacksonville Aviation Auth.* 8 So.3d 1076, 1089 (Fla. 2008).

11 *See Metric Engineering, Inc. v. Gonzalez*, 707 So.2d 354, 355 (Fla. 3d DCA 1998).

12 Section 766.106, Florida Statutes (2003).

13 87 So.3d 39 (Fla. 3d DCA 2012).

14 15 U.S.C. 631 (2010).

15 *Report to Congress Fraud Prevention System First Implementation Year,* Department of Health & Human Services Centers for Medicare & Medicaid Services (2012).

16 *Health Policy Brief*, Health Affairs July 31, 2012.

17 *Id.*

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Fourth District Court of Appeal agreed, but the patient was already back in Guatemala. Thereafter, the guardian filed suit for false imprisonment related to the transporting of the patient back to Guatemala. *See* Montejo v. Martin Mem'l. Med. Ctr., Inc., 874 So.2d 654 (Fla. 4th Dist. Ct. App. 2004). However, the hospital ultimately prevailed in the false imprisonment suit.

Martin Memorial establishes that a hospital cannot ask a state court judge to order that a patient who refuses to give consent to return to his home country or is unable to give consent be forced to return. There is no reported federal case on this issue and in the wake of this decision, hospitals have begun pursuing other available options to affect a safe discharge in similar situations involving undocumented aliens.

One suggestion is to use the current immigration laws as a sword – attempting to prompt U.S. Immigration & Customs Enforcement (ICE) to take action to investigate the patients and initiate deportation proceedings. An underlying issue in many of these cases, though, is how the hospital determines that the patient is in the country illegally and what the hospital can do with that information, considering, federal and state patient privacy laws. The Health Insurance Portability and Accountability Act (HIPAA) and its state counterparts are extremely protective of hospital records and make no exception for release of information contained therein for immigration-related matters. In our experience, Immigration and Customs Enforcement (ICE) has not been very interested in intervening to investigate these types of cases. Some health care attorneys have recently suggested filing an action seeking a writ of mandamus to force the federal government to act. To date there are no reported cases regarding this remedy.

The lack of interest by ICE makes the second scenario described above, relating to pregnant women from foreign countries coming to the U.S. to deliver their babies so they become automatic American citizens, almost impossible to resolve.

When hospitals are faced with these issues, a case by case analysis is needed. At this time, it appears that these matters can be most easily resolved by facilitating transport of the patient back to his or her home country, but this can only be accomplished easily with the consent of the patient. Although the transportation costs add to the hospital's expense, many hospitals will find this option much less expensive than providing uncompensated care to the patient for an extended period of time.

Endnotes

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1 Effective July 1, 2010, the Agency for Health Care Administration (AHCA) instituted a new "stabilization" standard to determine whether it would reimburse hospitals for the services they provide to undocumented aliens to treat an emergency medical condition. This rule was subsequently challenged by approximately twenty hospitals in an attempt to invalidate the new "stabilization standard" based on AHCA's failure to appropriately follow rulemaking procedures. On December 24, 2012, the Division of Administrative Hearings (DOAH) issued a Final Order invalidating AHCA's new "stabilization standard" as an unadopted rule and ordered AHCA to cease any reliance upon this unadopted rule. Though AHCA has announced its intention to appeal this Final Order, many industry experts believe that the findings of fact in the Final Order are well supported in the record and the conclusions of law are in accordance with Florida law. In the event that AHCA does not overturn DOAH's Final Order on appeal, all hospitals will stand to benefit from this ruling.

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First, one of EMRs biggest threats to the practice of medicine is its potential to expose physicians and healthcare facilities to additional malpractice liabilities that do not exist with paper records.[9] There are numerous potential liabilities and complications faced by physicians who switch from paper records to EMRs. Most notably, the transition to an electronic form requires proper implementation and significant training in the use of EMRs.[10] This translates to more costs as doctors and their staff are required to undergo expensive training on the use of their particular EMR systems.[11] And because there are so many EMR systems available for purchase, each with their own nuances, it may require training on the use of other EMR systems as well. It also may require the implementation of additional safeguards to ensure that mistakes do not occur.[12]

Doctors and healthcare facilities face the greatest risk of liability during the period of transition from paper to electronic form.[13] Mistakes are likely to occur during this adjustment period, as doctors and their staff learn the intricacies of the EMR system. Mistakes in using these new systems, including documentation errors, raise the risk of liability for physicians and healthcare facilities, at least in the short term.[14] As the healthcare field adjusts, researchers suggest that this risk of liability will actually decrease.[15] Researchers point to improved accuracy and ease of access to all patient information as just some of the reasons why medical liability will actually decrease as EMRs become standard in the field.[16]

While ease of access to patient information is a significant benefit to the transition to EMRs, it also poses a huge privacy and security concern - the risk of data breaches.[17] Patient information is now more vulnerable than ever to those wishing to hack into EMR systems to access medical histories, social security information, prescription records, and much more private patient information.[18] By transitioning to electronic form, patient information is now susceptible to hackers who can more easily access, and thus steal, a patient's entire medical record with the click of a few buttons. As a result, physicians and healthcare facilities may be held legally responsible for such privacy intrusions.[19] They may also be required to prevent against such security and privacy threats by purchasing protective software, but the full extent of this duty remains unclear.

While the threats to patient security and the risks involved for healthcare providers are great, laws such as the Health Insurance Portability and Accountability Act (HIPAA) were designed to tighten privacy and protect patient healthcare information from such breaches.[20] In addition, the American Recovery and Reinvestment Act (ARRA), which calls for a transition to EMRs by 2014, broadens privacy protections and strengthens patients' rights in the case of a breach of security by offering civil penalties and increasing enforcement provisions.[21] Under the provisions of ARRA, patients have the right to obtain a list of incidences in which their records were copied, exchanged, or released.[22] This measure offers patients more security in the way their EMRs are handled, but in turn

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creates more liability for physicians and healthcare providers.

Additionally, ARRA incentivizes healthcare providers to adopt EMR systems. "ARRA creates funding mechanisms for incentives to be paid directly to hospitals and physician practices that adopt and have 'meaningful use' of electronic medical records by 2014."[23] Conversely, the Act also imposes penalties for those healthcare providers who choose not to make the switch to EMRs.[24] It should be noted that while there are monetary incentives to adopting EMRs, those incentives may not cover the entire costs of the transition to EMRs. Thus, healthcare providers are left to voluntarily adopt EMRs.[25]

The biggest risk of liability to doctors and healthcare facilities lies in the information contained in the EMR itself. The electronic form of the medical record may contain far more detailed patient information than any paper file[26], especially if those records include those of other doctors and facilities. More detailed patient information may give doctors a better opportunity to make fully-informed decisions regarding patient care, but it also greatly increases a doctor's exposure to liability if he is required to go through a patient's entire medical history.[27] Since medical histories may span many years, important information may be small or difficult to recognize, and this failure to recognize may expose the doctor to greater liability for malpractice.[28] This point is more fully discussed in the next section.

In addition, more detailed information could make it easier for malpractice attorneys to use EMRs against physicians. Paper records do not offer attorneys the information that was available to the provider at the time the care was rendered.[29] Through the use of EMR systems, malpractice attorneys may be able to determine what information was available to a healthcare provider at the moment he consulted the EMR.[30] This can be done by mining the metadata embedded in EMRs to determine the state of the chart at the time the diagnosis was made.[31] This offers malpractice attorneys a unique and powerful tool both in the pursuit and defense of medical malpractice cases.

Second, the additional liabilities exposure as a result of EMRs has the potential to increase the number of medical malpractice lawsuits filed, as well as the potential to change the course of medical malpractice litigation.[32] "Beyond boosting the mere risk of lawsuits, EMRs also affect the course of such litigation by increasing the availability of data and documentation that can either defend or prove a malpractice claim."[33] EMRs are better organized, more detailed, and more legible than most paper records. Healthcare providers can describe in great detail a comprehensive patient examination using a few keystrokes and predesigned templates.[34] The wealth of information contained in EMRs may give healthcare providers information necessary to form a better diagnosis; however, it also has the potential to downplay or hide critical patient information.[35] This information can be easily overlooked by healthcare providers when scanning medical histories, especially when

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embedded in pages of boilerplate, thus greatly increasing the risk of malpractice and in effect, the number of lawsuits filed.[36]

In addition, courts will be required to determine previously unaddressed evidentiary issues, most notably the question of what constitutes a legal record.[37] Since EMRs contain more detailed patient information than paper records, when a plaintiff's attorney makes a request for the production of a patient's EMR, the court will need to address what constitutes the entire legal medical record – is it all the information stored in its electronic form, or is it the paper equivalent to the electronic record? Courts will struggle to define this and other evidentiary issues as creative malpractice attorneys challenge the use and production of EMRs.

Quite possibly the greatest impact of EMRs in the course of medical malpractice litigation may lie in its potential to change the standard of care for healthcare providers.[38] The most significant impact of the transition to EMRs is its potential to raise the standard of care for healthcare providers and healthcare facilities *whether or not they choose to adopt EMRs*.[39] Liability may result from mistakes in using the system itself, for example, by failing to perform all of the steps necessitated by the use of EMRs or by failing to spot something in a patient's potentially complex medical history.[40] Healthcare providers may face more liability if they are required to consult a potentially incomprehensible and complex EMR, especially one that combines multiples records across multiple providers and facilities, since problems could be small and difficult to recognize and charts could span years and even decades.[41]

Additionally, the failure to use EMRs at all when the technology is so readily available may be the basis of a plaintiff's claim for a deviation from the standard of care.[42] For example, a patient may sue his healthcare provider for failing to use the EMR system to find some piece of pertinent patient information that would have allowed the healthcare provider to make a proper, or better, diagnosis.[43] "When an EMR could, arguably, have avoided an adverse result, trial lawyers will be arguing that physicians were obligated to use this technology.[44] As the EMR technology becomes pervasive, failure to use it to avoid medical errors may also lead to malpractice claims."[45] If EMRs change the standard of care for those healthcare providers based on their failure to adopt such systems, then the transition to EMRs is not truly voluntary and those providers are left at a disadvantage. It appears inevitable that EMRs will eventually "become the 'standard of care.'"[46]

Finally, it should be noted that an even more complex problem could exist in the potential for complicated third party claims.[47] For example, imagine Doctor A fails to include a piece of important patient information in an EMR. Doctor B, without knowledge of this failure, relies on the EMR to make a diagnosis which ultimately results in a malpractice case against him. Can Doctor B file a claim against Doctor A, asserting that Doctor A is actually at fault for his failure to include such information? That in effect, Doctor B would have made a better diagnosis had he been given such information? The possibility of third-party claims against the original provider may ultimately lead to numerous cross claims and thus many legal complications.[48]

The transition from paper records to EMRs and its lasting effects on medical malpractice law as it relates to both the medical and legal fields remains unknown as researchers continue to study its impact on the number of cases litigated and the corresponding evidentiary issues. Doctors will continue to face new liabilities as they transition to EMRs, but those liabilities may lessen in time as EMRs improve the practice of medicine and eventually become the standard of care. Only time will tell whether the benefits of transitioning to EMRs will truly outweigh the potential risks to doctors, hospitals, and patients alike.

Endnotes

1 * Alyssa Mason is an attorney at Kirwin Norris in Orlando, Florida. She can be reached via email at amm@kirwinnorris.com.

Shana Campbell Jones, Joseph McMenamin & David C. Kibbe, *Analyzing the Laws, Regulations, and Policies Affecting FDA-Regulated Products: The Interoperable Electronic Health Record: Preserving Its Promise by Recognizing and Limiting Physician Liability,* 63 Food & Drug L.J. 75, 83 (2008).

2 Alicia Gallegos, *Legal Risks of Going Paperless*, American Medical News, Mar. 5, 2012, www.ama-assn.org/amednews/2012/03/05/prsa0305.htm.

3 Blake Carter, Note, *Electronic Medical Records: A Prescription for Increased Medical Malpractice Liability?*, 13 Vand. J. Ent. & Tech. L. 385, 385 (2011).

4 *Id.*

5 *Id.*

6 Steven I. Kern, *Hidden Malpractice Dangers in EMRs,* MedScape Business of Medicine, Dec. 3, 2010, www.medscape.com/viewarticle/589724.

7 Molly Gamble, *5 Legal Issues Surrounding Electronic Medical Records*, Becker's Hospital Review, Jan. 19, 2012, www.beckershospitalreview.com/legal-regulatory-issues/5-legal-issues-surrounding-electronic-medical-records.html.

8 *Id.*

9 Neil Versel, *Electronic Records May Increase Malpractice Lawsuit Risk*, Information Week, Oct. 25, 2011, www.Informationweek.com/healthcare/electronic-records-may-increase-malpract/231901621.

10 Carter, *supra* note iii, at 398.

11 *Id.*

12 *Id.*

13 Gallegos, *supra* note ii.

14 *Id.*

15 *Id* (citing a study released by Conning Research and Consulting in which researchers found that EMRs created easier access for attorneys, translating to an increase in the number of malpractice suits filed).

16 *Id.*

17 *Id.*

18 *Id.*

19 *Id.*

20 Kelly Mclendon, *Electronic Records for All Patients Mandated by 2014,* CentralFlorida-Medicine.Com, Aug. 3, 2009, www.spacecoastmedicine.com/2009/08/electronic-records-for-all-patients-mandated-by-2014.html.

21 *Id.*

22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.*

26 Gamble, *supra* note vii.

27 Jones et al., *supra* note i, at 83.

28 *Id.*

29 Versel, *supra* note ix (referencing a report conducted by the AC Group, a Montgomery, Texas, health IT research and consulting firm, which found that EMRs expose physicians and healthcare facilities to risks unknown before its introduction).

30 *Id.*

31 *Id.*

32 Gamble, *supra* note vii.

33 *Id.*

34 Versel, *supra* note ix.

35 *Id.*

36 *Id.*

37 Gamble, *supra* note vii.

38 Carter, *supra* note iii, at 395-401.

39 *Id.* at 395-96.

40 Jones et al., *supra* note i, at 83.

41 Versel, *supra* note ix.

42 Carter, *supra* note iii, at 398.

43 *Id.*

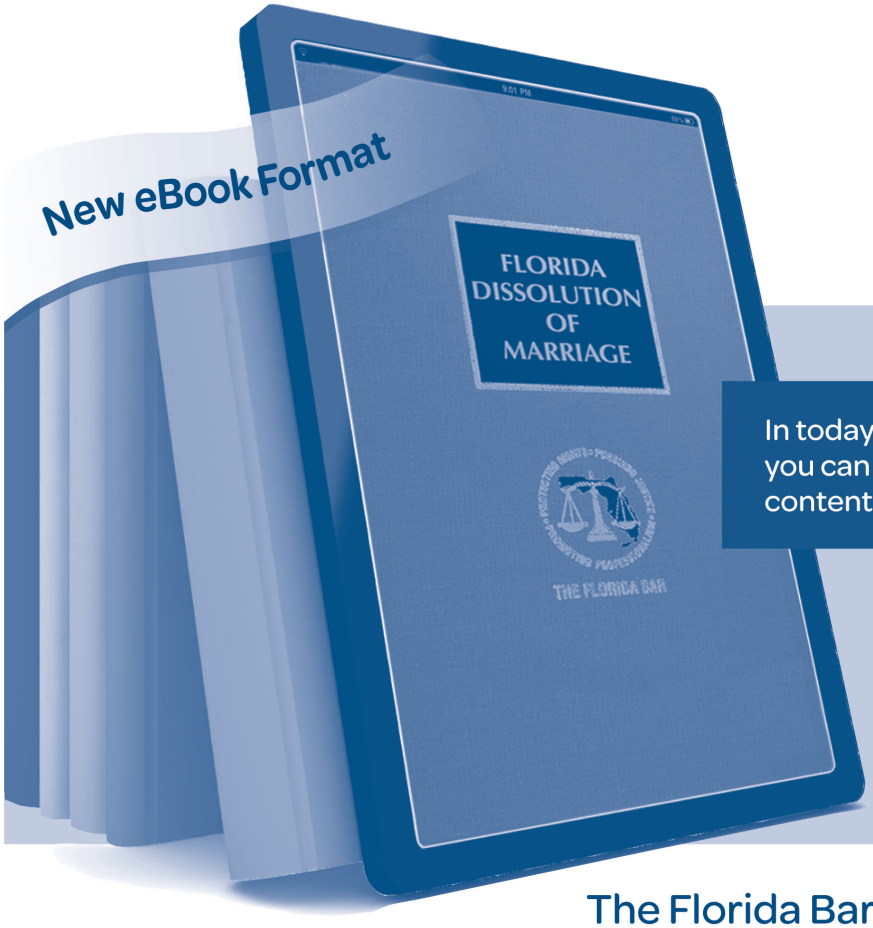
44 Versel, *supra* note ix.

45 *Id.*

46 *Id.*

47 Carter, *supra* note iii, at 399.

48 *Id.*



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