FUNDAMENTALS OF HEALTH CARE LAW

6.5 CLE Hours Including
1.5 Ethics Hour | 1 Professionalism Hour | 1 Trial Practice Hour

Sponsored By: Institute of Continuing Legal Education
Who are we?

**SOLACE** is a program of the State Bar of Georgia designed to assist those in the legal community who have experienced some significant, potentially life-changing event in their lives. SOLACE is voluntary, simple and straightforward. SOLACE does not solicit monetary contributions but accepts assistance or donations in kind.

How does SOLACE work?

If you or someone in the legal community is in need of help, simply email SOLACE@gabar.org. Those emails are then reviewed by the SOLACE Committee. If the need fits within the parameters of the program, an email with the pertinent information is sent to members of the State Bar.

What needs are addressed?

Needs addressed by the SOLACE program can range from unique medical conditions requiring specialized referrals to a fire loss requiring help with clothing, food or housing. Some other examples of assistance include gift cards, food, meals, a rare blood type donation, assistance with transportation in a medical crisis or building a wheelchair ramp at a residence.

Contact SOLACE@gabar.org for help.
The purpose of the SOLACE program is to allow the legal community to provide help in meaningful and compassionate ways to judges, lawyers, court personnel, paralegals, legal secretaries and their families who experience loss of life or other catastrophic illness, sickness or injury.

TESTIMONIALS

In each of the Georgia SOLACE requests made to date, Bar members have graciously stepped up and used their resources to help find solutions for those in need.

A solo practitioner’s quadriplegic wife needed rehabilitation, and members of the Bar helped navigate discussions with their insurance company to obtain the rehabilitation she required.

A Louisiana lawyer was in need of a CPAP machine, but didn’t have insurance or the means to purchase one. Multiple members offered to help.

A Bar member was dealing with a serious illness and in the midst of brain surgery, her mortgage company scheduled a foreclosure on her home. Several members of the Bar were able to negotiate with the mortgage company and avoided the pending foreclosure.

Working with the South Carolina Bar, a former paralegal’s son was flown from Cyprus to Atlanta (and then to South Carolina) for cancer treatment. Members of the Georgia and South Carolina bars worked together to get Gabriel and his family home from their long-term mission work.

Contact SOLACE@gabar.org for help.
Dear ICLE Seminar Attendee,

Thank you for attending this seminar. We are grateful to the Chairperson(s) for organizing this program. Also, we would like to thank the volunteer speakers. Without the unflinching dedication and efforts of the Chairperson(s) and speakers, this seminar would not have been possible. Their names are listed on the AGENDA page(s) of this book, and their contributions to the success of this seminar are immeasurable.

We would be remiss if we did not extend a special thanks to each of you who are attending this seminar and for whom the program was planned. All of us at ICLE hope your attendance will be beneficial as well as enjoyable. We think that these program materials will provide a great initial resource and reference for you.

If you discover any substantial errors within this volume, please do not hesitate to inform us. Should you have a different legal interpretation/opinion from the speaker’s, the appropriate way to address this is by contacting him/her directly.

Your comments and suggestions are always welcome.

Sincerely,
Your ICLE Staff

Jeffrey R. Davis
Executive Director, State Bar of Georgia

Tangela S. King
Director, ICLE

Rebecca A. Hall
Associate Director, ICLE
AGENDA

Presiding:
Rod G. Meadows, Program Chair, Meadows, Macie & Sutton, P.C., Stockbridge

7:45  REGISTRATION AND CONTINENTAL BREAKFAST (All attendees must check in upon arrival. A removable jacket or sweater is recommended.)

8:15  WELCOME AND UPDATE
Lynn M. Adam, Chair, Health Law Section; Khayat Law Firm, Atlanta

8:20  WELCOME
Joseph R. “Rusty” Ross, Chair, Georgia Academy of Healthcare Attorneys; Morris Manning & Martin LLP, Savannah

8:25  INTRODUCTION AND PROGRAM OVERVIEW
Rod G. Meadows

8:30  FEDERAL HEALTHCARE REGULATIONS
( Including Ethical Considerations)
Robert M. Keenan, III, King & Spalding LLP, Atlanta
Charlotte A. Combre, BakerHostetler LLP, Atlanta
Jonathan L. Rue, Parker Hudson Rainer & Dobbs LLP, Atlanta

10:00  BREAK

10:15  STATE HEALTHCARE REGULATIONS
Kathlynn Butler Polvino, KBP Law, P.C., Atlanta
Rachel L. King, Georgia Department of Community Health, Atlanta
John W. Ray, Ray & Gregory LLC, Atlanta
Roxana D. Tatman, Georgia Department of Community Health, Atlanta

11:30  THE CRIMINAL SIDE OF HEALTHCARE LAW
Brian F. McEvoy, Polsinelli PC, Atlanta

12:00  LUNCH AND PRESENTATION (Lunch included in registration fee.)
LEGENDS OF GEORGIA HEALTHCARE LAW HOW PROFESSIONALISM DEVELOPED IN GEORGIA HEALTHCARE LAW
Moderator: Richard D. Sanders, The Sanders Law Firm PC, Atlanta
Randy Hughes
Kevin E. Grady, Alston & Bird LLP, Atlanta
Richard L. “Rick” Shackelford, Attorney at Law, Atlanta
Robert Miller

1:15  MEDICAL MALPRACTICE LITIGATION:
PLAINTIFF’S PERSPECTIVE
James H. Webb, Jr., Webb & Taylor LLC, Peachtree City

1:45  MEDICAL MALPRACTICE LITIGATION:
DEFENDANT’S PERSPECTIVE
Robert G. Tanner, Weinberg Wheeler Hudgins Gunn & Dial LLC, Atlanta
2:15  **BREAK**

2:30  **HOSPITAL MERGERS AND ACQUISITIONS**
*Michelle A. Williams,* Alston & Bird LLP, Atlanta  
*W. Wright Banks, Jr.*, Deputy Attorney General, Georgia Attorney General’s Office, Atlanta  
*Bridget Bourgeois*, Ernst & Young, Atlanta

3:00  **THE TOP THREE HEALTHCARE ISSUES FOR VARIOUS SUB-SPECIALISTS**
- Hospitals  
  *Christie D. Jordan,* Southeast Georgia Healthcare System, Brunswick  
- Mental Health  
  *Robert B. Remar,* Rogers & Hardin LLP, Atlanta  
- Long Term Healthcare  
  *Brittany H. Cone,* Hall Booth Smith PC, Atlanta

4:00  **ADJOURN**
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>V</td>
</tr>
<tr>
<td>Agenda</td>
<td>VII</td>
</tr>
<tr>
<td>Fundamentals of Health Care Law</td>
<td>9-276</td>
</tr>
<tr>
<td>Appendix:</td>
<td></td>
</tr>
<tr>
<td>ICLE Board</td>
<td>1</td>
</tr>
<tr>
<td>Georgia Mandatory CLE Fact Sheet</td>
<td>2</td>
</tr>
</tbody>
</table>
8:15 WELCOME AND UPDATE
Lynn M. Adam, Chair, Health Law Section; Khayat Law Firm, Atlanta
8:20  WELCOME
Joseph R. “Rusty” Ross, Chair, Georgia Academy of Healthcare
Attorneys; Morris Manning & Martin LLP, Savannah
8:25  INTRODUCTION AND PROGRAM OVERVIEW
Rod G. Meadows
8:30  **FEDERAL HEALTHCARE REGULATIONS**  
(Including Ethical Considerations)  
*Robert M. Keenan, III*, King & Spalding LLP, Atlanta  
*Charlotte A. Combre*, BakerHostetler LLP, Atlanta  
*Jonathan L. Rue*, Parker Hudson Rainer & Dobbs LLP, Atlanta
Cybercrime Case Study
Georgia Fundamentals of Health Care Law
Rob Keenan
March 1, 2017

In order to meet “meaningful use” requirements, ABC Hospital has established an online patient portal to allow patients to remotely access the patient’s medical information stored in the hospital’s electronic health record. ABC Hospital’s IT department has installed a variety of technical measures to protect against unauthorized access to the EHR and is constantly monitoring for any indication of a compromise to the EHR.

Early one morning, the Hospital’s intrusion detection system records a potential unauthorized intrusion event that triggers an e-mail alert to ABC Hospital’s Chief Information Officer. The CIO gathers the IT staff to investigate. Within 12 hours of the alert, the IT staff has found forensic evidence indicating that an unauthorized person using compromised access credentials for a Hospital employee appears to have had access to over 1,000 patient records, including both detailed health information and social security numbers.

The CIO contacts ABC Hospital’s Chief Compliance Officer who also serves as the Hospital’s Chief Privacy Officer. The Chief Privacy Officer in turn contacts the General Counsel, and the three meet to discuss the potential breach situation. The CIO reports the facts described above. The Chief Privacy Officer and General Counsel agree to initiate the breach notification process by identifying the affected individuals, organizing contact information and preparing a draft notification letter.

The General Counsel and Chief Privacy Officer contact the CEO to brief her on the emerging situation. The Chief Privacy Officer goes over the requirements of the HIPAA breach notification rule, including the presumption of breach, the risk assessment factors and the obligation to furnish notice to individuals without unreasonable delay. The Chief Privacy Officer also advises the CEO that because more than 500 individuals may have been affected, ABC Hospital also will be required to notify prominent media outlets regarding the breach.

“This is a disaster,” says the CEO. “We do NOT need this kind of publicity. Do we know for sure that this hacker was able to download the information? And even if he did, do we know for sure that he’s going to disclose it to anybody else or use it for identity theft? It could be one of those geeks who do this for kicks just because they can, but without intending to harm anybody.”

“I think we need to get the notices out right away,” says the Chief Privacy Officer. “The risk is just too high. We’ll have the letters ready to go by the end of the day tomorrow, and we just can’t wait.”

The CEO turns to the General Counsel. “I want to give this a few days to see if we can get a better handle on what happened. Isn’t there some way we can investigate this, do a forensic analysis, or something? This is going to hurt us badly in the marketplace, and I don’t want to go public on this until we absolutely have to.”
(Discussion Points next page)

Discussion Points:

1. As the general counsel, your privacy officer says that breach notifications have to be sent out immediately, but your CEO is directing you to hold off pending an investigation. What do you do?

2. You conclude that there is a reasonable basis to delay notification pending an investigation. You attended a CLE and remember that an Assistant U.S. Attorney and FBI Special Agent who specialize in cybercrime issues spoke on a panel. You have their contact information and decide to call them to report the incident.

3. You have enlisted the support of the FBI and the U.S. Attorney’s Office to help investigate the suspected hacking incident, but several days have passed. The privacy officer comes by your office several times a day, checking on status, and urging you to authorize sending of the breach notifications. About 3 days in, during a status report meeting with the CEO, CIO and privacy officer, the privacy officer blurts out: “That’s it. We’ve waited too long. I can’t tolerate this anymore. Either the notices go out by the end of the day tomorrow or I’m calling the OCR and the media myself!” The privacy officer storms out.

   The CEO says: “You know, he’s not really a team player. And he’s not very good in a crisis. Can we fire him?” she asks.

4. After a week passes, you are starting to find yourself aligned with the privacy officer. You call the Assistant U.S. Attorney and let him know that unfortunately you will be needing to get notifications out asap. The AUSA asks you to delay notifications because the AUSA believes that notifications would impede the investigation.

5. You end up delaying notifications at the request of the U.S. Attorney’s office based on the U.S. Attorney’s view that notifications would impede a criminal investigation. Another week passes. Then, you get a call from the Assistant U.S. Attorney. The hacker has been identified, and he’s a member of known identity theft ring. You inform the CEO that it’s now unequivocally time to make the HIPAA required breach notifications. The CEO still refuses to follow your legal advice. How should you proceed?
Potentially Applicable Georgia Rules of Professional Conduct:

Rule 1.2  Scope of Representation and Allocation of Authority Between Client and Lawyer.

Rule 1.6  Confidentiality of Information.

Rule 1.13  Organization as Client.

Rule 1.16  Declining or Terminating Representation.

Others?
AN INTRODUCTION TO HIPAA AND THE STARK LAW

Fundamentals of Health Care Law
March 1, 2018

Rob Keenan
King & Spalding LLP
(404) 572-3591 (voice)
(404) 572-5132 (fax)
rkeenan@kslaw.com

Mass Hacking Incidents Have Become Commonplace

- Cybercriminals increasingly are targeting health data.
- Healthcare data are perceived as **vulnerable**:
  - Goals of consumer access and sharing among healthcare providers increase access points for cybercriminals.
- Healthcare data are **valuable**:
  - Used to make false insurance claims in addition to identity theft.
  - May be worth ten times the value of credit card numbers alone on the black market.
“Health Insurance Portability and Accountability Act of 1996”
Administrative Simplification

- Privacy
- Security
- Breach Notification
- Major statutory changes passed as part of stimulus bill signed into law February 17, 2009 (Pub. Law 111-005, Title XIII, Subtitle D; 42 U.S.C. § 17921 et seq.) (the “HITECH Act”).

HIPAA Administrative Simplification

- Applies to the following “covered entities”:
  - Health plans (including group health plans).
  - Health care providers that transmit any health information electronically in connection with a HIPAA-regulated health care financing transaction.
  - Health care clearinghouses.
- Applies directly to “business associates” as per HITECH and HITECH regulations.
**Business Associate Contracts**

Performs or assists in the performance of a covered entity function or activity; or

or

Performs certain services to or for a covered entity;

and

Creates, receives, maintains or transmits PHI

Includes subcontractors of business associates as a result of HITECH regulations.

---

**Privacy Regulation – Scope**

- Applies to covered entities and business associates with regard to “protected health information” or “PHI”

- PHI is individually identifiable information created/received by a covered entity (including demographic information) that relates to:
  - the provision of health care to an individual, or
  - the past, present or future physical or mental health or condition or payment for health care of an individual
Basic Privacy Rule Requirement

Cannot use or disclose PHI except as permitted or required by regulations.

Permitted Uses and Disclosures

• Without “authorization”
  – Treatment, payment and health care operations (TPO)
  – “National priority” purposes, such as for regulatory oversight of government healthcare programs, law enforcement and state law reporting obligations
  – Other specified purposes

• Otherwise, need the individual’s specific, written authorization.
Key Compliance Obligations

- Policies and procedures.
- Training.
- Minimum necessary use/disclosure.
- Business associate agreements.
- Administration of individual rights (access, amendment, accounting).
- Notice of privacy practices.
- State law – including in Georgia a constitutional right of privacy when health information is requested on behalf of the government.

Security Rule - Generally

- Applies to PHI transmitted or maintained electronically.
- Designed to ensure confidentiality, integrity and availability of electronic PHI.
- Key starting point is a security risk assessment.
- Compliance measures should be tailored to identified risks.
**Categories of Specific Security Measures**

- Administrative safeguards (overall security management process, workforce security, workforce training, sanctions mechanism).
- Physical safeguards (facility access, workstation security, device and media controls).
- Technical safeguards (unique user ID, automatic logoff, audit controls, data integrity mechanisms).
- Organizational requirements (business associate agreements).
- Policies and procedures/documentation.

---

**HITECH Act - Breach Notification**

42 U.S.C. § 17932
45 C.F.R. § 164.400 et seq.

- A CE that discovers a breach of “unsecured” PHI shall notify affected individuals.
- “Unsecured” PHI means PHI that is not secured through use of a technology/methodology listed in guidance issued by HHS.
  - Focus is on encryption and destruction.
HITECH Act - Breach Notification

• “Breach” originally defined to mean an unauthorized acquisition, access, use or disclosure of PHI that poses a significant risk of financial, reputational or other harm to the individual.

HITECH Act - Breach Notification

• As revised in the HITECH regulations, “breach” is presumed, unless the CE or BA determines that there is a low probability that the PHI has been compromised based on a risk assessment, to include at least the following:
  – Nature and extent of PHI involved;
  – Unauthorized person who accessed or received PHI;
  – Whether PHI actually was acquired or viewed; and
  – Extent to which risk has been mitigated.
HITECH Act - Breach Notification

- Notice to individuals w/o unreasonable delay and not later than 60 days after discovery.
- Media notice required if breach involves more than 500 residents of a state or jurisdiction (meaning a geographic area smaller than a state, such as a county, city or town).
- Must report to HHS at least annually, but promptly if breach involves 500 or more.
- A BA must give notice to its covered entity.
- HHS publishes on its website a list of entities suffering breaches applicable to 500 or more.

HITECH Act - Breach Notification

- Content of notice to individuals:
  - dates of breach and discovery
  - description of what happened
  - description of types of information involved
  - steps individuals should take to protect themselves
  - description of covered entity’s remedial actions
  - contact information for individuals to learn more
- May need to coordinate with notice required by state law.
Administrative Simplification Penalties and Enforcement

- Civil money penalties.
- Criminal fines and imprisonment.
- Interpretation/enforcement of privacy and security rules delegated to HHS Office for Civil Rights (“OCR”).

HITECH Act - Improved Enforcement

- Enhanced civil penalties:
  - unknowing violations: $100-$50,000 per violation
  - violations due to reasonable cause: $1,000-$50,000 per violation
  - violations due to willful neglect that are corrected: $10,000-$50,000 per violation
  - violations due to willful neglect that are not corrected: min. $50,000 per violation
- All violations are subject to calendar year penalty maximums of up to $1.5 million for violations of an identical requirement.
Recent Settlements – OCR Allegations

- Health care provider ($3.5 million) (Feb. 2018): Multiple breaches triggered by various causes; lack of an accurate and thorough risk assessment.
- Health care provider ($2.3 million) (Dec. 2017): Failure to implement suitable measures after FBI notification that patient information was illegally obtained, compromising the information of over 2 million individuals.
- Hospital ($387,000) (May 2017): Disclosure of an individual’s HIV information to the individual’s employer.
- Wireless health services provider ($2.5 million) (April 2017): Stolen laptop containing PHI of 1,391 individuals; entity failed to adopt and implement policies and procedures.
- Health care provider ($31,000) (April 2017): No business associate agreement.
- Federally qualified health center ($400,000) (April 2017): Hacker accessed information of 3,200 patients; no risk assessment conducted prior to breach.

HIPAA Compliance Areas of Focus

- Electronic security
  - Conduct risk assessment
  - Implement compliance measures mapped to security rule requirements and focused on identified risks
  - Encrypt portable devices and media
  - Implement anti-intrusion measures
- Workforce training and awareness
- Contractor diligence
- Insurance
- Incident response
HIPAA – Previews of Coming Attractions

• More cyber attacks.
• More routine OCR compliance audits.
• More OCR complaint/breach investigations, with higher dollar-value settlements.
• More private litigation:
  – Courts routinely hold that there is no private right of action under HIPAA, but
  – Affected individuals bring state law tort lawsuits using HIPAA to establish the standard of care.

OCR Website

• www.hhs.gov/ocr/hipaa/
Federal “Stark” Law

- Originally applied only to referrals for clinical laboratory services (“Stark I”).
- Expanded to apply to 10 additional categories of health services effective Jan. 1, 1995 (“Stark II”).
- CMS: The Stark law embodies a Congressional determination to discourage physicians from having financial relationships with entities to which they refer Medicare patients.
- Recent judicial decisions have applied Stark to Medicaid.

Federal Stark Law

- Unless an exception applies, the Stark Law prohibits a physician from:
  - making a referral
  - to an entity
  - for the provision of “designated health services” covered in whole or in part by Medicare (“DHS”) (has been held by courts to apply also indirectly to Medicaid)
  - when the physician (or immediate family member) has a financial relationship with the entity.
Federal Stark Law - Referral

- The term “referral” includes:
  - request by a physician for, the ordering of or the certifying or recertifying the need for a DHS item or service; or
  - establishment of a plan of care by a physician that includes the provision of DHS.
- Exception to “referral” definition for services of pathologists, radiologists and radiation oncologists, when ordering a service pursuant to a consultation requested by another physician.

Federal Stark Law - DHS

- Clinical lab
- PT, OT, and speech-language pathology
- Radiology and other imaging services
- Radiation therapy services and supplies
- DME and supplies
- Parenteral/enteral nutrients, equipment and supplies
- Prosthetics, orthotics and supplies
- Home health
- Outpatient Rx drugs
- Inpatient and outpatient hospital services
### Selected Entities That Provide Stark DHS

- Hospitals
- Diagnostic imaging centers
- Clinical laboratories
- Physicians and physician groups
- Pharmacies
- Home health agencies
- Physical therapy clinics

### Federal Stark Law - Financial Relationships

- **Ownership interests include:**
  - equity (including stock, LLC memberships, partnership interests, etc.)
  - debt (including loans, bonds or other instruments secured in whole or in part with an entity’s property or revenue)

- **Compensation arrangements include:**
  - Employment
  - Independent contractor services arrangements
  - Space/equipment leases
  - Sale/purchase transactions
  - Stock options/convertible securities
Direct and Indirect Financial Relationships

- The Stark Law applies to all ownership relationships—regardless of the number of links in the ownership chain.
- The same is not true for compensation arrangements.
  - Stark regulates direct and “indirect” compensation arrangements.
  - A direct compensation arrangement exists if there is a compensation arrangement between a referring physician and a DHS entity (like a hospital) with no intervening person or entity.
  - *Bona fide* physician owners of a physician practice “stand in the shoes” of the physician practice—removing the practice as an “intervening entity.”
  - Some relationships with intervening entities between the physician and the DHS entity are not regulated by Stark at all.

Federal Stark Law - Exceptions

- If there is a Stark-regulated financial relationship, a physician cannot refer to an entity for the provision of DHS, unless the arrangement meets all requirements of an applicable exception.
- Three categories of exceptions, as applicable to:
  - Both ownership and compensation.
  - Ownership only.
  - Compensation arrangements only.
Stark Exceptions Applicable to Both Ownership and Compensation

These include (among others):

• In-office ancillary services (key in the physician practice setting).
• Academic medical centers.
• Certain preventive screening tests.
• Eyeglasses and contact lenses following cataract surgery.
• EPO and other dialysis-related drugs.

Stark Exceptions Applicable to Ownership Only

These include:

• Publicly-traded securities.
• Mutual funds.
• Rural providers.
• Hospitals in Puerto Rico.
• Ownership in a “whole” hospital.
  – Limited by Affordable Care Act to grandfathered status.
Stark Exceptions Applicable to Compensation Arrangements Only

These include (among others):
• Rental of office space or equipment.
• Employment.
• Personal services arrangements.
• Physician recruitment.
• Certain “isolated” business transactions.
• Fair market value compensation.

Typical Compensation Arrangement Exception Requirements

• Arrangement is set forth in a writing signed by the parties.
• Compensation terms are set in advance.
• Compensation is consistent with fair market value without taking into account the volume or value of physician referrals to the entity.
• Arrangement is commercially reasonable in the absence of physician referrals to the entity.
**Key Prohibitions and Sanctions**

- Physician cannot make a DHS referral to an entity with which the physician has a prohibited financial relationship.
- The entity cannot bill for DHS provided pursuant to a prohibited referral.
- Civil money penalty of up to $15,000 per service for presenting or causing to be presented a claim that the person knows or should know is prohibited.
- Potential for exclusion from government health care programs.

**Stark Issues and Risks – Generally**

- Must satisfy all elements of an applicable exception.
- Strict liability – intent not relevant.
- Potential for “technical” violations.
- Financial consequences can be drastic.
- Stark violations are a natural predicate for federal False Claims Act (“FCA”) actions.
- Current FCA challenges are focused on fair market value and commercial reasonableness of physician compensation.
- Remember the federal anti-kickback statute and state law.
Selected Stark Settlements

- $4 million (Sept. 2017) – Allegations that hospital charged below market rent and furnished non-cash benefits to physician organization.
- $34 million (May 2017) – Allegations of excessive wRVU-based physician compensation.
- $17 million (July 2016) - Allegations related to practice acquisitions and employment of 28 physicians.
- $72.4 million (Oct. 2015) – Settlement of $237.4 million judgment after jury verdict.
  - Former CEO also paid $1 million and excluded for 4 years.
- $69.5 million (Sept. 2015) – Alleged physician compensation in excess of fair market value.
- $118.7 million (Sept. 2015) – Allegations of excessive physician compensation.


- Newly promulgated exceptions:
  - Timeshare arrangements
  - Assistance for recruitment of non-physician practitioners
- Revised exceptions/guidance:
  - Retention payments to physicians in underserved areas
  - Geographic area for physician recruitment by FQHCs and RHCs
  - Ownership of publicly traded securities
  - Physician ownership of hospitals
- Reform? – Revisions and clarifications regarding:
  - Writing requirements
  - Term requirements
  - Holdover arrangements
  - Temporary noncompliance with signature requirements
  - Remuneration
Stark: Final Considerations

- Enforcement will only increase
  - Government enforcement authorities
  - Whistleblowers
  - Increasing risk of individual liability

- CMS voluntary disclosure protocol

- Is reform possible?
  - Nov. 2015 Stark rules
  - Senate Finance/House Ways & Means Committee initiative
    - “Why Stark, Why Now?” – A Senate Finance Committee Majority Staff Report (June 30, 2016)
  - CMS announced in Jan. 2018 that it would form an interagency group to examine Stark law barriers to value-based payment reform
• Enforcement will only increase
  – Government enforcement authorities
  – Whistleblowers
  – Increasing risk of individual liability

• CMS voluntary disclosure protocol
  – http://www.cms.gov/Medicare/Fraud-and-
    Abuse/PhysicianSelfReferral/Self_Referral_Disclosure_Protocol.html

• Is reform possible?
  – Nov. 2015 Stark rules
  – Senate Finance/House Ways & Means Committee initiative

• “Why Stark, Why Now?” – A Senate Finance Committee Majority
  Staff Report (June 30, 2016)

  – CMS announced in Jan. 2018 that it would form an interagency group to
    examine Stark law barriers to value-based payment reform
I. **Introduction: Medicare and Medicaid**

A. Medicare Eligibility and Benefits
   1. Medicare Part A
   2. Medicare Part B
   3. Medicare Part C
   4. Medicare Part D

B. The Medicare-Provider Relationship
   1. Enrollment and Conditions of Participation
   2. Revalidation
   3. Provider Payment: Conditions of Payment

C. Penalties for Non-Compliance
   1. Recent CMS Penalty Decisions

II. **The Medicaid Program**

A. Medicaid Eligibility and Benefits
   1. Mandatory Eligibility and Covered Services
   2. Optional Eligibility and Benefits

B. The Administration of Benefits
   1. Generally
   2. Cost Sharing

C. The Medicaid-Provider Relationship

III. **Georgia Medicaid**

A. Eligibility
B. Covered Services
C. The Administration of Benefits
D. The Medicaid-Provider Relationship
   1. Revalidation

IV. **Conclusion**
I. Introduction: Medicare and Medicaid

Medicare and Medicaid affect nearly all aspects of the health care delivery system in the United States. Combined, the two programs provide health care coverage for over 130 million Americans enrolled for fiscal year 2018. See https://www.hhs.gov/about/budget/fy2018/budget-in-brief/index.html (accessed Jan. 21, 2018). Medicare and Medicaid are government funded health insurance programs created by amendments to the Social Security Act (“SSA” or the “Act”) in 1965 to increase access to medical services for the elderly and poor who were not receiving basic medical care.

The Medicare program is fully funded by the federal government and provides health care coverage for individuals over the age of 65, individuals under the age of 65 with certain disabilities and individuals with end-stage renal disease (“ESRD”). Eligibility for Medicare does not take into consideration income or financial resources.

The Medicaid program is jointly funded by federal and state governments and primarily serves low-income children, parents, the elderly and individuals with disabilities. Regulation places stringent income and resource limits on eligibility for most Medicaid programs. In 1997, Congress created the Children’s Health Insurance Program (“CHIP”) to provide health insurance for children who were ineligible for the Medicaid program and still uninsured.

The Medicare Program

Administered by the Centers for Medicare and Medicaid Services (“CMS”) under the operations of the U.S. Department of Health and Human Services (“HHS”), Medicare is composed of four parts: Parts A, B, C and D, that together offer beneficiaries a full range of health care services.
A. Medicare Eligibility and Benefits

1. Medicare Part A

   a. Eligibility

   Eligibility for Medicare Part A is generally attained by satisfying the criteria for Social Security benefits eligibility, as a result of age or disability, or an ESRD diagnosis. 42 C.F.R. § 406.5. An individual is eligible for Social Security retirement benefits after reaching the age of 62 and accumulating a total of 40 work credits, which according to the Social Security Administration is equivalent to approximately 10 years of work. See Social Security Retirement Benefits, Social Security Administration, January 2017 at 4, available at https://www.ssa.gov/pubs/EN-05-10035.pdf (accessed Feb. 1, 2018). Federal, state and local government employees who are age 65 and older may also be eligible for Medicare provided that the individual’s employment was not limited to work as a temporary employee, prison inmate, intern or student worker or an election worker. 42 U.S.C. § 426(a); 42 C.F.R § 406.15. In addition, individuals who have lived in the United States for five years and have reached the age of 65 can obtain Medicare Part A benefits by paying a premium. 42 C.F.R. §§ 406.5, 406.20.

   Individuals under the age of 65 who have a permanent disability can also obtain Part A benefits. For individuals with ESRD or those with amyotrophic lateral sclerosis (“ALS” or “Lou Gehrig’s Disease”), benefits are available immediately upon diagnosis. 42 C.F.R. § 406.5; see also Medicare at a Glance at 1, available at https://kaisersafewayfoundation.files.wordpress.com/2013/03/7067-02_medicare-at-a-glance.pdf (accessed Feb. 1, 2018). Other permanently disabled individuals are not eligible until after receipt of disability benefits under Social Security or receipt of benefits under the Railroad Retirement program for 25 consecutive months. 42 C.F.R. § 406.5.

   b. Benefits


   Inpatient hospital care is treatment provided in any hospital including “specialty” hospitals, such as orthopedic hospitals and heart hospitals, as well as those that provide more global services, such as acute care hospitals, long-term hospitals, critical care hospitals and psychiatric hospitals. See Alexander at 19; 42 U.S.C. § 1395e(a)(1), (3). Medicare coverage for inpatient care is limited to 90 days per benefit period. 42 C.F.R. § 409.61. “Benefit period” is defined as the period beginning upon admission to an inpatient hospital stay or SNF and ending when the inpatient stay has ceased for 60 days in a row. Beneficiaries are responsible for a deductible and coinsurance for any days after 60 days of admission, and beneficiaries incur larger deductible and
coinsurance payments if the admission lasts more than 90 days. *Id.* Beneficiaries have 60 lifetime reserve days in which Medicare will pay for all covered services except the daily coinsurance. 42 C.F.R. § 409.61(a)(2).

For beneficiaries needing skilled nursing care, Part A covers 100 days per benefit period, if the beneficiary was admitted to the hospital as an inpatient for at least three consecutive calendar days within 30 days of admission to the SNF. 42 C.F.R. § 409.61(b).

In regards to home health, Part A covers eligible services with no deductible, but subject to durable medical equipment (“DME”) payment limitations. 42 C.F.R. § 409.61(d). Eligibility for home health also requires that the patient’s physician certify the need for one or more of the following: intermittent skilled nursing care, physical therapy, or speech language therapy, continuing physical therapy or occupational therapy.

Terminally ill beneficiaries are eligible for hospice services for two 90-day periods followed by unlimited 60-day periods. See 42 C.F.R. § 418.21. The hospice provider must obtain written certification of terminal illness for each benefit period. 42 C.F.R. § 418.22. To qualify for coverage, (1) the beneficiary is required to file a hospice election statement that identifies the hospice that will provide care to the individual; (2) an acknowledgement from the individual or the individual’s representative that states that the individual understands that coverage for services related to treatment of the terminal condition has been waived; and (3) effective and end dates for the hospice election. 42 C.F.R. § 418.24. The services available under a hospice election include nursing care, medical social services, physicians’ services, counseling services, home health aide, medical appliances and supplies, and physical and occupational therapy. 42 C.F.R. § 418.

2. Medicare Part B

   a. Eligibility

Medicare Part B is voluntary coverage that requires the payment of a monthly premium. Medicare Part A beneficiaries are automatically enrolled in Part B unless they specifically decline coverage. Fundamentals at 96; 42 C.F.R. § 407.10. Individuals age 65 and older who are not eligible for Part A can also obtain benefits under Part B by paying a premium. *Id.* 42 C.F.R. § 407.10 (a)(2). In addition, all Part B beneficiaries are required to pay deductibles and coinsurance. The federal government pays 80% of the fee schedule amount and the beneficiary pays the remaining 20% after the annual deductible has been satisfied. Alexander at 43. The following services are not subject to a deductible: home health services, clinical diagnostic laboratory services, fecal occult blood tests, pneumonia and flu vaccines, kidney donation, and services provided in a Federally Qualified Health Center (“FQHC”). Alexander at 43.
b. Benefits

Medicare Part B provides “medical and other healthcare services.” 42 U.S.C. § 1295j-k; Fundamentals at 100. These services include treatments personally performed by a medical doctors or doctors of osteopathy, dentists, optometrists, podiatrists and chiropractors, under limited circumstances. Alexander at 44; see 42 U.S.C. §§ 1395d(a)(3), 1395k(a)(2)(A), 1295x(r). Part B also covers professional services provided by non-physician practitioners (“NPP”) including therapists, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, physician assistants, nurse practitioners, clinical nurse specialists and audiologists, provided that the services are performed “incident to” the physician’s services. Alexander at 45; see also, 42 C.F.R. §§ 410.26; 414.34; Medicare Benefit Policy Manual, Ch. 15, § 50. “Incident to” services are services that are considered an essential element of the physician’s professional services and are furnished under one of the following conditions (1) in a non-institutional setting when services are limited to non-institutional patients; (2) to a patient in a physician’s office; (3) in any setting under the physician’s direct supervision; or (4) by employees, leased employees or independent contractors of a health care facility. Id. Beginning in 2015, CMS allowed greater flexibility for clinical staff performing duties that were “incident to” chronic care management services. See 42 C.F.R. § 410.26. Diagnostic tests including x-ray, EKG, mammogram, and sleep studies are also included as Part B Services. Alexander at 46; see 42 C.F.R. § 410.32.

3. Medicare Part C

c. Eligibility

Medicare Part C, the Medicare Advantage Program (“Medicare Advantage”), provides health care coverage under a managed care benefits plan. See Alexander at 73-74; 42 C.F.R. § 422.50. Part C eligibility requires the beneficiary to be eligible for Part A and enrolled in Part B. ESRD beneficiaries are not eligible for most Part C plans. Id. at 72; 42 C.F.R., § 422.52.

d. Benefits

Medicare Advantage plans are required to offer all services covered by Part A and Part B, excluding hospice, that are available within the plan’s service area. Id. Depending on the plan, Medicare Part D prescription drug coverage may be also required. Id. at 74; 42 C.F.R. §§ 422.100, 422.101, 422.102 Plan administrators are given broad discretion with regards to determining which, if any, additional services will be covered. Id. at 72; 42 C.F.R. § 422.102.

The four basic categories of plans offered under Medicare Advantage are: (1) coordinated care plans, (2) private fee-for service plans, (3) medical savings account plans, and (4) religious fraternal benefit plans. Id. at 69; 42 C.F.R. § 422.4.
Coordinated care plans are benefits packages provided through a network of contracted providers. 42 C.F.R. § 422.112. Coordinated care plans are required to offer at least one benefits package that includes Part D benefits. Id. at 70, 74; 42 C.F.R. § 422.112. Religious fraternal benefits plans are a form of a coordinated care plan, but these plan administrators have discretion to decide whether Part D coverage will be included in benefits packages. Id.

Private fee-for-service plans pay providers on a fee-for-service basis and provide beneficiaries with a network of providers willing to treat beneficiaries enrolled in the plan. Id. at 71; 42 C.F.R. § 422.114. Fee-for-service plans have discretion to decide whether to include Part D coverage in benefits packages. Id. at 74; 42 C.F.R. § 422.114. Medicare Advantage Plans may also offer medical savings account plans. These high deductible plans include a medical savings account funded by CMS. Id. at 72. Medicare and Medicare and You, CMS, 69 (2017) available at https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf (accessed Feb. 1, 2018). CMS pays the premium and beneficiaries are permitted to use account funds to pay for covered services until the deductible is reached. See Your Guide to Medicare Savings Plans, CMS, 9, available at https://www.medicare.gov/Pubs/pdf/11206.pdf (accessed Feb. 1, 2018). Once the deductible has been satisfied, the plan pays 100% of covered services. Id. Savings account plans are not permitted to offer Part D coverage. Id. at 9.

4. Medicare Part D

Medicare beneficiaries who are entitled to benefits under Medicare Part A or enrolled in Part B are eligible to enroll in Part D. 42 C.F.R. § 423.30. Medicare Part D is voluntary and requires beneficiaries to participate in cost sharing. Fundamentals at 97. Beneficiaries must join a plan and pay co-pays and premiums in exchange for prescription drug benefits. See Id. at 86. Medicare Part D is offered through private payors that contract with CMS. Id. As discussed above in regards to Part C, Part D can be included as part of a Medicare Advantage plan; however, Part D benefits are also available as stand-alone plans. See Medicare at a Glance at 1. Beneficiaries have the opportunity to enroll in Part D annually during a specified timeframe, which occurs from October 15 through December 7. Tip Sheet: Understanding Medicare Enrollment Periods, CMS, 7 (Nov. 2011). Beneficiaries may owe a late enrollment penalty if, at any time after their initial enrollment period ends, they do not have Part D or other creditable prescription drug coverage for a period of 63 or more days in a row. Medicare Part D Late Enrollment Penalty, Medicare.Gov, available at http://www.medicare.gov/part-d/costs/penalty/part-d-late-enrollment-penalty.html (accessed Feb. 1, 2018). The late enrollment penalty is calculated by multiplying 1% of the “national base beneficiary premium” ($35.02 in 2018) times the number of full, uncovered months a beneficiary was eligible but did not join a Medicare Prescription Drug Plan and went without other creditable prescription drug coverage. Id.
e. Benefits

For a prescription drug to be covered under Part D, the drug must be (1) available only by prescription, (2) approved by the Food and Drug Administration (FDA), (3) used and sold in the United States, and (4) prescribed for a medically accepted indication. See 42 C.F.R. § 423.100; Medicare Part D Manual, Chap. 6, §§ 10.1, 10.6, 10.7. Part D generally does not cover drugs that may be excluded under Medicaid or certain drugs that are covered under Medicare Part A or B. Medicare Part D Manual at § 20.2. The following are excluded from Medicare coverage: drugs for anorexia, weight loss, or weight gain; drugs used to promote fertility; drugs used for cosmetic purposes or hair growth; drugs used for the symptomatic relief of cough and colds; prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; nonprescription drugs; outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale; barbiturates; benzodiazepines; and agents used for the treatment of sexual or erectile dysfunction except under certain conditions. Medicare Part D Manual at § 20.1.

B. The Medicare-Provider Relationship

1. Enrollment and Conditions of Participation

Enrollment in Medicare requires providers to complete and submit the appropriate enrollment application and sign a statement of participation whereby the provider agrees to comply with the Medicare conditions of participation. Most providers can enroll through the Internet-based Provider Enrollment, Chain and Ownership System ("PECOS"). Providers may also enroll through the paper enrollment process by filing the appropriate CMS 855 form.

Prior to enrollment, a provider must have a National Provider Identifier ("NPI"), which replaced other provider identifiers used in health care transactions. Providers obtain a NPI through National Plan and Provider Enumeration System ("NPPES").

Institutional providers, including hospitals, outpatient physical therapy, occupational therapy and speech pathology services’ FQHCs, hospices, rural health clinics ("RHCs"), ESRD facilities, home health agencies, community mental health centers, and comprehensive outpatient rehabilitation facilities enroll using an 855A Form. Other types of non-institutional providers, including physician group practices/clinics, independent diagnostic testing facilities and ambulatory surgery centers, are required to complete an 855B Form. Individual physicians and non-physician practitioners such as nurse practitioners and physician assistants who are enrolling in Medicare for the first time must submit an 855I Form. DME suppliers must submit an 855S Form. Physicians and other NPPs use the CMS form 855R to reassign Medicare benefits/receivables of the enrolled physician or other non-physician practitioner to his or her group practice or other employer. Providers and suppliers who do not wish to enroll in Medicare, but who order and refer Medicare reimbursed services must complete an 855O application.
The Affordable Care Act of 2010 ("ACA") required CMS to establish new screening procedures for Medicare enrollment, including a licensure check. 42 U.S.C. § 1395cc(j). The statute allows CMS to include any or all of the following additional screening measures: criminal background checks; fingerprinting; unscheduled, unannounced or pre-enrollment site visits; database checks; and other screening that the Secretary of HHS may determine to be necessary or appropriate. Id. at § 1395cc(j)(2)(B).

Providers must report changes in practice location and ownership (including changes in delegated and authorized officials) and final adverse actions within 30 days of the change. 42 C.F.R. § 424.516(d). All other changes must be reported within 90 days of the event. 42 C.F.R. § 424.516(e). It is important that providers regularly update their enrollment with their Medicare contractor.

For a health care facility to enroll and participate in Medicare for reimbursement under Medicare Part A, the provider must satisfy the Medicare conditions of participation ("CoPs"). CoPs set standards for the corporate governance of the facility and its medical staff and clinical operations. CoPs also address patient rights, quality assurance, infection control, and medical records management. Alexander at 23; see Conditions for Coverage and Conditions of Participation, CMS, available at https://www.cms.gov/CFCsAndCoPs/ (accessed Feb. 1, 2018).

A health care facility can be “deemed” to satisfy the CoPs through accreditation by a CMS-approved accrediting body. Alexander at 23. For example, there are currently three CMS-approved accrediting bodies for hospitals: the Center for Improvement in Healthcare Quality (CIHQ), The Joint Commission ("TJC") and Det Norske Virtas Healthcare, Inc. ("DNV Healthcare"). CMS, Survey and Certification, Accrediting Organization Contacts for Prospective Clients, available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation.html (accessed Feb. 1, 2018).

“Participation” in Medicare means that the provider agrees to accept assignment of all claims for all services he or she furnishes to Medicare beneficiaries. The provider agrees to accept Medicare-allowed amounts as payment in full and will not collect more than the allowed Medicare allowed deductible and coinsurance from Medicare beneficiaries. If a provider decides to be a “participating” physician he or she completes the CMS Form 460 during the initial enrollment process or enrollment period. The benefits to participating include a reimbursement 5% higher than those who do not participate; payments are issued directly to the provider; and claim information is forwarded to Medicare supplemental coverage insurers. Despite certain advantages, some providers elect not to participate in Medicare because reimbursement rates can be lower than for private insurance and Medicare coverage rules are complex, detailed, and subject to change.

It is also important to note that suppliers enrolled as non-participating are subject to “limiting charges” imposed by CMS, and physicians are able to “opt out” of

2. Revalidation

CMS regulation now requires most providers to update their enrollment information at least every five years through a process called revalidation. See CMS, Revalidations, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html (accessed Feb. 1, 2018). Revalidation applies to providers and suppliers that were enrolled prior to March 25, 2011. CMS regulations require this revalidation every five years and also reserve the right to perform “off-cycle” revalidations and site visits. 42 C.F.R. § 424.515 (2016). Providers and suppliers have 60 days from the post mark date of the revalidation letter from CMS to submit the required completed enrollment forms. CMS, Sample Revalidation Letter, available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf (accessed Feb. 1, 2018). Providers and suppliers can submit their revalidation form online through the Internet-based PECOS or through a paper application form.

The revalidation process can be cumbersome, but the deadlines for revalidation are rigid and the consequences for non-compliance can be severe. Failure to submit enrollment forms as requested may result in the deactivation of Medicare billing privileges. See Vizy and Weinberger vs. Centers for Medicare and Medicaid Services, Docket Nos. C-16-367 and C-16-368 (June 24, 2016) (upholding a CMS decision that two providers who failed to revalidate timely were not eligible to have their billing privileges retroactively dated to the original revalidation deadline, resulting in almost 6 months in lost billing privileges).

3. Provider Payment: Conditions of Payment

To receive payment for services, providers must comply with the Medicare conditions for payment. 42 C.F.R. § 424.32 (2016). These conditions require claims to be submitted on the proper form using the appropriate diagnostic coding. Id. There are six basic conditions for payment: (1) the services must be covered services or excluded but otherwise reimbursable services (as determined by regulation); (2) the services were provided by a qualified provider or supplier; (3) the services were rendered while the individual was eligible to have payment made for them; (4) the provider obtained certification that the services were needed (if required); (5) the provider, supplier, or beneficiary (as appropriate) filed a claim that include a reference to a request for payment; and (6) the provider, supplier, or beneficiary (as appropriate) furnishes sufficient information to determine whether payment is due and the amount of payment. Id. at § 424.5(a) (2016).

The claim must be signed by the beneficiary or on the beneficiary’s behalf and be filed within one full calendar year following the year in which the services were

C. Penalties for Non-Compliance

Providers can suffer civil and criminal penalties for Medicare non-compliance, in addition to the revocation of their enrollment and exclusion from the program. Penalties can stem from both intentional fraud and provider negligence. Some examples of activities that can trigger civil or criminal penalties for Medicare non-compliance include: inappropriately trying to increase utilization of care (in violation of the Anti-Kickback Statute and the Stark Law), waiving Medicare patient copays and deductibles, offering remuneration to an individual who is eligible for Medicare or Medicaid to influence the individual’s health care choices, upcoding and other billing and payment fraud, and failing to disclose overpayments. *Medicare Fraud & Abuse: Prevention, Detection, and Reporting*, CMS, 2–3, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf (accessed Feb. 1, 2018).

CMS has several programs in place to combat these types of abuses and non-compliance. These programs help prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The programs include the National Correct Coding Initiative, the Medical Unlikely Edits Program, the Medical Review Program, the Comprehensive Error Rate Testing Program, the Quality Improvement Organization review program, the Recovery Audit Program, and the Medical Review Program. *Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program*, CMS.gov, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf (accessed Feb. 1, 2018).

The False Claims Act (“FCA”) also provides the federal government with a powerful tool to combat Medicare non-compliance. The FCA imposes penalties on individuals or provider entities that knowingly submit false or fraudulent claims for payment to the government. 31 U.S.C. § 3729(a)(1)(A). The Justice Department can file an FCA action, but so can a qui tam relator who acts as a fraud whistleblower and brings the case on the government’s behalf. *Id.* at § 3730(a)–(b) FCA cases and settlements for reimbursement-related violations can result in huge monetary penalties because of the large number of Medicare reimbursement requests covered entities file and the ability of FCA plaintiffs to seek treble damages and attorney’s fees *Id.* at §§ 3729(a)(1)(G), 3729(a)(3).
The HHS Departmental Appeals Board (“DAB”) and Civil Remedies Division (“CRD”) oversee CMS’s revocation decisions through an appeal process. These two review departments release a number of opinions upholding CMS’s revocation decisions and in some instances issue opinions overturning CMS’s decision. Some examples of these decisions are highlighted below:

- DAB upheld the revocation of a home health agency’s provider number finding that the agency was not open to the public and “operational to furnish Medicare covered services” as required by 42 C.F.R § 424.510(d)(6). The agency’s doors were locked and no one responded when a site inspector visited. Docket No. A-16-145, Decision No. 2778 (App. Div.) (March 30, 2017).

- DAB upheld the revocation of a DMEPOS supplier’s enrollment and billing privileges for failure to maintain accreditation. While the DMEPOS supplier was accredited at the time of the appeal, its accreditation had lapsed for 7 months while it was in the process of changing accrediting agencies. Docket No. A-16-123, Decision No. 2766 (January 25, 2017).

- DAB upheld a CMS decision to revoke a provider’s Medicare enrollment for two years where she failed to include an explanation of license revocation in her individual Medicare revalidation application. Docket No. C-16-443, Decision No. CR4664 (July 26, 2016).

- DAB upheld a CMS decision to revoke a provider’s enrollment for three years because he failed to accurately report his practice location during revalidation and CMS uncovered the “mistake” during an attempted site visits. Docket No. C-15-3863, Decision No. 4511 (January 20, 2016).

- DAB upheld a CMS decision to revoke an orthopedic surgeon’s Medicare enrollment where the provider’s Medicaid billing privileges were terminated or revoked. Docket No. A-15-64, Decision No. 2663 (October 27, 2015).

- DAB upheld a CMS decision to revoke a physician’s enrollment for abuse of billing privileges because the physician billed more services than can possibly be provided during a given time period. Docket No. A-14-84, Decision No. 2592 (September 15, 2014).

- CRD upheld a CMS decision to revoke a home health provider’s enrollment for failing to report a change to its business address within 90 days. CRD also held that CMS did not have to accept a Plan of Correction from the provider and that CMS’s refusal to accept the plan is not reviewable. Docket No. C-14-691, Decision No. 3305 (July 22, 2014).

---

1 DAB and CRD publish their opinions at www.hhs.gov/dab/decisions/dabdecisions/index.html and www.hhs.gov/dab/decisions/civildecisions/index.html, respectively.
II. The Medicaid Program

All 50 states, the District of Columbia and United States territories have established Medicaid programs. Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues, Kaiser Commission on Medicaid and the Uninsured, April 2011. To receive federal funding for its Medicaid program, a state must designate a single state agency for administration of the program and devise a state plan that describes the administration of the program, individual eligibility, covered services, and reimbursement methodologies. 42 U.S.C. § 1902; Craig H. Smith, Fundamentals of Medicaid, AHLA Fundamentals of Health Law, November 13-115, 2011 at 5. The availability of federal funds for Medicaid benefits is further conditioned on a state’s compliance with its state plan. See 42 U.S.C. § 1396c. CMS must approve the state plan, amendments, waivers and significant changes to a State’s Medicaid program. Id. at 4-5.

A. Medicaid Eligibility and Benefits

1. Mandatory Eligibility and Covered Services

The SSA requires a state to provide to “all individuals wishing to make an application for medical assistance” the opportunity to do so. Smith at 8, see 42 U.S.C. § 1396a(a)(8). The state must make an eligibility determination “with reasonable promptness” and provide the decision to the applicant in writing. Id. Denial letters must include the reason for the denial and the specific regulation supporting the determination. 42 C.F.R. § 435.912. The SSA affords applicants a right to a hearing if their application is denied or if the state fails to make a timely eligibility determination 42 U.S.C. § 1396a(a)(3). Coverage for services can be made retroactive for three months prior to the month in which the individual submitted an application to the state Medicaid agency, provided that the individual was eligible for assistance during the retroactive time period. 42 U.S.C. § 1396a(a)(34).

a. Mandatory Eligibility

All states are required to provide medical assistance to five core groups of low-income, “mandatory categorically needy” individuals, which includes (1) pregnant women, (2) children, (3) parents, (4) the elderly, and (5) individuals with disabilities. Federal Core Requirements at 4. The federal poverty level (“FPL”) is used to determine economic eligibility for coverage. In 2018, FPL for a family of four is $25,100 per year. HHS Poverty Guidelines, available at https://aspe.hhs.gov/poverty-guidelines (accessed Jan. 21, 2018).

Aged, blind, and disabled individuals receiving or deemed eligible for receipt of Social Security Income can receive Medicaid coverage. 42 U.S.C. § 1396a(a)(10); Smith at. 9. Parents who would have qualified for Aid to Families with Dependent Children (“AFDC”), or Temporary Assistance to Needy Families (“GANF”) are also eligible, but beneficiaries qualifying under this option are required to have significantly lower incomes than other Medicaid beneficiaries. Id. In most states, to qualify for Medicaid
as a parent, a beneficiary must have an income of less than 50% FPL. Smith at 9; Federal Core Requirements at 4. Under the ACA, states would have been required to expand Medicaid eligibility across all core groups to 133% FPL and to include non-disabled adults without dependent children, who have historically been excluded from Medicaid eligibility. Federal Core Requirements at 4. However, in National Federation of Independent Business v. Sebelius, 132 S.Ct. 2566 (2012), the Supreme Court held the Medicaid Expansion unconstitutional. As a result, individual states have discretion to decide whether to adopt the ACA Medicaid expansion. As of January 2018, 33 states (Washington, D.C. included) have adopted some form of Medicaid expansion. Current Status of State Medicaid Expansion Decisions, available at https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/ (accessed Jan. 21, 2018). Georgia is among the states that chose not to expand Medicaid. With the status of the ACA in flux, there will likely be significant changes from either the Supreme Court or Congress.

b. Mandatory Benefits

Due to the diversity of the needs of Medicaid beneficiaries, Medicaid benefits are fairly broad in scope. Medicaid a Primer 2010, The Kaisers Commission on Medicaid and the Uninsured at 14. Figure 1 below identifies mandatory services.

**Figure 1: Mandatory Covered Services for Categorically Needy Beneficiaries**

1. Physician services, 42 U.S.C. § 1396d(a)(xvii)(5)(A)
2. Laboratory and x-ray services 42 U.S.C. 1396d(a)(xvii)(3)
3. Inpatient hospital services, except services in an institution for mental disease 42 U.S.C. § 1396d(a)(xvii)(1)
5. Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21, 42 U.S.C. § 1396d(a)(xvii)(4)(B)
6. Family planning services and supplies, including minors who can be considered sexually active, 42 U.S.C. § 1396d(a)(xvii)(4)(C)
7. Services offered at a rural health clinic (RHC) or federally-qualified health center (FQHC) 42 U.S.C. § 1396d(a)(xvii)(2)(B-C)
8. Nursing facility services for individuals 21 years of age or older, except services in an institution for mental disease, 42 U.S.C. § 1396d(a)(xvii)(4)(A)
10. Medical and surgical services furnished by a dentists, 42 U.S.C. § 1396d(a)(xvii)(5)(B)
11. Home health services, 42 U.S.C. § 1396d(a)(xvii)(7)
13. Services of a certified pediatric nurse practitioner or certified family nurse practitioner, 42 U.S.C. § 1396d(a)(xvii)(21)
14. Freestanding birth center services and other ambulatory services offered by a freestanding birth center, 42 U.S.C. § 1396d(a)(xvii)(28)*
15. Smoking cessation services for pregnant women, 42 U.S.C. § 1396d(a)(28)

Smith at 15-16

While states have no discretion whether to cover mandatory services for categorically needy beneficiaries, states are authorized to determine the amount, duration and scope of benefits offered under the Medicaid program. 42 C.F.R. §
The SSA further authorizes states to place utilization controls and medical necessity requirements on covered benefits. *Id.* This discretion is limited only by the stipulation that a restriction on a benefit cannot render the benefit insufficient to “achieve its purpose.” 42 U.S.C. § 1396a(a)(10)(B).

2. Optional Eligibility and Benefits
   a. Optional Eligibility

   Currently, no state’s Medicaid program eligibility is limited to mandatory categorically needy beneficiaries with benefits coverage restricted to mandatory services. Federal Core Requirements at 5 & 7. All states have expanded eligibility for children and pregnant women. http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/ (accessed Feb. 1, 2018). Every state has also expanded the scope of Medicaid services to include prescription drug coverage, but other optional benefits available vary widely from state to state. *Federal Core Requirements* at 7.

   b. Optional Benefits

   States are somewhat limited in their ability to expand the eligibility pool for Medicaid beneficiaries without applying for a waiver, waiver-like provision or amending the state plan. *Smith* at 28. Thus, states frequently expand eligibility based only on income measures. “Optional categorically needy” beneficiaries are generally considered low-income individuals, but their income and resource level exceed the limits set forth for mandatory categorically needy coverage. 42 U.S.C. § 1396a(a)(10)(A)(ii). Individual states determine the income and resource limits for eligibility as an optional categorically needy beneficiary. 42 U.S.C. § 1396a(a)(10)(A)(ii). A state has broad discretion to determine which additional optional services will be available to beneficiaries in the state. *Id.* Listed in Figure 2 are the benefits that a state can select.

   Generally, a state must ensure that identical benefits coverage is available to medically needy and categorically needy beneficiaries, respectively. 42 U.S.C. § 1396a(a)(10)(B)-(C); 42 C.F.R. § 440.240. Benefits must also be made available on a state-wide basis. 42 U.S.C. § 1396a(a)(1).

   The “medically needy” are unique among Medicaid beneficiaries, because their eligibility takes into account more than income and resources alone. 42 C.F.R. § 435.300. For an individual to be eligible as “medically needy,” the individual’s income level must be considered equivalent to an amount at or below the medically needy level for the state as established by the state under its state plan. 42 C.F.R. § 301.301(i)(i). The SSA, however, allows income and resource levels to be offset by medical expenses. 42 U.S.C. §§ 1396a(a)(10)(C)(i), 1396a(a)(17); 42 C.F.R. §§ 435.301, 435.811, 435.1007. Thus, if a medically needy individual has an income that exceeds the state’s preset maximum income level, the income and resources of the beneficiary are combined with debt. 42 C.F.R. § 435.301; *Smith* at 10. If medical debt subtracted from the individual’s income and resource levels is less than the requisite amount for eligibility as a medically needy beneficiary, the individual is deemed eligible for Medicaid coverage. *Id.*
As stated above, the services available to beneficiaries can vary widely from state to state. However, if a state elects to extend eligibility to medically needy beneficiaries, the services listed in Figure 3 become mandatory for such beneficiaries. 42 U.S.C. § 1396a(a)(10)); 42 C.F.R. §§ 440.220, 440.210.

The primary exceptions to benefit coverage rules are benchmark and benchmark equivalent plans, waivers and demonstration projects. The Deficit Reduction Act (“DRA”) of 2005 contained a provision that amended the SSA to allow states to vary the Medicaid benefit package available to Medicaid beneficiaries by using benchmark and benchmark equivalent plans. See Deficit Reduction Act Important Facts for State Policymakers, CMS, Feb. 2008. A state must amend its state plan to offer services using benchmark or equivalent plans. Smith at 27-28.
Benchmark plans allow states to limit benefits to coverage that is standard in the (1) Blue Cross Blue Shield preferred provider option under the Federal Employee Health Benefits Plan, (2) the HMO plan with the largest commercial, non-Medicaid enrollment in the state, (3) any generally available state employee plan, or (4) any plan that the Secretary of HHS deems appropriate. Id.; 42 U.S.C. § 1396u-7. Benchmark equivalent plans must minimally cover inpatient and outpatient hospital services, physician surgical and medical services, lab and x-ray services, well-baby and well-child care and other appropriate preventative services as designated by HHS. Id. In addition, states must ensure that children under the age of 21 have access to Early and Periodic Screening Diagnostic and Treatment (“EPSDT”) services and access to FQHC services either under the benchmark plan or equivalent, or via some other means. Id; 42 C.F.R. § 440.345. EPSDT coverage includes coverage for screening, preventive and early intervention services as well as diagnostic services and treatment necessary to correct or ameliorate a child’s physical or mental condition. Medicaid a Primer, 2010, The Kaiser Commission on Medicaid and the Uninsured at 14. This coverage is often more inclusive than what beneficiaries under private insurance plans can obtain. Id.

States are permitted to mandate beneficiary enrollment in benchmark and equivalent plans, but “traditional” Medicaid must be available to categorically needy beneficiaries, hospice patients, medically frail or special needs individuals, beneficiaries qualifying for long-term care services, or women whose coverage is based on their eligibility under the breast and cervical cancer programs. Id.; 42 C.F.R. § 440.335; see also Sarah Rosenbaum and Anne Markus, The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services, The Commonwealth Fund (Oct. 2006) at 36.

A state is permitted to modify coverage or services to specific beneficiary populations by using a § 1915(b) waiver. 42 U.S.C. § 1396n(b). A 1915(b) waiver allows states to implement a primary care case-management system or a specialty physician services arrangement that restricts the provider to whom a beneficiary may visit to obtain medical services. Id. The waiver also allows states to vary which benefits are available to beneficiaries based on geographic region and other factors. Id. States that
choose to operate their Medicaid program under a waiver are required to ensure that beneficiaries continue to have accesses to quality medical services when medically necessary. *Id.*

Demonstration projects are time-limited waivers of Medicaid eligibility and coverage restrictions that allow a state to expand or reform coverage of certain populations, provided that the waiver is “likely to assist in promoting the objectives of the Medicaid statute.” 42 U.S.C. § 1310; Smith at 28. States are not permitted to require individual Medicaid beneficiaries to participate in a demonstration project. 42 U.S.C. § 1310(b)(2)(B).

**B. The Administration of Benefits**

1. Generally

In addition to the flexibility that states are granted to determine eligibility and benefit coverage for Medicaid beneficiaries, states also have the ability to choose from two different delivery systems: fee-for-service (traditional Medicaid) or managed care. 42 U.S.C. § 1396u-2. Under the managed care option, there are two common program models: risk based managed care organizations (“MCOs”) and primary care case management (“PCCM”). *Medicaid and Managed Care: Key Data, Trends, and Issues*, Kaiser Commission on Medicaid and the Uninsured (February 2012) available at http://www.kff.org/medicaid/upload/8046-02.pdf (accessed Feb. 1, 2018). The key difference between the two models is the way in which the state compensates the managed care contractor for administering services to beneficiaries. MCOs are paid on a capitation basis, which means that the MCO is paid a monthly fee per enrollee. *Id.* As a result, an MCO assumes the financial risk for offering comprehensive care to enrollees when care for a beneficiary exceeds the capitation amount. *Id.* On the other hand, for PCCMs the state contracts with the beneficiary’s primary care physician who provides, manages and monitors the beneficiary’s primary care and is frequently responsible for authorizing specialty care. The primary care physician is paid a small per patient monthly fee for care management and on a fee-for-service basis for all other services. *Id.*

With the exception of Medicaid beneficiaries characterized as children with special needs, dual-eligible beneficiaries (i.e., beneficiaries who are eligible for both Medicare and Medicaid) and Native Americans, states are permitted to implement mandatory managed care enrollment for Medicaid beneficiaries. *Id.* at 2. In 2014, 77% of Medicaid beneficiaries nationwide received some or all of their services through managed care. *Medicaid Managed Care Enrollment and Program Characteristics, 2014* (issued September 2016) available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf (accessed Feb. 1, 2018).
2. Cost Sharing

Even under traditional Medicaid, states are permitted to impose cost sharing measures on Medicaid benefits; this includes enrollment fees, premiums, deductibles, coinsurance, and co-payments offset the cost of providing care. 42 U.S.C. § 1396o. However, there are limits on the services, amounts, and beneficiary groups for cost sharing initiatives. Elicia Herz, Medicaid: A Primer, Congressional Research Service (July 15, 2010). If a state imposes copayment obligations on beneficiaries, state discretion regarding the amount of the copay is limited. The SSA stipulates that the amount of the copayment must be “nominal.” 42 U.S.C. § 1396o; 42 C.F.R. § 447.53(a). In 2009, the maximum copayment allowed for services ranged from $1.15-$5.70. 42 C.F.R. § 457.55. After fiscal year 2009, “any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.” Id. at § 457.55(a)(1)(ii). Furthermore, states are prohibited from imposing co-payment obligations on services (1) provided to children under the age of 18, (2) related to pregnancy or any other medical condition that may complicate pregnancy, (3) emergency services, (4) furnished to individuals in inpatient hospitals, facilities, or institutions, (5) rendered to hospice patients, and (6) provided for family planning. 42 U.S.C. § 1396o(b)(2).

Similarly, enrollment fees and premiums cannot be imposed on care for pregnant women, infants under the age of 1 year, a disabled child, qualified disabled and working individuals, and Native Americans. 42 C.F.C. § 447.56(a). The regulations also set forth both minimum and maximum enrollment and premium limitations based on the gross family income of the beneficiary. Id.

C. The Medicaid-Provider Relationship

Physicians, providers, and their respective entities are required to enroll in Medicaid to be reimbursed for services provided under a state’s Medicaid program. Provider enrollment is typically processed through the Medicaid Management Information System (“MMIS”) which is an integrated computer system that is designed to facilitate the management of claims payment, reporting, system controls, administrative costs, and information retrieval. Legislative Brief: Medicaid Management Information Systems, The Georgia DCH, March 2009. States can manage MMIS internally or can contract with a fiscal agent to manage the System. Id.

In addition to enrolling to be reimbursed, the ACA now requires physicians or other eligible practitioners to enroll in the Medicaid Program to order, prescribe and refer items or services for Medicaid beneficiaries, even when they do not submit claims to Medicaid. 42 C.F.R. § 455.410(b). The new enrollment requirement for these providers does not mean that they must also see Medicaid patients or be listed as a Medicaid provider for patient assignments or referrals. Instead, the new requirement is part of the ACA’s new program integrity requirements designed to ensure all orders, prescriptions, or referrals for items or services for Medicaid beneficiaries originate from
appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.

For a provider to be eligible to bill Medicaid for their services, providers are required to enter into a provider agreement with the state, whereby among other things the provider agrees to accept Medicaid reimbursement for the services and not to request additional compensation from Medicaid beneficiaries. Smith at 22. A state is required to set reimbursement rates to providers at levels “sufficient to enlist enough providers so that care and services available under the [Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. § 1396(a)(30)(A).

The rates paid to providers must also be consistent with “efficiency, economy, and quality of care.” Id. This statutory requirement has been interpreted by CMS to place an upper payment limit on provider payment rates. Smith at 23. If a state elects to make payments to providers that exceed the upper limits specified by CMS, the state will not receive federal matching funds for those payments. Id.; 42 C.F.R. § 447.257. Generally, for inpatient providers (hospitals, nursing facilities, and intermediate care facilities for the mentally handicapped) and outpatient providers (hospitals and clinics), the payment limit takes into account the “aggregate Medicaid payments to a group of facilities” and cannot exceed “a reasonable estimate of the amount that would be paid for services furnished by the group of facilities under Medicare payment principles...” Smith at 23; 42 C.F.R. §§ 447.272, 447.321. For other inpatient and outpatient providers, states are permitted to pay the “customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable service under comparable circumstances.” 42 C.F.R. § 447.325.

III. Georgia Medicaid

A. Eligibility

Georgia extends Medicaid eligibility to optional categorically needy beneficiaries who (1) live in nursing homes; (2) are aged, blind or disabled and need regular nursing care and personal services but can stay at home with special community care services; (3) are terminally ill; and (4) medically needy pregnant women and children and aged, blind and disable individuals. Eligibility Criteria Chart, Georgia Department of Community Health, https://dch.georgia.gov/services/eligibility-criteria-chart (accessed Feb. 1, 2018). Georgia also expands eligibility to (1) pregnant women and their infants up to 200% of FPL, (2) children under the age of 1 up to 185% of FPL, and (3) children whose family income is 133% of FPL. Id. Furthermore, Georgia operates the Katie Beckett Medicaid Program (“Katie Beckett”). This program allows children who qualify as disabled under 42 U.S.C. § 1382c to also attain eligibility for Medicaid benefits if a severely disabled child lives at home instead of in an institution. Id. Additionally, the child must be financially ineligible for social security. TEFRA/Katie Beckett, Georgia Department of Community Health, available at http://dch.georgia.gov/tefrakatie-beckett (accessed Feb. 1, 2018).
B. Covered Services

Georgia has expanded eligibility to medically needy beneficiaries, so benefits in Georgia include the complete list of mandatory medically needy benefits listed above in Figure 3. Georgia Medicaid’s major services include prescription drug coverage, doctor visits, inpatient and outpatient hospital care, lab tests, x-rays, home health care, hospice care, medical equipment and supplies, non-emergency medical transportation services, and dental care (up to age 21). See http://dch.georgia.gov/medicaid-faqs (accessed Jan 21, 2018).

C. The Administration of Benefits

The Georgia Department of Community Health (“DCH”) currently contracts with four private care management organizations (“CMOs”) through a program called Georgia Families to provide managed care plans to Medicaid beneficiaries. See http://dch.georgia.gov/georgia-families (accessed Jan. 21, 2018). The four CMOs in Georgia are Amerigroup, CareSource, Peach State Health Plan, and WellCare of Georgia. Id. For eligible and non-statutorily excluded groups, enrollment in a CMO is mandatory. Id. Beneficiaries are permitted to select the CMO from which they wish to receive services, but if they fail to do so Georgia Families will select a plan for them. Id. Under a new program called Georgia Families 360°, Georgia offers a new managed care program for the approximately 27,000 children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system. See http://dch.georgia.gov/foster-care-adooption-assistance-juvenile-justice-%E2%80%93-georgia-families-360 (accessed Feb. 1, 2018). The program was launched 2014 with Amerigroup providing health care coverage for these populations.

D. The Medicaid-Provider Relationship

The conditions for participation in Georgia Medicaid are available in Part I of the Policies and Procedures for Medicaid/Peachcare for Kids Manual. All providers are required to be licensed without restriction and certified under applicable state and federal laws to perform the applicable category of service. Id. Generally, the conditions of participation require providers to be licensed and certified, bill DCH appropriately for services, not pay for referrals, or solicit patients through offering free services, appropriately maintain patient records, and comply with DCH requests for information. Providers are also prohibited from contracting with any person or entity previously terminated or suspended from participation in the Medicaid program. Id.

DCH’s Division of Medicaid is responsible for Medicaid provider enrollment and DXC Technology is the fiscal agent that manages the Georgia MMIS (“GAMMIS”). Effective January 1, 2015, all providers must enroll online. DCH Fact Sheet, available at http://dch.georgia.gov/sites/dch.georgia.gov/files/14-online-enroll-only.pdf. GAMMIS is the system used by providers to complete the initial enrollment process or update practice information. See https://www.mmis.georgia.gov/portal/ (accessed Feb. 1, 2018).
Providers participating in the Medicaid program including physicians, osteopaths, nurse practitioners and physician assistants are required to enroll. *Id.* Additional documentation is required for all applications: provider’s license, DEA Certificate, Board Certificate for Nurse Practitioners and a job description from the Georgia Composite Medical Board for Physician Assistants. If the provider reassigns his or her benefits to an entity that bills for services a power of attorney form is also required.

Georgia Medicaid enrolls providers and assigns Medicaid provider numbers to each location where a provider practices, including hospital locations. The provider will receive a Medicaid number for each location in which he or she is enrolled. Providers submit online applications via the GAMMIS website.

Under traditional Medicaid, Georgia pays providers on a fee-for-service basis. DCH reimburses providers “the lower of the physician’s lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service, the lowest price charged to other third party payers, or the statewide maximum allowable reimbursement allowed for the procedure code reflecting the service rendered. Part II Policies and Procedures for Physician Services, Georgia DCH, January 1, 2013, X1. Services of a physician assistant are limited to no more than 90% of the maximum allowable amount paid to a physician. *Id.* at X-2. DCH also publishes a schedule of maximum allowable payments for all provider types through the MMIS website.

As a condition of payment, DCH requires most providers to submit claims for payment using the CMS-1500 form. Georgia Medicaid/PeachCare for Kids Provider Billing Manual CMS 1500, at 19-20. Claims must be coded to reflect the appropriate services rendered and be submitted within six months from the date that the service was rendered. *Id.*

1. Revalidation

Medicaid enrolled providers must also revalidate their Medicaid enrollment with the State of Georgia. Providers must revalidate with Georgia Medicaid even if they have already revalidated with Medicare. DCH contracted with HPES to mail notices to complete the revalidation process for each provider and supplier, which occurred on a rolling basis until December 2015. Providers who did not complete revalidation within 60 days will have their enrollment deactivated or terminated from the Georgia Medicaid/PeachCare program. Unlike Medicare revalidation, DCH requires all providers to revalidate online only using the GAMMIS.

CMS has tried to align the Medicare and Medicaid revalidation requirements by requiring similar data input and revalidation timelines. Both Medicare and Medicaid revalidation focus on verification of a provider’s current enrollment status by requiring providers to verify their name, date of birth, Social Security Number, NPI, Tax ID
number and license numbers. In addition, Medicaid revalidation similarly follows the a
five-year revalidation cycle as Medicare. *Id.*

IV. **Conclusion**

Medicare and Medicaid fill important gaps in access to medical coverage for
many individuals, but the administration of these program is notably complex.
Attorneys representing client beneficiaries and medical providers must have a strong
grasp on the ins and outs of these programs to ensure effective representation.
I. Topics
   A. False Claims Act
   B. Anti-Kickback Statute
   C. Emergency Medical Treatment and Active Labor Act ("EMTALA")

II. Who is the Federal Government?
   A. Centers for Medicare and Medicaid Services ("CMS")
   B. Office of Inspector General Health & Human Services
   C. Federal Bureau of Investigation
   D. Department of Justice
   E. But that's not all...
      1. The DOJ includes the local U. S. Attorney. Each of the 93 U. S. Attorney's Offices has a designated criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. Also, IRS, Postal Service, and Defense Criminal Investigative Service. States also get involved through Medicaid Fraud Control Units.
   F. Why so many enforcement agencies? $$$ During FY 2017, the federal government won or negotiated $2.4 billion in civil health care fraud judgments and settlements. Between 2014 and 2016, for every $1.00 the federal government spent on health care fraud enforcement, it returned $5.00.

III. Who Helps the Government?
   A. Patients
      1. 1-800-HHS-TIPS
      2. EOBs
   B. Employees
   C. Qui tam relators (whistleblowers) - usually patients or employees.
IV. False Claims Act

A. Introduction

1. Lincoln sponsored the False Claims Act ("FCA") in 1863.

2. The statute was originally intended to reach defense contractor fraud against federal government.

3. The FCA evolved to reach all fraudulent claims for reimbursement intended to get the government to pay out money for property or services.

4. The statute deputizes private citizens as attorney generals, bounty hunters, or "relators" entitled to a percentage of the government's recovery.

5. Since the 1986 amendments to the whistleblower provisions, more than half of FCA suits have been brought against the health care industry.

   a) Over $13 billion has been recovered from the health care industry in the first 20 years of the FCA (1987-2007).

      (1) $3.3 billion recovered from the health care industry in FY 2016.

   b) 74% of qui tam recoveries under the FCA have been from the health care industry.

   c) In FY 2016, $527 million was paid to qui tam relators who filed whistleblower actions.


1. The Civil False Claims Act is the most important tool of government to combat health care fraud and abuse.

2. The Civil FCA prohibits knowingly submitting or causing to be submitted a false claim for payment to the government or using a false record to get a claim approved.

   a) The FCA is violated through submission of a false claim, submission of a false record to get a claim paid, or conspiring to get a false claim paid.

      (1) Reverse false claim - maintaining a false record to decrease obligation to pay money to the government.
b) **Knowingly:**
   
   (1) Actual knowledge;
   
   (2) "Deliberate ignorance;" or
   
   (3) "Reckless disregard."

c) **"False" claim**
   
   (1) If reasonable minds differ - is it false?

   (a) See United States v. Whiteside, 285 F.3d 1345 (11th Cir. 2002) (reversing criminal convictions where defendants' interpretation not unreasonable).

3. Substantial number of FCA cases involve health care fraud.
   
   a) 4 cases in 1987; 310 cases in 1999; 110 new cases in 2006.
   
   b) In FY 2016, U. S. Attorney's Offices opened 930 new civil health care fraud cases.
   
   c) Recoveries over $1 billion every year since 2003.

4. Up to 10 year statute of limitations.
   
   a) When does it run?
   
   b) 6 years after violation or 3 years after material facts are known, but not more than 10 years.

C. **Criminal False Claims Act - 42 U.S.C. § 1320a-7b**
   
   1. "Knowing[ly and willfully] makes or causes to be made any false statement or representation of a material fact" to obtain benefit from the program.
   
   2. "Willfulness" is the heightened standard of proof.

D. **FCA Liability**
   
   1. Cost of non-compliance
      
      a) Internal investigation, defense and remedy;
      
      b) Attorney's fees;
c) Civil and administrative penalties;

(1) $11,181 to $22,363 per claim as of January 29, 2018;
(2) Treble damages of the government's loss;
(3) Possible exclusion from participation in federal health care programs;
(4) Potential individual exposure.

d) Effect of voluntary disclosure

(1) Damages under the FCA are limited to double damages suffered by the government if the provider voluntarily discloses the false claims to the government within thirty (30) days of learning of the violation and prior to any government investigation involving the claims.

E. Why does the Government use the Civil False Claims Act?

1. Lower standard of proof
   a) Preponderance of the evidence standard.
   2. Lesser intent required - "knowingly" means with "actual knowledge" of the facts or "deliberate ignorance" of the true facts or in "reckless disregard" of the facts.
   a) Not "willfully;"
   b) See U.S. v. Laughlin, 26 F.3d 1523 (10th Cir. 1994) (criminal act requires knowledge that claims were false).

F. Uses of the False Claims Act

1. National initiatives (PATH, DRG 79; off-label promotion and marketing of prescription drugs);
2. Services not rendered;
3. Upcoding;
4. Cost reporting;
5. Quality of care;

6. Stark/Anti-Kickback:
   a) Physician relationships;
   b) Vendor relationships;

7. Examples:
   a) United States v. Rogan, 517 F.3d 449 (7th Cir. 2008).
      (1) $64 million judgment against CEO where a variety of contracts were used to disguise kickbacks;
      (2) Medical directors, physician recruitment, teaching, EKG reading - compensation "grossly" above fair market value.
   b) Example of acute care hospital settlements:
      (1) Hospital agreed to pay $5.7 million to settle FCA and Stark allegations. FCA and Stark violations alleged where medical director agreement was above fair market value and physicians were permitted to use hospital employees free of charge.
      (2) Large operator of acute care hospitals agreed to pay $98 million to settle allegations that it billed Medicare, Medicaid, and TRICARE for inpatient services that should have been provided in less costly outpatient or observation setting.
      (3) Hospital paid $85 million to resolve alleged violations of Stark.

G. Whistleblowers or Relators

1. The best way to catch a rogue is with a rogue - Sen. Grassley.
   a) Qui tam relators are often insiders/former employees.

2. Relator also has the benefit of a retaliation cause of action.

3. Relator is entitled to attorney's fees, costs and expenses.

4. Relator's role:
   a) Limited party if government intervenes;
   b) Principal party if government declines;
   c) Government is always real party in interest.
5. Relator's share:
   a) If government intervenes = 15-25%;
   b) If government does not intervene = 25-30%.

H. Fraud Enforcement Recovery Act of 2009
   1. 2009 Amendments to False Claims Act.
   2. Improper retention of overpayments is the basis of FCA action.
   3. Expanded liability for claims not submitted directly to government.
   4. Expanded retaliation provisions.
   5. Expanded statute of limitations.
   7. Greater cooperation between government and whistleblowers.

V. Anti-Kickback Statute - 42 U.S.C. § 1320a-7b

   A. Introduction
      1. The Anti-Kickback Statute ("AKS") is the second fundamental statute the government uses to prosecute health care fraud.
      2. Prohibited conduct:
         a) Knowing and willful
         b) Solicitation or receipt or offer or payment of
         c) Remuneration
         d) In return for referring a federal program patient, or
         e) To induce the purchasing, leasing, or arranging for or recommending purchasing or leasing items or services paid by the program.
      3. AKS also applies to inducements to beneficiaries.
      4. Prohibits payment, solicitation, receipt, or offer;
         a) Limited to federal program patients;
      5. Remuneration is broadly defined - i.e., any benefit.
B. Penalties

1. Criminal fines and imprisonment;
   a) Up to $25,000 fine and five years in prison;

2. Civil monetary penalty of $50,000 plus three times the amount of the remuneration;

3. Exclusion from participation in federal health care programs;

4. Liability under the False Claims Act:
   a) The 11th Circuit has held that violating the Anti-Kickback Statute is a false claim under the FCA. See U.S. ex rel. McNutt v. Haleyville Med. Supplies, Inc., 423 F.3d 1256 (11th Cir. 2005).
   b) The Patient Protection and Affordable Care Act of 2010 ("PPACA") includes a provision that specifically establishes that every claim for items or services resulting from a violation of the AKS automatically constitutes a "false or fraudulent claim" under the FCA;

5. Damage to reputation.

C. "Intent to Induce"

1. "One Purpose" Test
   a) United States v. Greber, 760 F.2d 68 (3d Cir. 1985) - If one purpose of the fee was to induce the ordering of services from defendant's company, the statute was violated.

   (1) Statute is violated even if another purpose is to compensate for professional services.

2. In Chicago case (Rogan), compensation was "grossly" above fair market value for medical directors, teaching, EKG reading, etc.

3. "[Defendants] cannot be convicted merely because they hoped or expected or believed that referrals may ensue from remuneration that was designed wholly for other purposes. Likewise, mere creation of an attractive place to which patients can be referred does not violate the law."
a) **United States v. Anderson**, 261 F.3d 993 (10th Cir. 2001) (Jury Instruction No. 32).

4. PPACA clarifies that, in order to establish a violation of the AKS, a person need not have actual knowledge of the AKS or specific intent to commit a violation of the AKS.

   a) **United States v. St. Junius**, 739 F.3d 193 (5th Cir. 2013)-Section 1320a-7b(h) clarifies that the Government is not required to prove actual knowledge of the Anti-Kickback Statute or specific intent to violate it. Instead, the Government must prove that the defendant willfully committed an act that violated the Anti-Kickback Statute.

D. Statutory Exceptions - 42 U.S.C. § 1320a-7b(b)(3)

1. Discounts;

2. Bona fide employment relationships;

3. Amounts paid by providers to a group purchasing organization;

4. Certain waivers of coinsurance;

5. Activities that are protected by the safe harbor regulations;

6. Certain risk sharing arrangements;

7. Certain waivers or reductions by pharmacies of cost sharing obligations;

8. Certain managed care arrangements;

9. Hardware, software, or information technology and training services used to receive and transmit electronic prescription information (see 42 U.S.C. § 1395w-104(e)).

E. Safe Harbors - 42 C.F.R. § 1001.952

1. Investment interests;

   a) Large publicly traded entities;

   b) Small entities;

2. Space rental;

3. Equipment rental;

4. Personal services and management contracts;
5. Sale of practice;
6. Referral services;
7. Warranties;
8. Discounts;
9. Employees;
10. Group purchasing organizations;
11. Waiver of co-insurance and deductibles;
12. Increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans;
13. Price reductions offered to health plans;
14. Practitioner recruitment;
15. Obstetrical malpractice insurance subsidies;
16. Investments in group practices;
17. Cooperative hospital service organizations;
18. Ambulatory surgical centers;
19. Referral arrangements for specialty services;
20. Price reductions offered to eligible managed care organizations;
21. Price reductions offered by contractors with substantial financial risk to managed care organizations;
22. Ambulance replenishing;
23. Health centers;
24. Electronic prescribing items and services;
25. Electronic health records items and services.

F. Applies to just about every aspect of the relationships between providers, their referral sources, vendors and patients. Also, cannot induce them not to order - i.e., inducement to physicians to order fewer services or tests (also CMPs).
1. Orthopedic implant manufacturers case - Four major producers of artificial hips and knees agreed to pay a total of $310 million in penalties to settle federal accusations that they used fake consulting agreements and other tactics to get surgeons to use their products.

2. Hospital/Physician recruitment - $21 million settlement of allegations involving relocation funds that went directly to physicians.

3. Acute care hospital/Physician relationships - allegations cost Hospital $5.7 million to resolve.

4. United States v. Rogan (7th Cir.) - $64 million judgment against CEO-medical director agreement, etc. used to disguise kickbacks.

G. Risk Reduction Analysis

1. Arrangements must be close to the safe harbors;
   a) Failure to satisfy a safe harbor does not necessarily result in prosecution by OIG.
   b) According to the OIG, the "degree of risk depends on an evaluation of many factors."

2. Fraud alerts;

3. OIG Guidance;
   a) Advisory opinions;
   b) Compliance guidance;

4. Industry practice and guidance;
   a) PhRMA, AMA.

H. Things to Remember

1. The Anti-Kickback Statute applies to everyone.

2. The Anti-Kickback Statute contains an intent element.

3. The Anti-Kickback Statute is criminal.

4. Under the Anti-Kickback Statute, behavior falling outside of a safe harbor may be permissible.

I. Role of Legal Counsel
1. **Compliance programs**
   a) Policies to help prevent, detect and report fraud or false claims;
   b) OIG/CMS have provided guidance;
   c) Every hospital and most physician groups should have one.

2. **Prevention**
   a) Education and training;
   b) The role of counsel prior to being faced with potential health care fraud issue - prevention.

3. **Government sources:**
   a) www.oig.hhs.gov;
   b) Compliance Program Guidance;
   c) Advisory Opinions;
   d) OIG Work Plans.

**VI. Emergency Medical Treatment and Active Labor Act (1986)**

A. **Introduction**

1. Originally enacted to prohibit hospitals from "dumping" patients, by transferring or refusing to treat them if they are unable to pay.

2. Emergency departments are now America's health care safety net:
   a) Over 28 million Americans lack health insurance;
   b) ED is primary component of health care delivery - substantial number of ED visits involve clinically non-urgent complaints;
   c) Point - highly utilized EDs result in delays in treating truly emergent patients and higher costs.

B. **EMTALA Basics - 42 U.S.C. § 1395dd; 42 C.F.R. § 489**

1. When a patient comes to the ED and a request for examination or treatment is made:
   a) The hospital must provide appropriate Medical Screening Exam ("MSE") without delay;
b) If emergency condition exists, treat it;

c) Stabilize;

d) Transfer if appropriate; and

e) Discharge.

2. Definitions:

   a) MSE is not defined - must be within the capabilities of the hospital, including ancillary services routinely available to the ED, by "qualified medical personnel."

   b) "Emergency medical condition" - acute symptoms of sufficient severity (including severe pain) requiring immediate medical attention.

   c) "Stabilized" - no material deterioration of condition is likely during, or as a result of, transfer, including discharge.

      (1) The provider only needs to stabilize to resolve the emergency condition, not resolve the illness.

3. EMTALA applies to all Medicare hospitals that have an ED when a patient presents on hospital property.

4. **Key** - cannot delay MSE or further treatment to inquire about method of payment.

   a) Do not delay or discourage treatment.

5. A hospital may transfer a patient prior to stabilization, if necessary, pursuant to certain restrictions.

C. Obligation of "Receiving" Hospitals - 42 C.F.R. § 489.24(f)

1. A "receiving" hospital must accept a patient who needs special capabilities or facilities if the hospital has capacity.

   a) "Reverse dumping" is prohibited - a hospital with special capabilities (burn unit, neonatal intensive care) may not refuse to accept a transfer.

2. The receiving hospital must have capacity.

3. Must be an "appropriate" transfer as defined by the regulations:

   a) Physician signed certification;

   b) Transfer of medical records, etc.
D. EMTALA Honor Code - 42 C.F.R. § 489.20(m)

1. Thou shalt not dump.

2. Recipient of an inappropriate transfer must report within 72 hours.

3. Also, the statute has whistleblower protections prohibiting hospitals from taking retaliatory action against any physician, employee, etc. reporting an EMTALA violation.

E. On-Call Physician Responsibility - 42 C.F.R. § 489.24(j)

1. If a physician is on-call, that physician must come in if called by an ED physician; 
   a) The on-call physician does not make the decision whether to come in - the ED physician does.

2. Hospitals must maintain an on-call list.

F. EMTALA = Strict Liability

1. Motive for the violation does not matter!

2. Despite the purpose of the statute, EMTALA does not just penalize errors that are motivated by financial screening.

G. Enforcement and Penalties

1. Enforcement is primarily complaint driven;
   a) Enforcement process usually involves notice of intent to exclude from Medicare; hospital files plan of correction (23 day process).

2. Penalties for a violation may include:
   a) Possible exclusion from Medicare;
   b) Up to $50,000 fine;
   c) Private right of action for "personal harm;"
   d) Adverse publicity;
   e) Civil liability.
FEDERAL HEALTH CARE REGULATIONS

Jonathan L. Rue
Parker, Hudson, Rainer & Dobbs LLP
Atlanta, Georgia
jrue@phrd.com
March 1, 2018

TOPICS

• False Claims Act
• Anti-Kickback Statute
• Emergency Medical Treatment and Active Labor Act
FALSE CLAIMS ACT
• Lincoln sponsored FCA in 1863.
• Originally intended to reach defense contractor fraud against federal government.
• Evolved to reach all fraudulent claims for reimbursement intended to get the government to pay money for property or services.
• Deputizes private citizens as attorney generals, bounty hunters, or "relators" entitled to a % of government's recovery.

CIVIL FALSE CLAIMS ACT
— The most important tool of government to combat health care fraud and abuse.
— Prohibits knowingly submitting or causing to be submitted a false claim for payment to the government or using a false record to get claim approved.
— About 50% of FCA cases involve health care fraud.
— Up to 10 year statute of limitations.

31 U.S.C. § 3729 et seq.

Who Is The Federal Government?
• Centers for Medicare and Medicaid Services ("CMS")
• Office of Inspector General HHS
• Federal Bureau of Investigation
• Department of Justice

Who Helps The Government?
• Patients
• Program Beneficiaries
• Employees
• Qui Tam Relators
  • (Whistleblowers)
FALSE CLAIMS ACT

• Lincoln sponsored FCA in 1863.
• Originally intended to reach defense contractor fraud against federal government.
• Evolved to reach all fraudulent claims for reimbursement intended to get the government to pay money for property or services.
• Deputizes private citizens as attorney generals, bounty hunters, or “relators” entitled to a % of government’s recovery.

CIVIL FALSE CLAIMS ACT

• The most important tool of government to combat health care fraud and abuse.
• Prohibits knowingly submitting or causing to be submitted a false claim for payment to the government or using a false record to get claim approved.
• About 50% of FCA cases involve health care fraud.
• Up to 10 year statute of limitations.
  31 U.S.C. § 3729 et seq.
Criminal False Claims Act

“Knowingly and willfully makes or causes to be made any false statement or representation of a material fact” to obtain benefit from program.

42 U.S.C. § 1320a-7b

FCA Liability

• Cost of Non-Compliance
  • Internal investigation, defense & remedy.
  • Attorney’s Fees.
  • Civil & Administrative penalties.

• Civil & Administrative Penalties
  • Per Claim - $11,181 to $22,363.
  • Treble Damages of the government’s loss.
  • Possible exclusion from participation in federal health care programs.
  • Potential Individual Exposure.
Why Does The Government Use The Civil False Claims Act?

- Lower standard of proof.
- Lesser intent requirement - “knowingly” means with “actual knowledge” of facts or “deliberate ignorance” of the true facts or in “reckless disregard” of the facts.
- Potent Fraud Fighting Tool-treble damages, penalties, exclusion.

Use Of The False Claims Act

- National initiatives (off-label promotion of prescription drugs)
- Knowing Retention of Overpayments
- Services not rendered
- Upcoding
- Cost reporting
- Quality of care
- Stark/Anti-Kickback
Whistleblowers or Relators

- Generate vast majority of FCA cases
- Retaliation cause of action
- Right to attorney’s fees, costs & expenses
- Relator’s role
  - Limited party if Government intervenes
  - Principal party if Government declines
  - Government always real party in interest
- Relator’s share
  - If Government Intervenes = 15-25%
  - If Government does not intervene = 25-30%

Anti-Kickback Statute

- Prohibited Conduct:
  - Knowing and willful
  - Solicitation or receipt or offer or payment of
  - Remuneration
  - In return for referring a federal health care program patient, or
  - To induce the purchasing, leasing, or arranging for or recommending purchasing or leasing items or services paid by the program.

42 U.S.C. § 1320a-7b
Anti-Kickback Statute

Penalties

- Criminal fines & imprisonment
- Civil money penalty of $50,000 plus 3X the amount of the remuneration
- Exclusion
- False Claims Act liability

"INTENT TO INDUCE"

United States v. Greber (3rd Circuit 1985)

- If one purpose of the fee was to induce the ordering of services from defendant’s company, the statute was violated.
Anti-Kickback Statute

• Statutory Exceptions
  ◦ Discounts
  ◦ Bona fide employment relationships
  ◦ Certain copayment waivers
  ◦ Certain managed care arrangements
• Safe Harbors (42 C.F.R. § 1001.952)

The Anti-Kickback Statute

• Joint Ventures
• Vendor Relationships
• Service Agreements
• Leases (Space and Equipment)
• Discounts
• Fair Market Value
• Physician Recruitment
• Personal Service Contracts

PARKER HUDSON RAINER & DOBBS
RISK REDUCTION ANALYSIS

- Fraud Alerts
- OIG Guidance – Advisory Opinions, Compliance Guidance
- Industry Practice and Guidance

ANTI-KICKBACK STATUTE

Things to remember:
- Anti-kickback law applies to everyone.
- Anti-kickback law contains an intent element.
- The anti-kickback law is criminal.
- Under anti-kickback statute, behavior or relationships falling outside of a safe harbor may be permissible.
Key Fraud and Abuse Provisions of PPACA (2010)

- To establish violation of anti-kickback statute, government does not have to prove that person had “actual knowledge” of statute or specific intent to violate statute.
- A violation of anti-kickback statute constitutes false or fraudulent claim for purposes of False Claims Act.
- False Claims Act liability where provider fails to report and return overpayment within 60 days of identification of overpayment.

Role of Legal Counsel

- Compliance Programs
- Prevention (Education and Training)
- Government Sources:
  - www.oig.hhs.gov
  - Compliance Program Guidance
  - Advisory Opinions
  - OIG Work Plans
EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (1986)

- Originally enacted to prohibit hospitals from “dumping” patients, by transferring or refusing to treat if unable to pay.
- EDs are now America’s health care safety net.

EMTALA Basics

- When patient comes to emergency department and makes request for treatment:
  - Must provide appropriate Medical Screening Examination (MSE) without delay;
  - If emergency condition exists, treat it;
  - Stabilize;
  - Transfer if appropriate; and
  - Discharge.
- Source: 42 U.S.C. § 1395dd
- 42 C.F.R. § 489
Obligation Of “Receiving” Hospitals

- **Must accept** patient who needs special capabilities or facilities if hospital has capacity.

  42 C.F.R. § 489.24(f)

EMTALA HONOR CODE

**Thou shalt not dump patients.**

42 C.F.R. § 489.20(m)
On Call Physician Responsibility

If you are on call, you must come in if called by ER doctor.

State Operations Manual at A404

EMTALA = STRICT LIABILITY

Motive for the violation does **not** matter!
Enforcement/Penalties

- Complaint Driven
- Possible Exclusion from Medicare
- Up to $50,000 fine
- Private right of action for “personal harm”
STATE HEALTHCARE REGULATIONS

Kathlynn Butler Polvino, KBP Law, P.C., Atlanta
Rachel L. King, Georgia Department of Community Health, Atlanta
John W. Ray, Ray & Gregory LLC, Atlanta
Roxana D. Tatman, Georgia Department of Community Health, Atlanta
Georgia’s Certificate of Need Program

Kathlynn Butler Polvino

Fundamentals of Healthcare Law
March 1, 2018

35 States*, D.C., Puerto Rico & the Virgin Islands have operated CON programs for 30-40 years.

CON in Georgia has been in place for nearly 39 years.

* NH repealed in 2016.
What is a CON?

Certificate of Need is an “official determination” of the Georgia Department of Community Health that a new or expanded health care service or facility is needed and complies with the criteria contained in the CON law and regulations.

Applicable Statutory & Regulatory Provisions

- State Health Planning & Development Act (O.C.G.A. §§ 31-6-1 et seq.)
- DCH Administrative Rules (Ga. Comp. R. & Regs. r. 111-2-1-.02 et seq.)
- CON Appeal Panel Rules (Ga. Comp. R. & Regs. r. 274-1-.01 et seq.)
Goals of the Georgia CON Program

• To ensure that adequate health care services and facilities are:
  • available to the citizens of the State;
  • developed in an orderly and economical manner; and
  • provided in a manner that avoids unnecessary duplication

• To ensure that only health care services that are found to be in the public interest are offered

• To ensure that health care services meet the various needs of the different regions of the State

Scope of the CON Law

• **New Institutional Health Services**
  • A CON is required prior to offering or developing a “New Institutional Health Service” (which may be a capital expenditure)

• **Exemptions**
  • The statute delineates certain facilities, services, and expenditures that do not require a CON even though they may otherwise be “New Institutional Health Services.” However, confirmation of the exemption generally is required.
In terms of number of services covered, Georgia remains one of the most rigorous programs in the country.

- CON is a potential barrier to market entry (new facilities/new services)
- CON considerations may impact or impede strategic initiatives for existing healthcare facilities and physicians (new or expanded services/new projects)
- CON considerations impact alignment strategies between various types of health care providers
- Unimplemented CONs may be at risk if facility transferred without permission from the Department
The Impact of CON Regulation

• CON considerations impact and may change the terms of transactions
  
  • What type of CON authorization or exemption is at issue?
  • Will the potential transaction jeopardize the CON authorization or exemption? Does the answer depend on the type of transaction (assets v. equity)?
  • Is prior approval/clarification required or prudent and how will it impact timing?

• CONs have value, which sometimes leads to disputes regarding who “holds” a CON

The Impact of CON Regulation

• CON may come with conditions/obligations (e.g., indigent & charity care commitment)

• There are penalties for non-compliance with the CON standards
  
  • Knowing development of a new institutional health service without a CON subject to fines of $5,000 per day up to 30 days, $10,000 per day from 31-60 days, and $25,000 per day after 60 days

• CON may be revoked for intentional provision of false information in CON application, failure to pay fines or moneys due DCH, or failure to maintain quality standards developed by DCH
Validity of a CON

• A CON is only valid for the defined scope, location, cost, service area, and person named in an application.

• A CON may not be transferred or assigned.

• However, the purchaser of existing health care facility that holds a valid CON acquires the CON as approved by the Department.
In Georgia, the term includes the “construction or other establishment of a new health care facility”

- General Acute Care Hospital
- Psychiatric or Specialty Hospital
- Long Term Care Hospital
- Ambulatory Surgery Center (unless exempt)
- Skilled Nursing Facility / Intermediate Care Facility
- Rehabilitation Hospital

The term also includes clinical health services not offered during the previous 12 months

- Pediatric Cardiac Catheterization
- Adult Diagnostic Cardiac Catheterization (although exempt in hospitals)
- Angioplasty (although may be exempt)
- Open Heart Surgery
- Obstetrical and Perinatal Services
- Inpatient Psychiatric and Substance Abuse Services
- Home Health Services
- Comprehensive Inpatient Physical Rehabilitation
- Positron Emission Tomography
- MegaVoltage Radiation Therapy
New Institutional Health Service”

• Expansions & upgrades are generally reviewable as a “NIHS” or under Service-Specific Rules. For example:
  • Increase in bed capacity (unless exempt)
  • Conversion or upgrade to a specialty hospital
  • Conversion from a non-reviewable facility to a reviewable facility
  • Increasing perinatal service level (e.g., adding NICU)
  • Adding OB beds or bassinets
  • Adding new counties for Home Health Services
  • Adding operating rooms (depending on cost, type, location)
  • Purchasing an additional Linear Accelerator

The 12–Month Rule

• Clinical health services that are offered in or through a health care facility, which were not “offered” on a regular basis in or through such health care facility within the twelve (12) month period prior to the time such services would be offered is a new institutional health service.
  • Open for acceptance of patients or performance of services
  • Has qualified personnel, equipment and supplies necessary to provide specified clinical health services
“New Institutional Health Service”

• Unless specifically exempted, any expenditure by or on behalf of a health care facility in excess of $2,963,314 (adjusted annually) is an “NIHS”

• Any expenditure to acquire medical equipment by a health care facility or any other party (except a freestanding imaging center) in excess of $1,288,884 (adjusted annually)

• Any expenditure to acquire equipment by a freestanding imaging center, regardless of amount

Expenditures Threshold Considerations (Equipment)

Value Does Not Include: Value Must Include:

• “build out costs,” which are defined to include expenditures related to electrical, plumbing, masonry, modular buildings, renovation, new construction, or administrative space unrelated to the functionality of the equipment

• operator training
• warranty for first five years
• transportation and insurance
• functionally related diagnostic or therapeutic equipment
• options, extra packages, and accessories
• shielding
• first-five-years’ service contract
• volume or bulk purchase discounts
Expenditures Threshold Considerations

- Includes “items or services that are associated with and simultaneously developed or proposed”
- “Share a relationship or association based on law, regulation, function, procedure or process”
- Equipment is used for “same or similar” health services
- Expenses that occur within a 6-month period calculated from operation of the activity or service to second expenditure or operation of the second activity or service
- Does not include expenses outside the 6-month window

STATUTORY CON EXEMPTIONS
Replacement Equipment Exemption

- The replacement of CON-approved or grandfathered equipment regardless of cost is exempt if:
  - the replaced equipment will be removed entirely from the premises (although there are provisions to maintain minimal functionality)
  - the replacement equipment will be located in the same defined location as the replaced equipment
  - the replacement equipment offers a comparable or similar functionality and is used for the same diagnostic or treatment purposes

Replacement Equipment for Certain Freestanding Imaging Centers

- Except in rural counties, existing freestanding imaging centers that obtained an LNR may spend less than $870,000 for repair or replacement of equipment without obtaining a new CON
Physician-Owned, Single Specialty Ambulatory Surgery Centers

- Can be constructed, developed, and established for up to $2,963,314 (adjusted annually) OR
- Must have two or fewer operating rooms AND only one per practice in each county AND
- Must have a hospital affiliation agreement AND
- Must provide 2% indigent and charity care if participates in Medicaid; if the facility will not participate in Medicaid, it must provide 4% indigent and charity care AND
- Must provide annual reports to DCH
- NOTE: Can include general surgeons (and ortho/hand/physiatrists)
- NOTE: Can be owned 15% by non-physicians

Joint Venture Ambulatory Surgery Centers

- Joint venture ASCs between a single hospital and a single physician or a single specialty group of physicians will not require a CON if the ASC:
  - Will be located in the hospital’s county or in a contiguous county if no hospital is located in the contiguous county
  - Will be owned between 30-70% by the single hospital with the remainder owned by a single physician or a single group practice of physicians (physician(s) must own 30% and may own up to 70%)
  - Will be constructed, developed and established for less than $5,926,628 (adjusted annually beginning in July 2009) (six month period for additional expenditures)
  - Commits to provide 2% indigent and charity care if it will participate in Medicaid or, in the alternative, if the ASC will not participate in Medicaid, it must commit to provide 4% indigent and charity care
  - Commits to provide annual reports to DCH (i.e., surveys)
Joint Venture Ambulatory Surgery Centers (Continued)

• The single specialty physician or group practice may consist of general surgeons

• There is no limit on the number of operating rooms

Therapeutic Cardiac Catheterization

• Hospitals that already offer diagnostic cardiac catheterization may seek exemption determination to offer therapeutic catheterizations if they can document that the service meets standards developed by the Department

• Detailed requirements, including volume projections, contained on DET Form

• Ability to offer service will be reevaluated annually (May 1 – May 15th DET filing requirement)

• Therapeutic caths will continue to be regulated by DCH under licensure standards to be developed in the future, with an emphasis on quality
Non-Clinical Projects Exemption

- Expenditures for non-clinical projects, including parking areas, computer systems, software, other information technology and medical office buildings, are exempt
  - Expenditures for such projects can exceed $2,963,314 and still be exempt
  - DCH interprets exemption such that other non-clinical projects, such as gift shops, physical plant repair, renovation to kitchen and laundry areas, etc. are not exempt

Relocation Exemption

- Healthcare facilities, including hospitals and ambulatory surgery centers may relocate without obtaining a new CON:
  - Any SNF or ICF within the same county (& may divide beds)
  - Any other healthcare facility in an urban county (> 35,000) within a 3-mile radius of the existing facility even if the new location is in another county
  - Any health care facility in a rural county within the same county
  - In order to qualify for the exemption, the healthcare facility may not offer new clinical health services that were not offered in the original location and may not expand existing clinical health services
Exemption for Increases in Bed Capacity

- A hospital may apply for an exemption to increase its medical-surgical bed capacity by up to ten beds or ten percent, whichever is greater if:
  - the hospital’s existing beds have attained a 75% utilization over the previous 12 month period; and
  - the hospital has not increased its capacity in the prior 2 year period

Other Miscellaneous Exemptions

- Expenditures for the acquisition of an existing health care facility (unless owned or operated by or on behalf of state actors)
- Offices of private physicians or dentists except cath labs, radiation therapy, lithotripsy or certain ASCs
- Educational or Business Infirmaries
- Infirmaries offered by or on behalf of Dept. of Corrections for sole purpose of providing services to prisoners
- Costs to prepare CONs, acquire sites, or commitment of funds conditioned on CON approval
- Capital expenditures required solely to eliminate or prevent safety hazards or licensure or accreditation standards
- Services offered by or on behalf of an HMO
CON EVALUATION

General Review Considerations

- Consistency with the State Health Plan
- Need
- Existing alternatives are neither currently available, implemented, similarly utilized nor capable of providing a less costly alternative
- Financial Feasibility
- Effects on payors are not unreasonable
- Costs are reasonable and adequate for quality care
- Financial accessibility
- Positive relationship with existing health care delivery system

- Encourages efficient utilization
- Providing services to out of area residents
- Fosters research
- Meets the needs of clinical training programs
- Fosters improvements and innovations, promotes quality
- Fosters the special needs of HMOs
- Meets minimum quality standards
- Ability to obtain necessary resources, including personnel
- Proposing to offer an underrepresented health service
“The population residing in the area served, or to be served, by the new institutional health service has a need for such services.”

-- O.C.G.A. § 31-6-42(a)(2)
Demonstrating Need for a Project

- Numeric Need Calculation for Certain Services
  - E.g., Open Heart: did existing cath lab generate 250 open heart procedures in each of past 2 years?
- Types of Service Specific Need Rules
  - Ambulatory Surgery
  - Perinatal Services
  - SNF
  - Home Health
  - Comprehensive Inpatient Rehabilitation Services
  - PET/CT services
  - Megavoltage Radiation Therapy
  - Psychiatric and Substance Abuse Inpatient Services

Need Projection: MegaVoltage Radiation Therapy

2016 Non-Special MegaVoltage Radiation Therapy Services Need Projection by State Service Delivery Region

<table>
<thead>
<tr>
<th>SSDR</th>
<th>2016 Resident Population</th>
<th>2016 Projected Patients</th>
<th>Average Visits per Patient</th>
<th>2015 Projected Patient Visits</th>
<th>2015 Projected Equivalent Visits by Type of Visit</th>
<th>2016 Projected Non-Special MRT Needed</th>
<th>Current Authorized Inventory</th>
<th>Unmet Need (Surplus/Deficit)</th>
<th>2010 Aggregate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSDR1</td>
<td>994,651</td>
<td>2,428</td>
<td>22</td>
<td>52,349</td>
<td>76,716</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>SSDR2</td>
<td>771,730</td>
<td>1,947</td>
<td>23</td>
<td>45,298</td>
<td>67,439</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>SSDR3</td>
<td>4,907,029</td>
<td>11,325</td>
<td>22</td>
<td>243,788</td>
<td>380,650</td>
<td>42</td>
<td>43</td>
<td>43</td>
<td>1</td>
</tr>
<tr>
<td>SSDR4</td>
<td>387,323</td>
<td>1,197</td>
<td>23</td>
<td>36,195</td>
<td>50,655</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>SSDR5</td>
<td>713,890</td>
<td>1,710</td>
<td>23</td>
<td>39,198</td>
<td>50,707</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>SSDR6</td>
<td>531,851</td>
<td>1,255</td>
<td>22</td>
<td>28,234</td>
<td>41,528</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>SSDR7</td>
<td>489,366</td>
<td>1,156</td>
<td>24</td>
<td>28,167</td>
<td>41,510</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>SSDR8</td>
<td>398,449</td>
<td>927</td>
<td>24</td>
<td>22,554</td>
<td>36,746</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>SSDR9</td>
<td>322,147</td>
<td>723</td>
<td>23</td>
<td>18,042</td>
<td>28,152</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>(1)</td>
</tr>
<tr>
<td>SSDR10</td>
<td>401,573</td>
<td>967</td>
<td>21</td>
<td>20,846</td>
<td>43,421</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>SSDR11</td>
<td>431,195</td>
<td>990</td>
<td>22</td>
<td>21,712</td>
<td>29,937</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>SSDR12</td>
<td>734,883</td>
<td>1,693</td>
<td>23</td>
<td>38,831</td>
<td>60,664</td>
<td>6</td>
<td>9</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Statewide</td>
<td>11,290,096</td>
<td>26,506</td>
<td>22</td>
<td>597,203</td>
<td>927,325</td>
<td>97</td>
<td>104</td>
<td>104</td>
<td>3</td>
</tr>
</tbody>
</table>
Exceptions to Need

- High utilization of existing service
  - E.g., >80% utilization of perinatal service over most recent 2 years
  - E.g., Actual utilization of radiation therapy unit > 90% of optimal utilization over most recent 2 years
- “Atypical barrier to care” based on cost, geographic or financial access or quality

CON APPLICATION AND REVIEW PROCESS
**Batching Review Process**

**Publication of Notice** (2 times per year)
- 30 Days

**Submission of Notice of Intent**
- 30 Days

**Submission of Application**
- 180 day application process (no extensions permitted)
- Applicable to Applications for Home Health, Skilled Nursing, Open Heart, Pediatric Cardiac Cath, Perinatal, OB, Freestanding Birthing Centers, Psych / Substance Abuse, Comprehensive Inpatient Rehab, ASC, PET, and Megavoltage Radiation Therapy
- Applications Must Be Submitted Only at Two Pre-Set Times Each Year

- **Meeting with Applicant / Opposition Form Must Be Submitted**
  - 75 Days

- **Additional Information Due**
  - 90 Days

- **Opposition Meeting and Submission of Substantive Written Opposition**
  - 100 Days

- **Letters of Support Due**
  - 110 Days

- **Amendment and Response to Opposition Due**
  - 120 Days

- **Decision Issued**

**Batching Schedule**

- **Fall/Spring (HHA, SNF, ICF, Perinatal, Inpatient Rehab and Amb/Surg)**
  - September // March  Batching Notice
  - October // April  LOIs Due (5 p.m. deadline)
  - November // May  CONs Filed (12 p.m. deadline)
  - January // July  60 day Meetings & Notice of Opp. Due
  - February // August  Opposition Meeting
  - March // September  Decision

- **Winter/Summer (PET, MVRT, OHS, Psych/SA, Birthing Centers)**
  - December // June  Batching Notice
  - January // July  LOIs Due (5 p.m. deadline)
  - February // August  CONs Filed (12 p.m. deadline)
  - April // October  60 day Meetings & Notice of Opp. Due
  - May // November  Opposition Meeting
  - June // December  Decision
The Notice of Intent to apply must include:

- name and address of applicant;
- contact person;
- facility name and address;
- proposed site location;
- brief summary of proposed project;
- proposed service area; and
- estimated cost of the project

Application must be submitted on exactly the thirtieth day after the Notice of Intent was submitted (unless falls on weekend or holiday)
Opposition Meetings

• A single representative from each opponent must present the reasons for opposition to the Department at the meeting

• Applicants are not allowed to speak at the Opposition Meeting but may attend

• In order to have standing to appeal, opposing parties must participate in the Opposition Meeting
The parties who have standing to appeal the Department’s CON Decision are limited to:

- The Applicant (if denied)
- Any competing (joined or batched) applicant
- Any competing healthcare facility that:
  - notified the Department of its opposition;
  - attended an opposition meeting; and
  - is aggrieved by the Decision
- Any county or municipal government in whose boundaries the proposed project will be located

- The Chair of the Appeal Panel is responsible for determining whether a party has standing, which is construed broadly
Administrative Appeals Process Considerations

- Appeals go before the Certificate of Need Appeal Panel, an independent body composed of up to 5 hearing officers appointed by the Governor for four-year term (2 vacancies remain)
- $1,500 filing fee must be paid with appeal request
- First administrative appeal is de novo and is heard by a hearing officer randomly assigned by the Chair of the Appeal Panel

Scope of Administrative Appeal Hearing

- The issues to be decided by the hearing officer are limited to the following:
  - whether the application is consistent with the review considerations
  - whether the Department committed prejudicial procedural error in the consideration of the application
  - whether the appeal lacks substantial justification
  - whether the appeal was undertaken primarily for the purpose of delay or harassment
- The hearing officer is precluded from determining whether the Department’s rules are correct, adequate, or appropriate
• The hearing officer’s decision may be appealed by filing “specific objections” to the Department’s Commissioner within 30 days of the date of the hearing officer’s decision.

• There is no express statutory or regulatory timeframe for the DCH Commissioner (or the Commissioner’s designee) to issue a decision, but once interpreted to be 60 days from decision.

• The Commissioner is not required to hold a further hearing or hear oral arguments.

• Findings of fact accepted unless lack of “any competent substantial evidence”.

• Interpretation subject to “reasonableness” standard.

**JUDICIAL APPEALS PROCESS**

- Superior Court petitions must be heard within four months of receipt and the Court must issue a decision within 30 days of the hearing.
- A losing petitioner must pay all attorneys' fees and court costs (with some exceptions).

- Superior Court Decision Issued

  - Hearing Held in Superior Court
    - Submission of Petition for Judicial Review
      - DCH Commissioner Decision Issued

  - Appeal to Georgia Supreme Court
    - Appeal to Court of Appeals
      - No Timeframe Specified
• Any party to an appeal, except the Department, may seek judicial review of the Commissioner’s decision
  
  • The Petition must be brought either in Fulton County or the County of Residence of the appellant
  • The Petition must be sought within 30 days of the Commissioner’s decision

• Any Appellant whose Petition fails to prevail must pay all costs and attorney’s fees

- The superior court may reverse or modify the Commissioner’s decision only if the Department’s final decision is:
  - in violation of constitutional or statutory provisions
  - in excess of the statutory authority of the Department
  - made upon unlawful procedures
  - affected by other error of law
  - not supported by substantial evidence (in excess of “any evidence”)
  - arbitrary and capricious

• Strong precedent that the Court is to defer to the Department’s final decision
Further Judicial Review

The Superior Court’s decision must hold a hearing or issue a decision within 120 days of docketing of the Petition or the Department’s final decision is affirmed by operation of law.

A decision of the Superior Court may be reviewed by the Court of Appeals or the Supreme Court of Georgia.
Exemption Determinations (DET)

“Any person proposing an activity that would make it a health care facility unless exempted from prior CON review and approval... shall be required... to submit a request for a letter of determination from the Department... A party is not authorized to commence or undertake the activity in question which it believes falls within any one or more of the statutory exemptions in O.C.G.A. § 31-6-47 until written approval is issued by the Department...”

• Capital Expenditures v. Statutory Exemptions

Exemption Determinations (DET)

• The Department requires a $250 fee and the submission of a determination request form
• Opposition must be filed within 30 days of DCH receipt of request
• The Department’s rules do not mandate a timeframe for response to such determination requests
• No formal process for expedited requests
Letters of Non-Reviewability (LNR)

- Applicable to equipment expenditures and the development of single specialty ambulatory surgery centers (physician owned or joint venture)
- Detailed form for equipment LNR requests
- Requests for LNR must be submitted with a $500 request fee
- Opposition must be filed within 30 days of DCH receipt of LNR request

Appeal of LNRs and DETs

- Requesting party may appeal negative determination to Commissioner or her designee within 30 days
- Opposing parties have the right to request a “fair hearing” if the Department issues favorable determination as long as the party properly opposed the request
- Appeals subject to same Judicial Review procedures as CONs
Projects that do not involve construction or equipment are effective for 12 months. (E.g., conversion of observation beds to inpatient beds)

Projects that solely involve the acquisition of equipment are effective for 12 months, by which time the applicant must be in possession of equipment.

Projects that involve construction are effective based on a schedule set forth in the application. However, for construction projects, an applicant must satisfy the “initial performance requirements” within the first 12 months:
- construction plans approved by State
- construction contract signed (with start and end dates)
- construction materials and equipment are on site

Extensions may be granted due to “circumstances beyond control”
Periodic Reports

• The Department will fine and/or revoke certificates of need if health care facilities do not comply with requirements to submit annual and periodic reports and surveys:
  • If surveys are late or incomplete, the Department may levy a fine of up to $500 per day for the first 30 days and $1,000 per day for every day over thirty days that the surveys are past due or incomplete
  • In addition to levying fines, the Department may revoke a health care facility’s CONs if surveys are not submitted in a complete and accurate fashion within 180 days of the due date
  • CON applications may be rejected for failure to complete surveys (including with batched projects)
STATE HEALTH CARE REGULATIONS

REPORTING REQUIREMENTS

John W. Ray, Jr.
Preeti A. Garde
Ray & Gregory, LLC
6000 Lake Forrest Drive
Suite 385
Atlanta, GA 30328
404-892-3600 telephone
404-892-0445 fax
jray@rayandgregory.com
pgarde@rayandgregory.com
State Health Care Regulations

John W. Ray, Jr.
Preeti A. Garde
Ray & Gregory, LLC
Atlanta, Georgia
jray@rayandgregory.com
pgarde@rayandgregory.com

Table of Contents

Introduction ..................................................................................................................... 1

Acquisition of a Health Care Facility ........................................................................... 1
A. Reporting Requirement for an Entity that Acquires a Health Care Facility ............ 1
   1. Reporting Requirement: .................................................................................... 1
   2. Who Must Report: .......................................................................................... 2
   3. What Information Must Be Reported: .............................................................. 2
   4. When Must the Report Be Made: .................................................................... 2
   5. Where Must the Report Be Made: .................................................................... 2
   6. Additional Considerations: ............................................................................ 2
B. Licensure Reporting Requirements for Changes in Ownership ....................... 2
   1. Hospital Requirements: ................................................................................ 2
   2. Requirements for Other Health Care Providers: .......................................... 3
C. Reporting to the Attorney General Regarding the Acquisition of a Nonprofit Hospital 5
   1. Reporting Requirement: ................................................................................ 5
   2. Who Must Report: ........................................................................................ 6
   3. What Information Must Be Reported: ............................................................ 7
   4. When Must the Report Be Made: .................................................................... 10
   5. Where Must the Report Be Made: .................................................................... 10

III. Hospital Closure and Accreditation ...................................................................... 11
A. Hospital Reporting Requirement if Hospital Closes or Ceases Operations .......... 11
   1. Reporting Requirement: ................................................................................ 11
   2. Who Must Report: ........................................................................................ 11
   3. What Information Must Be Reported: ............................................................ 11
   4. When Must the Report Be Made: .................................................................... 11
   5. Where Must the Report Be Made: .................................................................... 11
   6. Additional Considerations: ............................................................................ 11
B. Accreditation Issues .......................................................................................... 12
   1. Accreditation Reports: ................................................................................. 12
   2. When the Report Must Be Made: ............................................................... 12

IV. **Administrative Changes** ........................................................................... 12
A. Hospital Reporting Requirement of a Change in the Chief Executive Officer/Administrator of the Hospital ......................................................... 12
   1. Reporting Requirement: ........................................................................... 12
   2. Who Must Report: ....................................................................................... 12
   3. What Information Must Be Reported: ...................................................... 13
   4. When Must the Report Be Made: .............................................................. 13
   5. Where Must the Report Be Made: .............................................................. 13
B. Personal Care Home Reporting Requirement if Director of the Facility Changes ............................................................. 13
   1. Reporting Requirement: ........................................................................... 13
   2. Who Must Report: ....................................................................................... 13
   3. What Information Must Be Reported: ...................................................... 13
   4. When Must the Report Be Made: .............................................................. 14
   5. Where Must the Report Be Made: .............................................................. 14
C. Other Facilities: .............................................................................................. 14

V. **Reporting Requirements Regarding Patient Events, Operational and Other Matters** ........................................................................ 14
A. Hospital Reporting Requirements for Certain Patient Incidents ..................... 14
   1. Reporting Requirement: ........................................................................... 14
   2. Who Must Make the Report: ...................................................................... 16
   3. What Information Must Be Reported: ...................................................... 16
   4. When Must the Report Be Made: .............................................................. 16
   5. Where Must the Report Be Made: .............................................................. 17
   6. Additional Considerations: ....................................................................... 17
B. Reporting of Events Involving Hospital Operations ..................................... 18
   1. Reporting Requirement: ........................................................................... 18
   2. Who Must Make the Report: ...................................................................... 18
   3. What Information Must Be Reported: ...................................................... 18
   4. When Must the Report Be Made: .............................................................. 19
   5. Where Must Report Be Made: ................................................................... 19
   6. Additional Considerations: ....................................................................... 19
C. Reporting Requirements for End Stage Renal Dialysis (“ESRD”) Facilities of Certain Events .............................................................. 19
   1. Reporting Requirement: ........................................................................... 19
   2. What Information Must be Reported: ...................................................... 20
   3. When Must the Report be Made: .............................................................. 21
4. Where Must the Report be Made: ................................................................. 21
5. Additional Considerations: ........................................................................ 21

D. Licensure Reporting Requirements for Personal Care Homes .................. 22
1. Reporting Requirement - Elopement: ....................................................... 22
2. Reporting Requirement - Sentinel Events: ............................................... 22

E. Licensure Reporting Requirements for Certain Incidents in Assisted Living Communities ................................................................. 24
1. Reporting Requirement - Elopement: ....................................................... 25
2. Reporting Requirement - Sentinel Events: ............................................... 25

VI. Non-Accidental Patient Injuries ............................................................ 27
A. Health Care Facility Reporting Requirement ......................................... 27
1. Reporting Requirement: .......................................................................... 27
2. Who Must Make the Report ................................................................. 27
3. What Information Must Be Reported: .................................................. 27
4. When Must the Report Be Made: .......................................................... 27
5. Where Must Report Be Made: ............................................................... 28
6. Additional Considerations: ....................................................................... 28

VII. Medical Staff Privileges ...................................................................... 28
A. Reporting Requirements For Denial, Restrictions or Revocation of Medical Staff Privileges ................................................................. 28
1. Reporting Requirement: .......................................................................... 28
2. Who Must Report: .................................................................................. 29
3. What Information Must Be Reported: .................................................. 29
4. When Must the Report Be Made: .......................................................... 29
5. Where Must the Report Be Made: .......................................................... 29
6. Additional Considerations: ....................................................................... 30

VIII. Abuse Reporting ................................................................................. 30
A. Reporting of Child Abuse by Physicians, Hospital Personnel and Others ................................................................. 30
1. Reporting Requirement: .......................................................................... 30
2. Who Must Report: .................................................................................. 31
3. What Information Must Be Reported: .................................................. 31
4. When Must the Report Be Made: .......................................................... 32
5. Where Must the Report Be Made: .......................................................... 32
6. Additional Considerations: ....................................................................... 32

B. Reporting of Abuse or Exploitation of Residents of Long-term Care Facilities by Physicians, Hospital Employees and Others ................................................................. 33
1. Reporting Requirement: .......................................................................... 33
2. Who Must Report: .................................................................................. 33
3. What Information Must Be Reported: ................................................................. 34
4. When Must the Report Be Made: ................................................................. 34
5. Where Must the Report Be Made: ................................................................. 34
6. Additional Considerations: ................................................................. 35

IX. Specific Physician Reporting Requirements ........................................ 35
A. Physicians Must Report Inability to Practice With Reasonable Skill and Safety ................................. 35
   1. Reporting Requirement for Physicians Unable to Practice: ........................................ 35
   2. Who Must Report: ................................................................. 35
   3. What Information Must Be Reported: ................................................................. 35
   4. When Must the Report Be Made: ................................................................. 35
   5. Where Must the Report Be Made: ................................................................. 35
   6. Additional Considerations: ................................................................. 36
B. Physician Notification Requirements Due to Retirement/Sale of Practice ................................. 37
   1. Notification of Patients: ................................................................. 37
   2. Publication in Newspaper: ................................................................. 38
   3. Signage in Office: ................................................................. 38
I. **Introduction.**

Health care attorneys are frequently asked by their clients whether certain incidents or transactions require disclosure or approval by a state regulatory agency. In our experience, it is not uncommon for these requests to be made in the late afternoon on the date the report or notification is due. As a result, these requests can often set off a panicked scramble to review the relevant statutes and regulations to determine whether a report is required, and if so, the proper form and substance of the report.

This paper provides a reference guide to the major circumstances/incidents that trigger a state law reporting/notification obligation. Please note that Georgia law contains a seemingly infinite number of reporting/notification requirements that apply to different types of health care providers under a variety of circumstances, some of which are obscure and others, more common. The goal of this paper is to address the more common occurrences that precipitate a state law reporting or notification requirement.

II. **Acquisition of a Health Care Facility.**

A. **Reporting Requirement for an Entity that Acquires a Health Care Facility.**

1. **Reporting Requirement:**

   Any person who acquires a health care facility through a stock or asset purchase, merger, consolidation, or other lawful means must report the transaction to the Department of Community Health. O.C.G.A. § 31-6-40.1.

   For purposes of this reporting requirement, a “health care facility” is a hospital, destination cancer hospital, special care unit including podiatric facilities, SNF, intermediate care facility, personal care home, ambulatory surgical center, obstetrical facility, health maintenance organization, home health agency and certain diagnostic, treatment or rehabilitation centers. O.C.G.A. § 31-6-2.
2. **Who Must Report:**

   The entity that acquires the health care facility must make the report. O.C.G.A. § 31-6-40.1.

3. **What Information Must Be Reported:**

   The report must include the nature of the acquisition, the date of the acquisition and the name and address of the acquiring entity. Id.

4. **When Must the Report Be Made:**

   The report must be made within forty-five (45) days following the acquisition. Id.

5. **Where Must the Report Be Made:**

   The report must be made to the Department of Community Health. Id. Since this reporting requirement is mandated by the Certificate of Need ("CON") law, this reporting should be made to the Department of Community Health, Division of Health Planning.

6. **Additional Considerations:**

   The Department of Community Health may fine the acquiring entity $500.00 for each day that the notification is late. Id.

**B. Licensure Reporting Requirements for Changes in Ownership.**

1. **Hospital Requirements:**

   a. Hospitals must submit an application for a new operating permit due to a change in ownership. O.C.G.A. § 31-7-3; Rule 111-8-40-.05(d).

   b. **Who Must Report:**

      Since the acquiring entity will be the new permit holder, the acquiring entity submits the application. Id.
c. What Information Must be Reported:
The application for the new operating permit must be submitted to the Department. Proof of ownership documents, as required by the application, must be submitted upon the completion of the transaction changing ownership. Id.

d. When Must the Report be Made:
The application for a new permit due to a change in ownership must be submitted at least thirty (30) days prior to the ownership change whenever possible. Id.

e. Where Must the Report be Made:
The report must be made to the Department of Community Health, Healthcare Facility Regulation Division.

2. Requirements for Other Health Care Providers:

Other health care providers must also submit an application for a new operating permit/license if they undergo a change of ownership or there is a change in their governing bodies.

a. Ambulatory Surgical Centers (Rule 111-8-4-.05): The application for a new permit must be submitted at least thirty (30) days prior to the change in ownership.

b. Assisted Living Communities (Rule 111-8-63-.06): The new owner must submit an application for a new permit if there is a change in ownership.

c. Birthing Centers: (Rule 290-5-41-.02): The application for a new permit must be submitted at least sixty (60) days prior to the change in ownership.

d. Community Living Arrangements (Rule 290-9-37-.29): The new owner must submit an application for a new license if there is a change in ownership.
e. Drug Abuse Treatment and Education Programs (Rule 111-8-19-.05): The new owner must submit an application for a new license if there is a change in the governing body.

f. End Stage Renal Disease Facilities: (Rule 111-8-22-.04): The application for a new license must be submitted at least thirty (30) days prior to the change in ownership.

g. Home Health Agency (Rule 111-8-31-.02): The new owner must submit an application for a new license at least thirty (30) days prior to the anticipated date of the opening of the home health agency.

h. Hospices (Rule 111-8-37-.04): The application for a new license must be submitted at least thirty (30) days prior to the change in ownership.

i. Intermediate Care Homes (Rule 111-8-47-.19 and Rule 111-8-47-.20): The new owner must submit an application for a new permit at least thirty (30) days prior to the anticipated date of the opening of the home.

j. Clinical Laboratories (Rule 111-8-10-.04): The new owner must submit an application for a new license if there is a change in ownership.

k. Narcotic Treatment Programs (Rule 111-8-53-.05): The new owner must submit an application for a license if there is a change in the governing body.

l. Nursing Homes (Rule 111-8-56-.19 and Rule 111-8-56-.20): The new owner must submit an application for a new permit at least thirty (30) days prior to the anticipated date of the opening of the home.

m. Personal Care Homes (Rule 111-8-62-.06): The new owner must submit an application for a new permit if there is a change in ownership or if the governing body significantly changes.
n. Private Home Care Providers (Rule 111-8-65-.05): The new owner must submit an application for a new license if there is a change in ownership.

o. Residential Mental Health Facilities for Children and Youth (Rule 111-8-68-.04): The new owner must submit an application for a new permit at least thirty (30) days prior to the anticipated date of the opening of the facility.

p. Traumatic Brain Injury Facilities (Rule 111-8-71.05): The new owner must submit an application for a new permit if there is a change in the governing body.

q. Radiation Emitting Equipment (Rule 290-5-.22-.02): All users (including facilities) of radiation machines must register their machines with the Department of Human Resources. Any person who sells, leases, transfers, or otherwise disposes of a radiation machine must notify the Department in writing of, when applicable, the name and address of the new owner, lessee, and/or facility, the date of the transaction, and the model and serial number of the machine or machines.

C. Reporting to the Attorney General Regarding the Acquisition of a Nonprofit Hospital.

1. Reporting Requirement:

In the event of an acquisition of a nonprofit hospital, the following notifications must be made to the Office of the Attorney General: (i) the entity acquiring the hospital must provide notice of the acquisition; and (ii) the nonprofit corporation that owns, controls, or operates, directly or indirectly, the hospital that is being acquired must also provide certain information and certifications related to the transaction. O.C.G.A. § 31-7-401.

For purposes of this reporting requirement, an “acquisition” means a purchase or lease by an acquiring entity of the assets of a hospital which is owned, controlled, or operated by a nonprofit corporation and which meets one or more of the following conditions:
a. Constitutes a purchase or lease of fifty (50%) or more of the assets of the hospital; or

b. Constitutes a purchase or lease which, when combined with one or more transfers between the same or related parties occurring within a five-year period, constitutes a purchase or lease of fifty (50%) or more of the assets of the hospital.

O.C.G.A. § 31-7-400.

An “acquisition” does not include:

a. A restructuring of a hospital owned by a hospital authority involving a lease of assets to any not-for-profit or for-profit entity which has a principal place of business located in the same county where the main campus of the hospital in question is located and which is not owned, in whole or in part, or controlled by any other for-profit or not-for-profit entity whose principal place of business is located outside such county; or

b. A restructuring of a nonprofit health system involving the purchase or lease of the assets of a hospital controlled as of March 1, 1999, by the health system's nonprofit parent corporation by another nonprofit entity which is both exempt from federal income taxation and controlled by the same nonprofit parent corporation.

O.C.G.A. § 31-7-400.

2. **Who Must Report:**

The entity that acquires the hospital and the nonprofit corporation that owns, controls or operates the hospital that is being acquired.

Id.
3. **What Information Must Be Reported:**

The acquiring entity and the nonprofit corporation being acquired must provide the following information in conjunction with this reporting:

a. the name of the seller or lessor;

b. the name of the acquiring entity and other parties to the acquisition;

c. the county in which the main campus of the hospital is located;

d. the terms of the proposed agreement and any related agreements including leases, management contracts and service contracts;

e. the acquisition price;

f. a copy of the acquisition agreement and any related agreements including leases, management contracts and service contracts;

h. a financial and economic analysis and report from any expert or consultant retained by the seller or lessor which addresses each of the criteria set forth in O.C.G.A § 31-7-406;

i. articles of incorporation and bylaws of the nonprofit corporation being acquired and related entities and foundations;

j. all donative documents reflecting the purposes of prior gifts of more than $100,000.00 in value by donors to the nonprofit corporation being
acquired or any related entities or foundations for or on behalf of the hospital; and

k. all documents pertaining to the disposition of assets, including those documents which are included as schedules or exhibits to the acquisition agreement and any related agreements.

O.C.G.A. § 31-7-402.

In addition to the information set forth above, two certifications (executed under oath) must also be provided by each member of the governing board and the chief executive officer of the nonprofit corporation which owns, operates or controls the hospital being acquired, and from each member of the governing board and the chief executive officer of any nonprofit corporation that holds a membership, stock, or controlling interest in the nonprofit corporation. O.C.G.A. § 31-7-403. Such certifications do not have to be provided by governing board members who vote to oppose the proposed acquisition of the hospital.

The first certification must disclose whether the director or officer of the nonprofit corporation is or may become, within the three-year period following the completion of the acquisition, a member or shareholder in, or officer, employee, agent, or consultant of, or will otherwise derive any compensation or benefits, directly or indirectly, from the acquiring entity or any related party in connection with or as a result of the transaction.

The second certification must:

a. disclose any financial interest held by the individual or the individual’s family, or held by any business in which such individual or the individual’s family owns a financial interest, in any business which: (a) within the immediately preceding twelve (12) month period sold products, property interests, or services to the nonprofit corporation being acquired; or (b) within the immediately preceding twelve (12) month period sold or within the three-year period after the
completion of the transaction may sell products, property interests, or services to the acquiring entity;

b. disclose any contract pursuant to which a sale was made or may be made of those products, property interests, or services regarding financial interests which are disclosed pursuant to paragraph (1);

c. state that the nonprofit corporation being acquired has received fair market value for its assets or, in the case of a proposed disposition of the hospital to a not-for-profit entity or a hospital authority, stating that the nonprofit corporation has received an enforceable commitment of fair and reasonable community benefits for its assets;

d. state that the market value of the hospital's assets has not been manipulated to decrease their value;

e. state that the terms of the transaction are fair and reasonable to the nonprofit corporation being acquired;

f. state that the transaction is authorized by the nonprofit corporation's governing documents and is consistent with the intent of any major donors who have contributed over $100,000.00;

g. state that the proceeds of the transaction will be used solely in a manner consistent with the charitable purposes of the nonprofit corporation and will not be used, directly or indirectly, to benefit the acquiring entity; and

h. state that the transaction will not adversely affect the availability or accessibility of health care services in the county in which the main campus of the hospital is located.

Id.
4. **When Must the Report Be Made:**

The report must be made at least ninety (90) days notice prior to the proposed acquisition. O.C.G.A. § 31-7-401.

5. **Where Must the Report Be Made:**

The report must be made to the Office of the Attorney General. Id.

6. **Notice, Hearing and Attorney General Report:**

Within ten (10) business days of receiving notice of a proposed acquisition of a nonprofit hospital, the Attorney General must: (i) publish notice of the proposed acquisition in a newspaper of general circulation in the county in which the main campus of the hospital is located; and (ii) notify the governing authority of the county in which the main campus of the hospital is located. O.C.G.A. § 31-7-404. The notice must state: (i) that the Attorney General has received notice of the proposed acquisition; (ii) the names of the parties to the proposed transaction; (iii) the date, time and place of a public hearing regarding the proposed transaction; and (iv) the process by which individuals can submit written comments to the Attorney General regarding the proposed transaction. Id.

A public hearing regarding the proposed acquisition must occur within sixty (60) days of the date on which the Attorney General receives notice of the transaction. O.C.G.A. § 31-7-405. The Attorney General is required to issue a report of its findings of whether the proposed transaction is in the public's interest within thirty (30) days of the public hearing. O.C.G.A. § 31-7-407.1. Parties to such a proposed acquisition who fail to follow the notice, disclosure and certification requirements set forth above may be fined up to a total of $50,000 and the proposed acquisition may be nullified. O.C.G.A. § 31-7-412.
III. Hospital Closure and Accreditation.

A. Hospital Reporting Requirement if Hospital Closes or Ceases Operations.

1. **Reporting Requirement:**

   A hospital must notify the Department of Community Health, Healthcare Facility Regulation Division, if the hospital plans to close or stop operating. Rule 111-8-40-.03.

2. **Who Must Report:**

   The hospital's governing body must submit the report to the Department. Id.

3. **What Information Must Be Reported:**

   In addition to providing notification of the hospital's closure, the governing body must inform the Department of Community Health of the location at which the hospital will store patients' medical records, medical staff information, and all other information after the hospital's closure. Id.

4. **When Must the Report Be Made:**

   The report must be made at least thirty (30) days prior to the anticipated closure. Id.

5. **Where Must the Report Be Made:**

   The Department of Community Health, Healthcare Facility Regulation Division. The hospital must also notify the Department of Transportation ("DOT") of the anticipated date of closure so that the DOT can arrange for the removal of hospital locator signs. Id.

6. **Additional Considerations:**

   The hospital must publish a notice in a widely circulated newspaper(s) in the hospital's service area indicating where hospital medical records and all other information of the hospital can be retrieved by individuals. Id. Additionally, following the
closure of the hospital, the hospital has an ongoing responsibility to notify the Department if there is a change in the location of the patients’ medical records, medical staff information, and all other information from the published location. When the hospital ceases to operate, it must also return its operating permit to the Department of Community Health within ten (10) days of closure. Please note, if the hospital is closing for a period of less than twelve (12) months and plans to reopen under the same ownership, name, classification, and bed capacity, the hospital may request to have its permit placed on temporary inactive status. Id.

B. Accreditation Issues.

1. Accreditation Reports:

Hospitals that receive accreditation from an accrediting body (e.g., Joint Commission) must file with the Department of Community Health, Healthcare Facility Regulation Division, a copy of the full accreditation report each time there is an inspection by the accrediting body as well as copies of any reports related to the hospital’s accreditation status. Rule 111-8-40-.07(1)(e)1.

2. When the Report Must Be Made:

The hospital must file the report(s) within thirty (30) days of receipt of the final report of the inspection.

IV. Administrative Changes.

A. Hospital Reporting Requirement of a Change in the Chief Executive Officer/Administrator of the Hospital.

1. Reporting Requirement:

The hospital must report a change in its chief executive officer/administrator to the Department of Community Health. Rule 111-8-40-.09.

2. Who Must Report:

Hospital administration is responsible for filing this report. Id.
3. **What Information Must Be Reported:**

The report must notify the Department of Community Health of the change in the designation of its chief executive officer/administrator. *Id.*

4. **When Must the Report Be Made:**

The report must be made immediately upon a change in the designation of the chief executive officer/administrator of the hospital. *Id.*

5. **Where Must the Report Be Made:**

The report must be made to the Department of Community Health, Healthcare Facility Regulation Division. *Id.*

B. **Personal Care Home Reporting Requirement if Director of the Facility Changes.**

1. **Reporting Requirement:**

A personal care home must notify the State of any change in the director/administrator of its facility. O.C.G.A. § 31-7-258.

2. **Who Must Report:**

The licensee of the personal care home must file the report. *Id.*

3. **What Information Must Be Reported:**

The report must include notification of the change and any additional information that the Department may require regarding the newly designated director/administrator of the facility, including, but not limited to, any information the licensee may have regarding preliminary or fingerprint records check determinations regarding the new director/administrator. *Id.*
4. **When Must the Report Be Made:**

The report must be made after a new director/administrator of the personal care home has been designated. Id.

5. **Where Must the Report Be Made:**

The report must be filed with the Department of Community Health, Healthcare Facility Regulation Division. Id.

C. **Other Facilities:**

Please note that the licensing regulations applicable to most licensed providers require the provider to notify the Department of any change in control of the facility, which depending upon the facts and circumstances could include changes to senior management such as the facility’s administrator or CEO.

V. **Reporting Requirements Regarding Patient Events, Operational and Other Matters.**

A. **Hospital Reporting Requirements for Certain Patient Incidents.**

1. **Reporting Requirement:**

*Current reporting requirement.* Hospital peer review committee(s) must report the following incidents that involve its patients or that the hospital has reasonable cause to believe involve its patients:

   a. Any unanticipated patient death not related to the natural course of the patient’s illness or underlying condition;

   b. Any rape which occurs in a hospital, and

   c. Any surgery on the wrong patient or the wrong body part of the patient.

Rule 111-8-40-.07(2)(a):1(i)-(iii).
Future reporting requirements.¹ Effective three (3) months after the Department provides written notification to all hospitals, the hospital's duly constituted peer review committee(s) shall also report to the Department, whenever any of the following incidents involving hospital patients occurs or the hospital has reasonable cause to believe that a reportable incident involving a hospital patient has occurred:

a. Any patient injury which is unrelated to the patient's illness or underlying condition and results in a permanent loss of limb or function;

b. Second or third degree burns involving twenty (20) percent or more of the body surface of an adult patient or fifteen (15) percent or more of the body surface of a child which burns were acquired by the patient in the hospital;

c. Serious injury to a patient resulting from the malfunction or intentional or accidental misuse of patient care equipment;

d. Discharge of an infant to the wrong family;

e. Any time an inpatient, or a patient under observation status, cannot be located, where there are circumstances that place the health, safety, or welfare of the patient or others at risk and the patient has been missing for more than eight (8) hours; and

f. Any assault on a patient, which results in an injury that requires treatment.

Rule 111-8-40-.07(2)(a)1(iv).

¹ The Department of Community Health has not to date issued notice requiring hospitals to self-report these seven (7) incidents.
2. **Who Must Make the Report:**

The hospital's peer review committee(s) must file the report. Rule 111-8-40-.07(2)(a). The Department must maintain the confidentiality of these materials. Rule 111-8-40-.07(2)(a).4. The report to the Department does not violate the prohibition against the disclosure of peer review information. See O.C.G.A. § 31-7-133(a).

3. **What Information Must Be Reported:**

The report must include the following information:

a. The name of the hospital;

b. The date of the incident and the date the hospital became aware that a reportable incident may have occurred;

c. The medical record number of any affected patient(s);

d. The type of reportable incident suspected, with a brief description of the incident; and

e. Any immediate corrective or preventative action taken by the hospital to ensure against the replication of the incident prior to the completion of the hospital's investigation.

Rule 111-8-40-.07(2)(a)2

The Department has developed a reporting form for purposes of this reporting requirement, which is attached hereto as Exhibit "A."

4. **When Must the Report Be Made:**

The hospital's peer review committee(s) shall make the self-report of the incident within twenty-four (24) hours or by the next regular business day from when the hospital has reasonable cause to
believe an incident has occurred. *Id.* The report shall be held in confidence by the Department.

5. **Where Must the Report Be Made:**

The report must be filed with the Department of Community Health, Healthcare Facility Regulation Division.

6. **Additional Considerations:**

**Required Investigation and Documented Root Cause Analysis.** Rule 111-8-40-.07(2)(a)3 requires the hospital’s peer review committee(s) to conduct an investigation of any of the incidents listed above and complete and retain on site a written report of the results of the investigation within forty-five (45) days of the discovery of the incident.

The complete report of the investigation shall be available to the Department for inspection at the facility and shall contain at least:

a. An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or other systematic analysis;

b. Any findings or conclusions associated with the review; and

c. A summary of any actions taken to correct identified problems associated with the incident and to prevent recurrence of the incident and also any changes in procedures or practices resulting from the internal evaluation using the hospital’s peer review and quality management processes.

Rule 111-8-40-.07(2)(a)3.

**Confidentiality of the Report.** The Department shall hold the self-report made through the hospital’s peer review committee(s) concerning a reportable patient incident in confidence as a peer review document or report and not release the self-report to the public. Rule 111-8-40-.07(2)(a)4. However, where the Department
determines that a rule violation related to the reported patient incident has occurred, the Department will initiate a separate complaint investigation of the incident. Id. The Department’s complaint investigation and the Department’s report of any rule violation(s) arising either from the initial self-report received from the hospital or an independent source shall be public record. Id.

B. Reporting of Events Involving Hospital Operations.

1. Reporting Requirement:

Rule 111-8-40-.07(2)(b) requires a hospital to report to the Department whenever any of the following events involving hospital operations occurs or when the hospital becomes aware it is likely to occur, to the extent that the event is expected to cause or causes a significant disruption of patient care:

   a. A labor strike, walk-out, or sick-out;

   b. An external disaster or other community emergency situation; and

   c. An interruption of services vital to the continued safe operation of the facility, such as telephone, electricity, gas, or water services.

2. Who Must Make the Report:

Hospital administration must file the report. Id. Unlike some of the information provided for above, this information is not peer review information, and thus, the peer review committee(s) is not required to submit the report.

3. What Information Must Be Reported:

The report shall include:

   a. The name of the hospital;

   b. The date of the event, or the anticipated date of the event, and the anticipated duration, if known;
c. The anticipated effect on patient care services, including any need for relocation of patients; and

d. Any immediate plans the hospital had made regarding patient management during the event.

Rule 111-8-40-.07(2)(b)(2).

The Department has developed a reporting form for purposes of this reporting requirement, which is attached hereto as Exhibit “B.”

4. **When Must the Report Be Made:**

The hospital’s administration shall make the self-report of the incident within twenty-four (24) hours or by the next regular business day from when the hospital has reasonable cause to believe an incident has occurred. *Id.*

5. **Where Must Report Be Made:**

The Department of Community Health, Healthcare Facility Regulation Division.

6. **Additional Considerations:**

Within forty-five (45) days following the discovery of the event, the hospital shall complete an internal evaluation of the hospital’s response to the event where opportunities for improvement relating to the emergency disaster preparedness plan were identified. The hospital shall make changes in the emergency disaster preparedness plan as appropriate. The complete report of the evaluation shall be available to the Department for inspection at the facility. Rule 111-8-40-.07(2)(b)(3).

C. **Reporting Requirements for End Stage Renal Dialysis (“ESRD”) Facilities of Certain Events.**

1. **Reporting Requirement:**

ESRD facilities must report the following incidents involving patients receiving dialysis services:
a. Any unanticipated patient death not related to the natural course of the illness or the patient’s underlying condition occurring at the facility or as a direct result of treatment received in the facility;

b. Any serious injury resulting from the malfunction or intentional or accidental misuse of patient care equipment;

c. Exsanguination while at the facility;

d. Any patient dialyzed with another patient’s dialyzer where the facility reuses the hemodialyzers;

e. Any deviation in fulfilling the patient prescription which results in a significant adverse patient outcome; and

f. Any sexual or physical assault of or by a patient which is alleged to have occurred in the facility.

Rule 111-8-22-.07(3).

2. **What Information Must be Reported:**

The initial report shall be received by the Department in confidence, and shall include at least:

a. The name of the facility;

b. The date of the incident and that date that the facility became aware that a possible reportable incident may have occurred;

c. The medical record number(s) of any affected patient(s);

d. The type of incident suspected, with a brief description of the incident; and
e. Any immediate corrective action or preventative action taken by the facility to ensure against the replication of the incident prior to the completion of the facility investigation.

Rule 111-8-22-.07(4).

3. **When Must the Report be Made:**

The facility shall make an initial report of the incident within twenty-four (24) hours or by the next business day from when the incident occurred, or from when the facility has reasonable cause to suspect a reportable incident. \(\text{Id.}\)

4. **Where Must the Report be Made:**

The report must be made to the Department of Community Health, Healthcare Facility Regulation Division. A copy of the reporting form is attached hereto as Exhibit “C.”

5. **Additional Considerations:**

The facility is required to conduct an investigation of any of the incidents listed above and to complete and retain on site a written report of the results of the investigation within forty-five (45) days of the discovery of the incident. The complete report of the investigation shall be available to the Department for inspection at the facility, and shall contain at least the following:

a. An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or other appropriate quality improvement process or tool;

b. Any findings and conclusions associated with the review; and
c. A summary of any actions taken to correct identified problems associated with the incident, and to reduce the potential for recurrence of the incident.

Rule 111-8-22-.07(5).

D. Licensure Reporting Requirements for Personal Care Homes.

1. **Reporting Requirement - Elopement:**

   Personal care home staff must call the local police department to report the elopement of any resident within thirty (30) minutes of the staff having actual knowledge that such resident is missing from the home in accordance with the Mattie's Call Act and the requirements of O.C.G.A. § 35-3-170 et seq. See Rule 111-8-62-.30(1). The personal care home must report the initiation and discontinuation of a Mattie’s call to the Healthcare Facility Regulation Division utilizing the Department’s complaint intake system within thirty (30) minutes of communicating the same with local law enforcement. Id.

2. **Reporting Requirement - Sentinel Events:**

   a. Personal care home staff must report the following serious incidents utilizing the Department’s complaint intake system when the following incidents occur or when there is reason to believe the events may have occurred:

   i. accidental or unanticipated death of a resident not directly related to the natural course of the resident’s underlying medical condition;

   ii. serious injury to a resident that requires medical attention;
iii. rape, assault or battery on a resident, or abuse, neglect or exploitation of a resident in accordance with the Long Term Care Resident Abuse Reporting Act (O.C.G.A. § 31-8-80 et. seq. (See Section VIII.B. of this paper);

iv. external disaster or other emergency situation affecting the continued safe operation of the residence;

v. circumstances where a member of the governing body, administration, staff or family member of staff is associated with an account at a financial institution, will, trust, benefit of a substantial value or life insurance policy of a resident or former resident to verify that such a gift is knowingly and voluntarily made and is not the result of coercion; and

vi. when an owner, director or employee acquires a criminal record.

Rule 111-8-62-.30(2).

b. What Information Must be Reported:
The report must be submitted through the Department’s complaint intake system. The reporting form is attached hereto as Exhibit “D.” The report must contain the name of the home and the administrator or site manager. Additionally, the report must contain the date of the incident and the date the home became aware of the incident, along with the type of incident that is suspected including a brief description of the incident. Finally, the report must contain the remedial and quality measures determined through the home’s peer review process to be undertaken by the home to make the injury less likely to reoccur. See Rule 111-8-62-.30(3)(a)-(d).
c. When Must the Report be Made:
The report must be made within twenty-four (24) hours after the incident occurred or was believed to have occurred. See Rule 111-8-62-.30(2).

d. Where Must the Report be Made:
The report must be submitted through the complaint intake system with the Department of Community Health, Healthcare Facility Regulation Division. Id.

e. Confidentiality of the Report:
The Department shall hold the report made through the personal care home’s peer review process in confidence. Rule 111-8-62-.30(3). However, where the Department determines that a rule violation related to the reported patient incident has occurred, the Department will initiate a separate complaint investigation of the incident. 111-8-62-.30(4). The Department’s complaint investigation and the Department’s report of any rule violation(s) arising either from the initial report received from the personal care home or an independent source is subject to disclosure in accordance with applicable law. Id.

E. Licensure Reporting Requirements for Certain Incidents in Assisted Living Communities.

Brief Background. Assisted living communities are personal care homes with 25 or more residents that provide “assisted living care” to adults who require assistance with activities of daily living but do not require continuous medical or nursing care.

“Assisted living care” means the provision of specialized care and services to residents, including the provision of personal services (e.g., eating, bathing, toileting, ambulation, assistance with or supervision of self-administered medications, etc.), the administration of medications by a certified medication aide to residents who cannot or chose not to self-administer their medications, and the provision of staff assistance to residents who need help to safely exit the premises in the event of an emergency. Rule 111-8-63-.03.
1. **Reporting Requirement - Elopement:**

   Assisted living community staff must call the local police department to report the elopement of any resident within thirty (30) minutes of the staff having actual knowledge that such resident is missing from the assisted living community in accordance with the Mattie’s Call Act and the requirements of O.C.G.A. § 35-3-170 et seq. See Rule 111-8-63-30(1). The assisted living community must report the initiation and discontinuation of a Mattie’s call to the Healthcare Facility Regulation Division within thirty (30) minutes of communicating the same with local law enforcement. *Id.*

2. **Reporting Requirement - Sentinel Events:**

   a. Assisted living community staff must report the following serious incidents to the Department when the following incidents occur or when there is reason to believe the events may have occurred:

   i. accidental or unanticipated death of a resident not directly related to the natural course of the resident’s underlying medical condition;

   ii. serious injury to a resident that requires medical attention;

   iii. rape, assault or battery on a resident, or abuse, neglect or exploitation of a resident in accordance with the Long Term Care Resident Abuse Reporting Act (O.C.G.A. § 31-8-80 et. seq. (See Section VIII.B. of this paper);

   iv. external disaster or other emergency situation affecting the continued safe operation of the residence; and
v. when an owner, director or employee
acquires a criminal record.

Rule 111-8-63-.30(2).

b. What Information Must be Reported:
The reporting form is attached hereto as Exhibit “D.” The report must contain the name of the assisted living community and the administrator or site manager. Additionally, the report must contain the date of the incident and the date the assisted living community became aware of the incident, along with the type of incident that is suspected including a brief description of the incident. Finally, the report must contain the immediate corrective or preventive action taken by the assisted living community to ensure against the replication of the incident. See Rule 111-8-63-.30(3)(a)-(d).

c. When Must the Report be Made:
The report must be made within twenty-four (24) hours after the incident occurred or was believed to have occurred. See Rule 111-8-63-.30(2).

d. Where Must the Report be Made:
The report must be filed with the Department of Community Health, Healthcare Facility Regulation Division. Id.

e. Confidentiality of the Report:
The Department shall hold the report made by the assisted living community in confidence. Rule 111-8-63-.30(3). However, where the Department determines that a rule violation related to the reported patient incident has occurred, the Department will initiate a separate complaint investigation of the incident. 111-8-63-.30(4). The Department’s complaint investigation and the Department’s report of any rule violation(s) arising either from the initial report received from the assisted living community or an independent source is subject to disclosure in accordance with applicable law. Id.
VI. Non-Accidental Patient Injuries.

A. Health Care Facility Reporting Requirement.

1. Reporting Requirement:

Caregivers who are involved in the care and treatment of patients and security personnel of a medical facility must report, as provided below, if such person has reason to believe that a patient has suffered injuries other than by accidental means. O.C.G.A. § 31-7-9(b).

2. Who Must Make the Report:

Any of the following caregivers involved in the care and treatment of patients must make the required report: (i) physicians; and (ii) licensed registered nurses and other employees of a hospital (including destination cancer hospitals or specialty hospitals), institutional infirmary, public health center or DTRC, including an ASC and a freestanding imaging center. All security personnel employed by any medical facility listed above must also file such a report. Id.

3. What Information Must Be Reported:

The report must contain the name and address of the patient, the nature and extent of the patient’s injuries, any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator. O.C.G.A. § 31-7-9(c).

4. When Must the Report Be Made:

An oral report shall be made immediately by telephone or otherwise and shall be followed by a report in writing, if requested, to the person in charge of the medical facility or his designated delegate. The person in charge of the medical facility or his designated delegate shall then notify the local law enforcement agency having primary jurisdiction in the area in which the medical facility is located of the contents of the report. Id.
5. **Where Must Report Be Made:**

The report must be made to the person in charge of the medical facility. The person in charge must then report the information to the local police authority. *Id.*

6. **Additional Considerations:**

Any person or persons participating in the making of a report or causing a report to be made to the appropriate police authority pursuant to this Code section or participating in any judicial proceeding or any other proceeding resulting therefrom shall be immune from any civil liability that might otherwise be incurred or imposed, provided such participation pursuant to this Code section shall be in good faith. See O.C.G.A. § 31-7-9(d).

VII. **Medical Staff Privileges.**

A. **Reporting Requirements For Denial, Restrictions or Revocation of Medical Staff Privileges.**

1. **Reporting Requirement:**

Hospitals must report to the appropriate licensing board when, for any reason involving the medical care provided to a patient, the hospital: (i) denies an application for medical staff privileges of a doctor of medicine, osteopathy, podiatry or dentistry; or (ii) restricts or revokes the medical staff privileges of such an individual who already holds privileges at the hospital. O.C.G.A. § 31-7-8(a); Rule 111-8-40-.09.

The hospital is also required to report all resignations from the hospital's medical staff of any doctor of medicine, osteopathy, podiatry or dentistry. *Id.*

No report is required for temporary suspensions for failure to comply with medical record regulations. *Id.*
2. **Who Must Report:**

According to O.C.G.A. § 31-7-8(a), the hospital administrator or chief executive officer must submit the report.

This requirement is also applicable to personal care homes, assisted living communities, nursing homes, freestanding ambulatory surgery centers, abortion facilities, birthing centers, specimen collection or testing facilities, traumatic brain injury facilities and certain imaging centers. See O.C.G.A. § 31-7-1(4).

3. **What Information Must Be Reported:**

The report must contain a statement detailing the nature of the restriction, denial or revocation of medical staff privileges, the date such action was taken and the reasons for such action. O.C.G.A. § 31-7-8(c).

If the action is a voluntary resignation or restriction of medical staff privileges, which was the result of action initiated by the institution, the report shall contain the circumstances involved therein. Id.

4. **When Must the Report Be Made:**

The report must be made within twenty (20) working days following final action by the hospital on the restriction, denial, or revocation of medical staff privileges. O.C.G.A. § 31-7-8(b).

The results of any legal appeal of such action shall be reported within twenty (20) working days following a final court decision on such appeal. Id.

5. **Where Must the Report Be Made:**

The report must be filed with the appropriate licensing board (i.e., the Composite Medical Board, the Board of Podiatry or the Board of Dentistry, as applicable).
6. **Additional Considerations:**

**Civil and Criminal Immunity.** O.C.G.A. § 31-7-8(d) states that there shall be no civil or criminal immunity and no cause of action for damages against any administrator, chief executive officer or any other authorized person who in good faith files the report(s) required by this Code Section.

**Confidentiality.** Information contained in any report made to the appropriate licensing board pursuant to this Code section shall be confidential and shall not be disclosed to the public. Access to such reports shall be limited to members of the appropriate licensing board or its staff for their use and to interested institutions for their use in the review of medical staff privileges at the institution. O.C.G.A. § 31-7-8(e). The Board’s confidentiality obligation does not extend to the information the Board is required to gather and maintain regarding each licensed physician’s professional profile. See id; O.C.G.A. § 43-34A-3.

**Failure to Report.** Failure to make the required reports constitutes grounds for denial, refusal to renew, or revocation of the hospital’s operating permit. O.C.G.A. § 31-7-8 (f).

**Psychologist Reports.** When any health service provider psychologist is denied staff privileges or is removed from the medical or professional staff, such action shall be reported by the facility to the State Board of Examiners of Psychologists. O.C.G.A. § 31-7-165.

VIII. **Abuse Reporting.**

A. **Reporting of Child Abuse by Physicians, Hospital Personnel and Others.**

1. **Reporting Requirement:**

A physician, a hospital staff member and the individuals listed below who have reasonable cause to believe that a child is being abused must notify the Georgia Department of Human Services, Division of Family and Children Services ("DFCS") of the suspected child abuse. O.C.G.A. § 19-7-5.
2. **Who Must Report:**

Any of the following individuals who have reasonable cause to believe a child is being abused must report the abuse: physicians licensed to practice medicine, physician assistants, interns or residents; hospital or medical personnel; dentists; licensed psychologists and persons participating in internships to become a licensed psychologist; podiatrists; registered professional nurses or licensed practical nurses; professional counselors, social workers or licensed marriage and family therapists; school teachers; school administrators; school guidance counselors, visiting teachers, school social workers or certified school psychologists; child welfare agency personnel; child-counseling personnel; child service organization personnel; law enforcement personnel, or reproductive health care facility or pregnancy resource center personnel and volunteers. *Id.*

If a person is required to report child abuse because he/she attends to a child as a result of his/her duties as an employee or volunteer of a hospital, school, social agency or similar facility, such person must notify the person in charge of the facility or his/her designated delegate, of the suspected child abuse. *Id.* The individual in charge of the facility is then responsible for reporting the child abuse to DFCS and may not change or modify the information provided by the reporter. *Id.*

If a person required to report child abuse has reasonable cause to believe that child abuse has occurred involving a person who attends to a child as a result of his/her duties as an employee or volunteer of a hospital, school, social agency or similar facility, such person must notify the person in charge of the facility or his/her designated delegate, of the suspected child abuse. *Id.* The individual in charge of the facility is then responsible for reporting the child abuse to DFCS and may not change or modify the information provided by the reporter. *Id.*

3. **What Information Must Be Reported:**

The report must include the names and addresses of the child and the child's parents or caretakers (if known), the child's age, the nature and extent of the child's injuries, including any evidence of
previous injuries, and any other information that the reporter believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator. Id.

4. **When Must the Report Be Made:**

An oral report of the child abuse must be made immediately, but in no case later than twenty-four (24) hours from the time there is reasonable cause to believe that the child has been abused. DFCS may request the reporter to provide a written report of the child abuse after the oral report has been made. Id.

5. **Where Must the Report Be Made:**

The report must be made with the Georgia Department of Human Services, Division of Family and Children Services. Id.

6. **Additional Considerations:**

**Photographs.** Photographs of the child's injuries to document and support the allegations made by hospital staff, physicians, law enforcement personnel, school officials, or staff of legally mandated public or private child protective agencies may be taken without the permission of the child's parent or guardian. Such photographs must be made available as soon as possible to DFCS and the police.

**Immunity.** Any person or persons, partnership, firm, corporation, association, hospital, or other entity participating in the making of a child abuse reporting to DFCS or to the police, or participating in any judicial proceeding or any other proceeding resulting from the child abuse reporting, is immune from any civil or criminal liability that may arise from the reporting provided that the reporting is made in good faith.

**Privileged Communications.** Any person who is required to report suspected child abuse must report the abuse even if the reasonable cause to believe such
abuse has occurred or is occurring is based in whole or in part upon any communication that is otherwise privileged or confidential by law except for certain communications with clergy.

Failure to Report. Any person or official who is required to report a suspected case of child abuse and knowingly and willfully fails to do so may be guilty of a misdemeanor.

Id.

B. Reporting of Abuse or Exploitation of Residents of Long-term Care Facilities by Physicians, Hospital Employees and Others.

1. Reporting Requirement:

A physician, a hospital employee and any other individual listed below who has knowledge that any resident or former resident of a long-term care facility has been abused or exploited while residing in a long-term care facility must notify the Department of Community Health of the suspected abuse or exploitation. O.G.C.A. § 31-8-82.

Abuse means any intentional or grossly negligent act or series of acts or an intentional or grossly negligent omission to act which causes injury to the resident including, but not limited to, assault or battery, failure to provide treatment or care, or sexual harassment of the resident. O.G.C.A. § 31-8-81.

Exploitation means an illegal or improper use of a resident or the resident's resources through undue influence, coercion, harassment, duress, deception, false representation, false pretense or other similar means for one's own or another's profit or advantage. Id.

2. Who Must Report:

Any of the following individuals who have knowledge that a resident of a long-term care facility has been abused or exploited while a resident at such facility must report the abuse/exploitation:
any person required to report child abuse as provided in O.C.G.A. §19-7-5 (See Section VIII.A. of this paper), an administrator, manager or other employee of a hospital or long-term care facility, physical therapist, occupational therapist, day-care personnel, coroner, medical examiner, EMS personnel, an employee of a public or private agency engaged in professional services to residents and clergyman. O.G.C.A. § 31-8-82.

3. What Information Must Be Reported:

A report of suspected abuse or exploitation must include the following: the name and address of the person making the report unless such person is not required to make a report; the name and address of the resident or former resident; the name and address of the long-term care facility; the nature and extent of any injuries or the condition resulting from the suspected abuse or exploitation; the suspected cause of the abuse or exploitation; and any other information which the reporter believes might be helpful in determining the cause of the resident's injuries or condition and in determining the identity of the person or persons responsible for the abuse or exploitation. Id.

4. When Must the Report Be Made:

The report must be made immediately upon learning of the abuse/exploitation to the Department of Community Health by either telephone or in person and the report must be made to the appropriate law enforcement agency. A written report must also be submitted to the Department within twenty-four (24) hours after making the initial, oral reporting regardless of where it was made. Id.

5. Where Must the Report Be Made:

The report must be made to the Department of Community Health, Healthcare Facility Regulation Division. Id.
6. **Additional Considerations:**

Any person who in good faith makes a resident abuse reporting or provides information or evidence in connection with the same is immune from liability for such actions. O.G.C.A. § 31-8-85.

IX. **Specific Physician Reporting Requirements.**

A. **Physicians Must Report Inability to Practice With Reasonable Skill and Safety.**

1. **Reporting Requirement for Physicians Unable to Practice:**
   It shall constitute “unprofessional conduct” (which is subject to disciplinary proceedings, including loss of license) if a physician fails to report to the Composite Medical Board that he/she is unable to practice medicine with reasonable skill and safety due to illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical condition. O.C.G.A. §§ 43-1-19(a)(10); 43-34-8(a)(13); 43-34-5.1; Rule 360-3-.02.

2. **Who Must Report:**

   The physician in question must make the report. Rule 360-3-.02(20).

3. **What Information Must Be Reported:**

   The physician must report the circumstances regarding his/her inability to practice with reasonable skill and safety. Id.

4. **When Must the Report Be Made:**

   The report must be made within thirty (30) days of becoming unable to practice medicine with reasonable skill and safety due to one of these three conditions. Id.

5. **Where Must the Report Be Made:**

   The report must be filed with the Composite Medical Board. Id.
6. **Additional Considerations:**

The failure to report shall be grounds for disciplinary proceedings against the physician, including the loss of the physician’s license. Id.

7. **The Georgia Professional Health Program – Physicians, Physician Assistants and Respiratory Therapists Who Suffer From Addictive Disorders:**

The **GA PHP**. In 2012, the Board selected Georgia PHP, Inc. (the “GA PHP”) to implement the State’s new program to help physicians and other health care professionals who develop addictive disorders. The GA PHP is a not-for-profit foundation established to carry out the authority of the Board through: (i) coordinated evaluations and/or assessment of health care professionals to determine whether the professional can practice with reasonable care and safety; and (ii) the monitoring and rehabilitation of such professionals, as necessary. O.C.G.A. § 43-34-5.1; Rule 360-11-.01.

**Purpose.** The GA PHP provides initial triage, referral to treatment and long-term monitoring services for physicians, physician assistants and respiratory therapists with addictive disorders. This program does not extend to physicians with mental health disorders; however, providers with a dual diagnosis (addictive disorders and mental health disorders) may be candidates for the program. The primary goal of the GA PHP is to assure that physicians enrolled in the program return to practice only when they can do so with reasonable skill and safety. See Rule 360-11-.01 et seq.

**No Report to Board.** If a practitioner enrolls in the GA PHP, the practitioner does not need to report his/her impairment to the Board. Rule 360-3-.02(20).

**GA PHP Reporting Requirements.** The GA PHP is required to make a written report to the Board, within 72 hours of each instance where a health care professional has:
a. failed to comply with the terms of participation in the GA PHP;

b. Refused to cease practice when he/she has been found to be unable to practice with reasonable skill and safety;

c. withdrawn from participation in the program against medical advice;

d. engaged in conduct or behavior which indicates that the health care professional is believed to constitute an imminent danger to the public or to himself or herself; or

e. failed to abide by the terms and conditions of a monitoring agreement.

Rule 360-11-.03(6). Information regarding the GA PHP is contained in Exhibit “E”.

B. Physician Notification Requirements Due to Retirement/Sale of Practice.

Physicians must maintain a patient’s complete medical and treatment records for a period of no less than ten (10) years from the patient’s last office visit. Rule 360-3-.02(16)(a). This requirement shall not apply to a physician who has retired from or sold his or her medical practice; provided, however, that the physician meets the requirements set forth below. Id.

1. Notification of Patients:

Physicians who have retired or sold their medical practice must notify his or her patients of retirement from or sale of their practice by mail, at the last known address of his or her patients, offering to provide the patient’s records or copies thereof to the patient or another provider of the patient’s choice. Rule 360-3-.02(16)(b).
2. **Publication in Newspaper:**

Physicians who have retired or sold their medical practice must also publish a notice in the newspaper of greatest circulation in each county in which the physician practices and in a local newspaper that serves the immediate practice area. The notice must contain the date of the retirement or sale and offer to provide the patient's records or copies thereof to the patient or another provider of the patient's choice. Rule 360-3-.02(16)(b)2.

3. **Signage in Office:**

Physicians who have retired or sold their medical practice must also place in a conspicuous location in or on the façade of the physician's office, a sign announcing their retirement or sale of the practice. The sign shall be placed thirty (30) days prior to retirement or the sale of the practice and shall remain until the date of retirement or sale. Rule 360-3-.02(16)(b)3. The notice must advise the physician's patients of their opportunity to transfer or receive their records. Rule 360-3-.02(16)(b)4.
REQUIRED HOSPITAL SELF REPORTS TO THE DEPARTMENT FORM
(Please Type Form)

FACILITY INFORMATION

Name of Hospital: __________________________________________________________

Hospital Type: _______________________________ License #: ___________________

Address: _________________________________________________________________

City: ____________________________ State: __________________ Zip Code: _________

Person Reporting Incident: __________________________ Title: ________________

Contact Person(s): ___________________________ Phone Number of Contact: ______

Fax #: __________________________ Email Address: ____________________________

Patient/Reporting Information

Date _______ Time _______ a.m./p.m. Reported to HFRD

Date _______ Time _______ a.m./p.m. Incident Occurred

Date _______ Time _______ a.m./p.m. Hospital was Aware that Reportable Incident May
have Occurred

Patient Name: ___________________________ Age: _______ Sex: _______ Date of Birth: ______

Medical Record #: ___________________________ Date of Admission: ______

Diagnosis (all): __________________________________________________________

________________________________________________________________________

________________________________________________________________________

Type of Incident: Please check appropriate boxes. (Attach a copy of incident report if applicable)

[ ] Any unanticipated patient death not related to the natural course of the patient’s illness or
underlying condition

[ ] Any surgery on the wrong patient or the wrong body part of the patient

[ ] Any rape which occurs in the hospital

EXHIBIT A
**Briefly describe circumstances of the incident:**

(attach additional sheet if necessary)

---

**Immediate Corrective or Preventive Action Taken:**

(attach additional sheet if necessary)

---

**Note:**
If the incident involved a death, was the medical examiner notified? [ ] Yes [ ] No
Was an autopsy requested? [ ] Yes [ ] No
Name and contact number of Medical Examiner

---

**Additional Required Reports: Please check appropriate boxes**

The hospital shall make a report of the event within 24 hours or by the next regular business day from when the reportable event occurred or from when the hospital has reasonable cause to anticipate that the event is likely to occur.

---

**Acknowledgement of Information Reported:**

I swear that the information reported within this form is true and accurate and completed to the best of my knowledge.

---

**Signature of Person Completing Form**

**Title**

**Date Completed**

---

**Print Name**

---

### For Department Use Only

Received in S/A Date: __________________________

Reviewed By: __________________________

Date: __________________________

Reporting time frame of 24 hours next business day met? [ ] Yes ( ) No

Action Required [ ] Yes ( ) No

Self Report ID #: __________________________

Complaint Number: __________________________

---

This report is required as set forth in the Hospital Rules §230-9-7-.07 (2) and must be submitted to the Department within twenty-four (24) hours or by the next regular business day from when the incident occurred, or from when the facility has reasonable cause to suspect a reportable incident §230-9-7-.07.2.
Healthcare Facility Regulation Division

Sample Flow Chart for Decisions in Self-Reporting Unanticipated Patient Deaths

(Note: Every incident/event is unique. This document is only intended to provide guidance. If in attempting to evaluate your event, you continue to have doubt about whether or when to make a self-report, you may wish to go ahead and send the report, or call for assistance.)

1. Patient dies.

Evaluate available information from records and staff reports at the time of the death.

- Is there reason to believe the death was expected, or that the patient died as a result of the natural course of their illness?
  - Yes
  - No

- Is there any reason to believe the death was due to a fall or accident at the hospital, or was a purposeful act on the part of the patient (suicide)?
  - Yes
  - No

- Does preliminary review show a reason to believe there was a deviation in the standard of care during treatment that could have caused or contributed to the patient death?
  - Yes
  - No

- In the absence of any of the above, is there reason to believe on preliminary review that one of the patient's comorbidities contributed to or caused the death?
  - Yes
  - No

Proceed with hospital's internal investigation.

- If the investigation reveals the patient's death was caused by a natural course of the patient's illness or by the patient's comorbid conditions, the death does not need to be reported.
- Do investigation findings reveal a deviation in standard of care or that the death was not caused by the comorbid condition as previously suspected?
  - Yes
  - No

Report to HFRO within 24 hours of awareness of a reason to believe a deviation in the standard of care may have caused or contributed to the patient death.

Any patient death due to a fall or accident at the hospital must be reported within 24 hours. Also report within 24 hours of discovery of reason to believe the event was a suicide.

Report to HFRO within 24 hours; proceed with hospital's internal investigation (including autopsy, if applicable) after reporting.

HFRO Decision Flow Chart for Reporting Unanticipated Deaths.doc Revised 01/2010
Healthcare Facility Regulation Division
Sample Flow Chart for Decisions in Hospital Self-Reporting of Rape Allegations

Note: Every incident/event is unique. This document is only intended to provide guidance. If in attempting to evaluate your event, you continue to have doubt about whether or when to report a specific event, you may wish to go ahead and report, or call for assistance.)

1. Hospital is aware of an allegation of rape or sexual assault:
   - Evaluate available information at the time you are aware of the allegation

2. (1) Are there any indications that there may have been an opportunity for the event to have occurred?
   - Yes: Report the allegation to HFRD within 24 hrs. of the time you are aware there may have been an opportunity for the event to have occurred.
   - No: Proceed with hospital's internal investigation

3. (2) Are there any physical findings consistent with the event having occurred?
   - Yes: Report the allegation to HFRD within 24 hrs. of the time you are aware there may have been an opportunity for the event to have occurred.
   - No: Proceed with hospital's internal investigation

4. (3) Is there any corroboration of sexual contact, or reason to believe such contact occurred?
   - Yes: Report the allegation to HFRD within 24 hrs. of the time you are aware there may have been an opportunity for the event to have occurred.
   - No: Proceed with hospital's internal investigation

5. During the hospital's investigation, does the answer to (1), (2), or (3) become "yes"?
   - No: Proceed with hospital's internal investigation
   - Yes: Report the allegation to HFRD within 24 hours of the time it is discovered that the answer to (1), (2), or (3) is "yes".

No self-report to HFRD is necessary if the hospital's investigation (and any legal investigation) fails to substantiate the allegation of rape or sexual assault.

HFRD Flow chart for Decisions for Self-Reporting Rape Allegations Rev 1.7.2010
Healthcare Facility Regulation Division
Sample Flow Chart for Decisions in Hospital Self-Reporting of Wrong Site Surgeries

Hospital is aware of a surgery on the wrong patient or wrong body part of a patient

Report to HFRD within 24 hours of awareness of the event

HFRD Flow chart for Decisions for Self-Reporting Wrong Site Surgeries Rev_1.7.2010
FACILITY INFORMATION

Name of Hospital: ____________________________

Hospital Type: ____________________________ License #: ____________________________

See Chapter 20-9-7-0(c)(1)

Address: __________________________________________

City: ____________________________ State: ____________________________ Zip Code: ____________________________

Contact Person(s): ____________________________ Title: ____________________________

Phone Number of Contact: ____________________________ Fax #: ____________________________

Email Address: __________________________________________

Incident Information

Date: ____________ Time: ____________ a.m./p.m. Incident Occurred

Date: ____________ Time: ____________ a.m./p.m. Hospital was Aware that Reportable Incident May have Occurred

Date: ____________ Time: ____________ a.m./p.m. Reported to HFRD Agency

Type of Event / Incident: Please check appropriate boxes
The hospital shall make a report of the event within 24 hours or by the next regular business day from when the reportable event occurred or from when the hospital has reasonable cause to anticipate that the event is likely to occur. The following events/incidents are reportable if significant disruption of patient care has occurred or is expected to occur.

[ ] A labor strike, walk-out, or sick-out
[ ] An external disaster or other community emergency situation
[ ] An interruption of services vital to the continued safe operation of the facility, such as telephone, electricity, gas, or water services

Anticipated effect on patient care services, including any need for relocation of patient:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

- 1 -
Immediate plans by the hospital regarding patient management during the event:

Acknowledgement of Information Reported:

I certify that the information reported within this form is true, accurate, and complete to the best of my knowledge.

Signature of Person Completing Form

Title

Date Completed

Print Name

For Department Use Only

Received in SA Date: ________________________

Reviewed By: ________________________________

Date: ________________________

Reporting time frame of 24 hours/next business day met? ( ) Yes ( ) No

Action Required ( ) Yes ( ) No

Self Report ID #: ____________________________ Complaint Number: ____________________________

This report is required as set forth in the Hospital Rules §290-9-7-.07 (2) and must be submitted to the Department within twenty-four (24) hours or by the next regular business day from when the incident occurred, or from when the facility has reasonable cause to suspect a reportable incident §290-9-7-.07(2)(b)
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
HEALTH CARE FACILITY REGULATION DIVISION
HEALTH CARE SECTION
2 Peachtree Street, N.W. Suite 31-445
Atlanta, Georgia 30303
Tel. 404-657-5559 Fax 404-657-8934

REQUIRED ESRD SELF REPORTS
(Please Type Form)

FACILITY INFORMATION

Name of Facility: ____________________________

Facility Type: ____________________________ License #: ____________________________

Address: ____________________________

City: ____________________________ State: ____________________________ Zip Code: __________

Person Reporting Incident: ____________________________ Title: ____________________________

Contact Person(s): ____________________________ Phone Number of Contact: ____________________________

Fax #: ____________________________ Email Address: ____________________________

PATIENT/REPORTING INFORMATION

Date ________ Time ________ a.m./p.m. Reported to HFRD Agency

Date ________ Time ________ a.m./p.m. ESRD Facility Was Aware that reportable incident may have occurred

Date ________ Time ________ a.m./p.m. Incident Occurred

M/F

Patient Name ____________________________ Age ________ Sex ________ Date of Birth

Medical Record # ____________________________ Date of Admission ____________________________ Date Dialysis Started

Diagnosis (all): ____________________________ (Use narrative format, not ICD-9 coding)

Patients Current Condition: (check one) [ ] Dialyzing in center [ ] In Hospital [ ] Deceased

Type of Incident: Please check appropriate boxes. (Attach a copy incident report if applicable)

[ ] Death
[ ] Serious injury/malfunction of equipment
[ ] Exsanguination at facility
[ ] Use of another patient’s dialyzer
[ ] Deviation in patient’s prescription
[ ] Sexual/Physical assault of patients

EXHIBIT C
Page 2- ESRD Incident Reporting Form

Briefly describe circumstances of the incident: (attach additional sheet if necessary)

CATEGORY OF STAFF INVOLVED IN THE INCIDENT (check all that apply)

[ ] Attending MD [ ] MD Resident [ ] LPN [ ] RN [ ] PA [ ] NP [ ] SW [ ] Dietician
[ ] Trainee (specify type)______________________ [ ] PCT (specify type)______________________
[ ] Other (specify type)______________________

Immediate Corrective or Preventative Action Taken: (attach additional sheet if necessary)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Note: If the incident involved a death, was the medical examiner notified? [ ] Yes [ ] No
Was an autopsy requested? [ ] Yes [ ] No
Name and contact number of Medical Examiner ________________________________

Acknowledgement of Information Reported:

I swear that the information reported within this form is true and accurate and completed to the best of my knowledge.

Signature of Person Completing Form __________________________ Title __________ Date Completed __________

Print Name __________________________

For Department Use Only

Received in S/A Date: ________________

Reviewed By: _______________________

Date: ______________________________

Reporting time frame of 24 hours met: ( ) Yes ( ) No

Action Required ( ) Yes ( ) No

Self Report ID# ________________ Complaint # ________________

This report is required as set forth in the ESRD Rules §290-9-9-07(c) 1 through §290-9-9-07(c) 6 and must be submitted to the Department within twenty-four (24) hours or by the next regular business day from when the incident occurred, or from the facility has reasonable cause to suspect a reportable incident §290-9-9-07(f).
# ALC/CLA/PCH Incident Reporting Form

**Facility:**

**County:**

**Phone:**

**Fax:**

**Email:**

**Administrator or Site Manager:**

**Type of Incident (check all that apply):**

- Abuse: Physical  Verbal  Sexual  Mental  Resident to resident  Staff to resident
- Death: Unexpected  Waiver request pending  Hospice provided  911 called (Time: ____________)
- PCH initiated CPR by (Staff Name: ____________)
- Serious Injury: Resulted in death  Hospital admission  ER visit  MD visit
- External Disaster: Fire  Flood  Damage to physical plant  Residents relocated
- Missing Resident: Police notified (Date: ____________ Time: ____________)  Resident has memory impairment
- Other: Neglect  Exploitation  Owner/staff acquires criminal record  Insurance/will
- Other (specify) ____________

**Resident Name(s):**

**Date of Incident:**

**Time of Incident:**

**Details of Incident:** (attach a page for additional details, if needed)

<table>
<thead>
<tr>
<th>Notifications</th>
<th>Date</th>
<th>Time (AM or PM)</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/guardian/responsible party</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Alleged Perpetrator Name:**

**Relationship to Resident:**

**Current Address:**

**City:**

**State:**

**Zip:**

**Phone:**

**Witness Names**

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone Number</th>
<th>Relationship to Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immediate correction or steps taken to prevent further incidents:**

**Reporter:**

**Title:**

**Signature:**

**Date of Report:**

**Time of Report:** 03/31/2012

---

**EXHIBIT D**
The Georgia Professional Health Program is a non-profit 501(c)3 organization dedicated to the well-being of medical professionals in Georgia, providing confidential referral, treatment oversight, and monitoring of potentially impairing conditions, mental illnesses, and substance abuse disorders.

Our goal is to ensure the health of healthcare professionals and to ensure that they are safe to practice in their specialty. Since August 2012, the Georgia PHP has provided services for physicians, physician assistants, and respiratory therapists licensed in Georgia. Governed by a Board of Directors, the Georgia PHP maintains an active relationship with the Georgia Composite Medical Board to ensure the success of the Georgia PHP and its participants.

It is our belief that healthy professionals provide the best healthcare.

For more information on the Georgia PHP, news and events, visit gaphp.org.
Our Objectives

- To **Educate** concerned parties, such as hospitals, medical associations, clients, and malpractice carriers about mental health and substance abuse issues among Georgia healthcare professionals.

- To promote **Prevention** and early detection of these conditions through lectures, seminars, and other training venues.

- To provide **Intervention** for physicians, physician assistants, and respiratory therapists who need to enter medical care for mental health and substance abuse issues.

- To **Monitor** the status and safety of program participants once primary treatment has been completed.

- To **Coordinate** with and maintain the trust of the Georgia Composite Medical Board in order to balance participants' needs for care with public safety.

- To oversee and provide **Quality Control** over the providers who offer treatment for Georgia PHP participants.

- To provide **Resources and Support** for the families of Georgia healthcare professionals monitored by the Georgia PHP.

The Georgia PHP Leadership

**Paul H. Earley, M.D., FASAM**
Medical Director

With more than 30 years of experience as an addiction medicine physician, Dr. Paul Earley specializes in the assessment and treatment of healthcare professionals.

Dr. Earley is a nationally- and internationally-renowned speaker on the topics of addiction and treatment and has penned numerous books and articles on the subject, including "The Cocaine Recovery Book," and a chapter focused on addiction among physicians and physician health programs featured in the "Principles of Addiction Medicine," the textbook for the American Society of Addiction Medicine.

His work has been featured in the documentary series "Bill Moyers on Addiction: Close to Home," and he has appeared in recovery in two appearances on "The Oprah Winfrey Show." Dr. Earley serves as a Fellow of ASAM and has served on the ASAM Board of Directors for more than 12 years.

**Robin McCown**
Executive Director

Robin McCown is a healthcare and rehabilitation specialist with more than 25 years of experience in addiction and mental health treatment focused on outreach and referral development.

McCown has served as the Executive Director of the Georgia Chapter of the American Society of Addictive Medicine and as a professional outreach coordinator for various specialty treatment facilities, also serving on the Advisory Commission of Lawyers Assistance Programs and the North Georgia EAPA Executive Board.
11:30  THE CRIMINAL SIDE OF HEALTHCARE LAW

Brian F. McEvoy, Polsinelli PC, Atlanta
12:00  **LUNCH AND PRESENTATION** (Lunch included in registration fee.)

**LEGENDS OF GEORGIA HEALTHCARE LAW**

**HOW PROFESSIONALISM DEVELOPED IN GEORGIA HEALTHCARE LAW**

Moderator: **Richard D. Sanders**, The Sanders Law Firm PC, Atlanta

**Randy Hughes**

**Kevin E. Grady**, Alston & Bird LLP, Atlanta

**Richard L. “Rick” Shackelford**, Attorney at Law, Atlanta

**Robert Miller**
MEDICAL MALPRACTICE LITIGATION: PLAINTIFF’S PERSPECTIVE

James H. Webb, Jr., Webb & Taylor LLC, Peachtree City
Musings of a Lawyer Who Has Been Handling Medical Negligence Cases for Forty Years

By: James H. Webb, Jr.
Webb & Taylor, LLC
400 Westpark Court, Suite 220
Peachtree City, GA 30269
Musings of a Lawyer Who Has Been Handling Medical Negligence Cases for Forty Years

I. Recent Verdicts
   A. Fulton County- over $46,000,000
   B. Gwinnett County- over $25,000,00
   C. Across State, including what are generally thought to be “conservative” counties
      1. Several verdicts in the $5,000,000 to $10,000,000 range
      2. More verdicts for plaintiffs in general

II. Significant tort reform enacted in 2005 to make it more difficult for an injured party to prevail
   A. Included a damages cap on pain and suffering - declared unconstitutional - violation of constitutional right of trial by jury
   B. Many cases interpreting new law decided – clarifying some areas – others still unclear
   C. Plaintiffs have “navigated” their way around most significant hurdles

III. Unanticipated outcomes
   A. Fewer lawyers handling plaintiff cases - ones handling them are more experienced and better funded.
   B. Plaintiff lawyers even more selective about cases they take
   C. Defense costs much higher
      1. 50% reduction in claims but same total costs to defend
      2. Defense lawyers do more to defend because new laws-
         A. still subject to interpretation
         B. trying to prevent excess verdicts
         C. doctors have right to refuse to settle
1. they hear about statistics concerning win percentages
2. on their permanent record

IV. Other causes of large and more frequent verdicts
A. Few “small town” doctors
B. Medical care more “big business”
C. Doctors earnings squeezed
   1. see more patients
   2. order more tests
D. Care more impersonal
E. All jurors know someone harmed by medical error

V. Insurance companies said to despise jury system but privately knew juries protected healthcare providers far more often than harming them - that faith eroding.

VI. People learning more about truth through statistics
A. In spite of spending most money per person on health care- US healthcare very average (not in top thirty worldwide)
B. Automobile accidents significantly harm or kill about 200,000 people per year in the United States- medical negligence roughly twice that amount
C. Leading causes of death in the United States
   1. cardiac
   2. cancer
   3. medical negligence

VII. Conclusion
Considering the money the U.S. spends on health care each year, our system stinks!
VIII. What can we do?

A. Must reinvent healthcare

B. Can’t be left to politicians to enact effective reform

C. Discussed worker’s compensation type system- medical side doesn’t want that solution- too may claims!

D. Real solution
   1. Blue ribbon committee
   2. All “interested” parties at table
   3. Reinvent healthcare
   4. Enact new rules and keep politics out of it

IX. Is it possible?

A. Probably not

B. Look at tax system, SSN, etc., does anyone really think it’s the best we can do?

C. Sadly, we will likely keep making small revisions to this broken system and it will continue to get worse.

D. There is inadequate political will to make meaningful, positive changes. The system is too complex for the average politician to comprehend and there is too much wasted money in the system to make political reform plausible.

E. The only solution is for our citizens to end their apathy and demand change.
MEDICAL MALPRACTICE LITIGATION:
DEFENDANT’S PERSPECTIVE

Robert G. Tanner, Weinberg Wheeler Hudgins Gunn & Dial LLC, Atlanta
VENUE CONSIDERATIONS

A. Introduction

The basic rule for venue in tort actions is established in the Georgia Constitution, art. VI, § 2, ¶ 6. Such cases “shall be tried in the county where the defendant resides…” Where there are multiple alleged joint tort-feasors, residing in different counties, the suit may be brought in either county. Ga. Const. art. VI, § 6, ¶ 4.

Where the defendant is a corporation or limited liability company, venue is determined in accordance with O.C.G.A. § 14-2-510 and O.C.G.A. § 14-11-1108(b): “In civil proceedings generally, [venue is] in the county of this state where the corporation maintains its registered office…” O.C.G.A. § 14-2-510(b)(1).

O.C.G.A. 9-10-31.1 sets out Georgia’s rules on forum non conveniens: “[s]o as to a claim or action that would be more properly heard in a different county of proper venue within this state, the venue shall be transferred to the appropriate county.” O.C.G.A. § 9-10-31.1(a). The statute sets out seven criteria for the court to consider in determining whether transfer from one court of proper venue to another court of proper venue is appropriate.

B. Pleading Requirements

O.C.G.A. § 9-11-8(a)(2) sets out basic requirements for allegations to appear in a complaint, which includes the following: “An original complaint shall contain facts upon which the court’s venue depends.” O.C.G.A. § 9-11-8(a)(2).

O.C.G.A. § 9-11-12(b)(3) specifies that a challenge for improper venue must be asserted either in a responsive pleading or by written motion. “A motion making any of these defenses shall be made before or at the time of pleading if a further pleading is permitted.” Failure to raise such defenses at the proper time results in a waiver.

VENUE CONSIDERATIONS

A. Introduction

The basic rule for venue in tort actions is established in the Georgia Constitution, art. VI, § 2, ¶ 6. Such cases “shall be tried in the county where the defendant resides...” Where there are multiple alleged joint tort-feasors, residing in different counties, the suit may be brought in either county. Ga. Const. art. VI, § 6, ¶ 4.

Where the defendant is a corporation or limited liability company, venue is determined in accordance with O.C.G.A. § 14-2-510 and O.C.G.A. § 14-11-1108(b): “In civil proceedings generally, [venue is] in the county of this state where the corporation maintains its registered office...” O.C.G.A. § 14-2-510(b)(1).

O.C.G.A. 9-10-31.1 sets out Georgia’s rules on forum non conveniens: “[a]s to a claim or action that would be more properly heard in a different county of proper venue within this state, the venue shall be transferred to the appropriate county.” O.C.G.A. § 9-10-31.1(a). The statute sets out seven criteria for the court to consider in determining whether transfer from one court of proper venue to another court of proper venue is appropriate.

B. Pleading Requirements

O.C.G.A. § 9-11-8(a)(2) sets out basic requirements for allegations to appear in a complaint, which includes the following: “An original complaint shall contain facts upon which the court’s venue depends.” O.C.G.A. § 9-11-8(a)(2).

O.C.G.A. § 9-11-12(b)(3) specifies that a challenge for improper of venue must be asserted either in a responsive pleading or by written motion. “A motion making any of these defenses shall be made before or at the time of pleading if a further pleading is permitted.” Failure to raise such defenses at the proper time results in a waiver. Orkin Extermination Co. v. Morrison, 187 Ga. App. 780, 781-82 (1988); see also O.C.G.A. § 9-11-12(h)(1)(B).
C. How Not to Plead Venue (Example from actual case filed in Fulton County, GA) against a medical professional corporation.

Defendant __________ “is a resident of the State of Georgia, with its principal place of business located at _____, Galleria Parkway, Atlanta, Fulton County, Georgia.” The address given is clearly not in Fulton Country but, rather in Cobb County. Complaint further alleges the defendant “has offices throughout metropolitan Atlanta and has its registered agent for service of process in the State of Georgia at the aforementioned address” (which, again is not in Fulton County).

D. How to Use Erroneous Venue to Defendant’s Advantage

By failing to raise venue objections at an appropriate time, a defendant waives the defense of improper venue in the county where plaintiff has brought the action. Morrison, 187 Ga. App. at 781-82. By waiving the defense, the defendant submits to the jurisdiction of the court, thus making venue proper in that county. See Nadew v. Alemu, 217 Ga. App. 438, 440 (1995). In that posture, plaintiff then lacks standing to object to venue and cannot move to transfer the case. See Fletcher v. Hatcher, 278 Ga. App. 91, 92 (2006); see also Richardson v. Gilbert, 319 Ga. App. 72, 74 (2012) (“A plaintiff lacks standing to object to jurisdiction or venue over a nonresident defendant who waived his venue defenses.”). Result: Plaintiff may be stuck in a county he does not now prefer.

E. Practical pointers for Defense

• Know where your defendant lives/works.
• Where you have a choice, select the best venue for defense.
• Your corporate client’s registered office does not have to be in the most plaintiff friendly county in Georgia.

EXPERT WITNESS CONSIDERATIONS

A. Introduction

For claims against a medical professional listed in O.C.G.A. § 9-11-9.1(g), an expert witness is required to testify to a deviation from some accepted professional norm. O.C.G.A. § 9-11-9.1(a). O.C.G.A. § 24-7-702, modeled on Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 113 S. Ct. 2786 (1993) sets out qualifications that expert must possess to opine concerning
scientific, technical or other specialized knowledge. The statute then goes further and specifies certain additional requirements which an expert must meet in order to be qualified to testify in a medical malpractice action. O.C.G.A. § 24-7-702(c). Such testimony “shall be admissible only if, at the time the act or omission is alleged to have occurred, such expert:

(1) Was licensed by an appropriate regulatory agency to practice his or her profession in the state in which such expert was practicing or teaching in the profession at such time; and

(2) In the case of a medical malpractice action, had actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given as the result of having been regularly engaged in:

(A) The active practice of such area of specialty of his or her profession for at least three of the last five years, with sufficient frequency to establish an appropriate level of knowledge, as determined by the judge, in performing the procedure, diagnosing the condition, or rendering the treatment which is alleged to have been performed or rendered negligently by the defendant whose conduct is at issue; or

(B) The teaching of his or her profession for at least three of the last five years as an employed member of the faculty of an educational institution accredited in the teaching of such profession, with sufficient frequency to establish an appropriate level of knowledge, as determined by the judge, in performing the procedure, diagnosing the condition, or rendering the treatment which is alleged to have been performed or rendered negligently by the defendant whose conduct is at issue; and

(C) Except as provided in subparagraph (D) of this paragraph:

(i) Is a member of the same profession;

(ii) Is a medical doctor testifying as to the standard of care of a defendant who is a doctor of osteopathy; or

(iii) Is a doctor of osteopathy testifying as to the standard of care of a defendant who is a medical doctor; and

(D) Notwithstanding any other provision of this Code section, an expert who is a physician and, as a result of having, during at least three of the last five years immediately preceding the time he act or omission is alleged to have occurred, supervised, taught, or instructed nurses, nurse practitioners, certified registered nurse anesthetists, nurse midwives, physician assistants, physical therapists, occupational therapists, or medical support staff, has knowledge of the standard of care of that health care provider under the circumstances at issue shall be competent to testify as to the standard of that health care provider. However, a
nurse, nurse practitioner, certified registered nurse anesthetist, nurse midwife, physician assistant, physical therapist, occupational therapist, or medical support staff shall not be competent to testify as to the standard of care of a physician. *Id.*

B. Affidavit Considerations

Pursuant to O.C.G.A. § 9-11-9.1 in an action alleging professional malpractice plaintiff “shall be required to file with the complaint an affidavit of an expert competent to testify, which affidavit shall set forth specifically at least one negligent act or omission claimed to exist and the factual basis for each such claim.” O.C.G.A. § 9-11-9.1(a). This statute means what it says. When there are multiple defendants, the affidavit must set forth at least one negligent act or omission as to each defendant. *HCA Health Services of Georgia, Inc. v. Hampshire*, 206 Ga. App. 108, 110 (1992). And the requirement to set out a specific act of negligence is not to be overlooked; for example, merely stating a defendant did not follow the procedures expected of a licensed professional is insufficient and can result in the case being dismissed. *Edwards v. Vanstrom*, 206 Ga. App. 21, 22 (1992).

Plaintiff must “obtain an expert who has significant familiarity with the area of practice in which the expert opinion is to be given.” *Hope v. Kranc*, 304 Ga. App. 667, 369 (2010). The Georgia Court of Appeals has also held that, “[i]t is not sufficient that the expert have just a minimum level of knowledge in the area in which the opinion is to be given. Instead, the expert must have regularly engaged in the active practice of the area of specialty in which the opinion is to be given and must have done so with sufficient frequency to establish an appropriate level of knowledge.” *Aguilar v. Children’s Healthcare of Atlanta, Inc.*, 320 Ga. App. 663, 666 (2013). See also *Hendrix v. Fulton DeKalb Hosp. Auth.*, 330 Ga. App. 833, 837, 769 (2015) (citing *Nathans v. Diamond*, 282 Ga. 804 (2007) (“A minimum level of knowledge in the area in which the expert opinion is to be given is not sufficient.”)).

C. Burden of Proof on Expert Qualifications

Exclusion of an expert based under O.C.G.A. §24-7-702 is within the discretion of the trial court. *Cotton v. Philips*, 280 Ga. App. 280 (2006). In a Daubert motion, the non-moving party shoulders the burden of offering a preponderance of proof, that the expert proposal meets the statutory foundation. *Allison McGhan Medical Corp.*, 184 F.3d, at 1300 (11th Cir. 1999).
D. Practical Pointers for Defense

- Do not attempt to disqualify expert while discovery is ongoing.
- Think carefully if you want the expert disqualified at all.
- Do you have literature he/she wrote which contradicts the position asserted in your matter.
- Has witness contradicted himself in prior depositions.
- Has witness testified based on incomplete review of records.

If you have a motion to disqualify you are likely to win, you may not want to file it.
2:30  HOSPITAL MERGERS AND ACQUISITIONS

Michelle A. Williams, Alston & Bird LLP, Atlanta
W. Wright Banks, Jr., Deputy Attorney General, Georgia Attorney General’s Office, Atlanta
Bridget Bourgeois, Ernst & Young, Atlanta
HOSPITAL MERGERS AND ACQUISITIONS AND THE GEORGIA HOSPITAL ACQUISITION ACT

W. Wright Banks, Jr., JD
Deputy Attorney General, Office of the Attorney General

Bridget Bourgeois, CPA
Ernst & Young LLP

Michelle Williams, JD
Partner, Alston & Bird LLP

MARCH 1, 2018
GEORGIA ICLE
Hospitals keep up swift pace of mergers, alliances

The new year is bringing a rash of big hospital deals in Georgia, as health systems look to bulk up in size and add to their medical territory.

The first transaction came a week ago, with the completion of Tennessee-based HCA’s acquisition of Memorial Health in Savannah.

Still pending are three other major combinations.

It will still be called Memorial Health, and the hospital will operate as Memorial Health University Medical Center. But there are some immediate changes in appearance.

As part of the new system, Memorial’s ‘orange dot’ logo has been replaced by HCA’s ‘caring star.’
**Mayo News Release**

**Satilla Health Services Inc., of Waycross, Ga., To Integrate with Mayo Clinic**

Tuesday, February 28, 2012

JACKSONVILLE, Fla. — Satilla Health Services, Inc., parent company of Satilla Regional Medical Center, joins with the Jacksonville campus of Mayo Clinic effective March 1. Satilla will be renamed "Mayo Clinic Health System in Waycross."

---

**Georgia Health News - Shock as Mayo Clinic cuts loose Waycross hospital**

November 23, 2015 - Andy Miller

Mayo Clinic's startling decision to pull out of its “integration agreement” with Satilla Health Services has left the South Georgia hospital with an uncertain future.
Waycross, GA, Hospital Joins HCA South Atlantic & Reflects 61 Years of Caring for Southeast Georgians in New Name - Memorial Satilla Health

Memorial Satilla Health (https://memorialsatillahealth.com) May 02, 2017

Hospital leadership and its Board of Directors are celebrating the successful integration of the Waycross, GA, hospital into HCA's South Atlantic Division.

Navicent Health and Atrium Health Announce Plans to Form Strategic Combination to Serve Communities in Central and South Georgia
The Georgia Hospital Acquisition Act
O.C.G.A. § 31-7-400 et seq.

- Effective October 31, 1997
- Applies to acquisitions involving the purchase or lease of 50% or more of a nonprofit hospital’s assets
- Ultimate goal is to preserve charitable assets

### Acquisition Act Review Criteria
O.C.G.A. § 31-7-406

<table>
<thead>
<tr>
<th>Party</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seller</td>
<td>1. Whether the disposition is permitted under Chapter 3 of Title 14, the &quot;Georgia Nonprofit Corporation Code,&quot; and other laws of Georgia governing nonprofit entities, trusts, or charities.</td>
</tr>
<tr>
<td>Seller</td>
<td>2. Whether the disposition is consistent with the directives of major donors who have contributed over $100,000.00.</td>
</tr>
<tr>
<td>Seller</td>
<td>3. Whether the governing body of the nonprofit corporation exercised due diligence in deciding to dispose of hospital assets, selecting the acquiring entity, and negotiating the terms and conditions of the disposition.</td>
</tr>
<tr>
<td>Seller</td>
<td>4. The procedures used by the nonprofit corporation in making its decision to dispose of its assets, including whether appropriate expert assistance was used.</td>
</tr>
<tr>
<td>Seller</td>
<td>5. Whether any conflict of interest was disclosed, including, but not limited to, conflicts of interest related to directors or officers of the nonprofit corporation and experts retained by the parties to the transaction.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>6. Whether the seller or lessor will receive fair value for its assets, including an appropriate control premium for any relinquishment of control or, in the case of a proposed disposition to a not for profit entity, will receive an enforceable commitment for fair and reasonable community benefits for its assets.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>7. Whether charitable assets are placed at unreasonable risk if the transaction is financed in part by the seller or lessor.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>8. Whether the terms of any management or services contract negotiated in conjunction with the transaction are reasonable.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>9. Whether any disposition proceeds will be used for appropriate charitable health care purposes consistent with the nonprofit corporation’s original purpose or for the support and promotion of health care in the affected community.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>10. Whether a meaningful right of first refusal to repurchase the assets by a successor nonprofit corporation or foundation has been retained if the acquiring entity subsequently proposed to sell, lease, or transfer the hospital to yet another entity.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>11. Whether sufficient safeguards are included to assure the affected community continued access to affordable care and to the range of services historically provided by the nonprofit corporation.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>12. Whether the acquiring entity has made an enforceable commitment to provide health care to the disadvantaged, the uninsured, and the underinsured and to provide benefits to the affected community to promote improved health care.</td>
</tr>
<tr>
<td>Seller &amp; Purchaser</td>
<td>13. Whether health care providers will be offered the opportunity to invest or own an interest in the acquiring entity or a related party, and whether procedures or safeguards are in place to avoid conflict of interest in patient referrals.</td>
</tr>
</tbody>
</table>
What is the Standard for Approval?

- Public interest determination
- Must be adequate disclosure
  - To insure that the transaction is authorized
  - To safeguard the value of charitable assets
  - To insure that proceeds of the transaction are used for appropriate charitable health care purposes.

Public Hearing - Purpose

- To provide full disclosure of the purpose and terms of the proposed disposition of the assets of the hospital.
- To provide an opportunity for local public input to ensure that the public’s interest is protected when the proposed disposition is completed.
Case Law

• Can the parties to a transaction sign a Purchase and Sale Agreement prior to submitting the Notice filing?
  – No, the agreements should not be signed prior to AG approval.
  – Some parties have entered into a good faith side agreement.

Common Mistakes

• Not contacting the Attorney General for a determination when there is a question
• Attempting to file before the Notice is ready
• Not filing with sufficient time to close the transaction
• Attempting to execute the sale documents (you may have an unsigned draft) before AG issues report
• Not calling to discuss
Review Criteria

- **Seller’s Valuation Consultant**
  - Prepare a financial and economic analysis
    - Value of hospital as a “going concern”
    - Whether the consideration matches or exceeds that value
      - When not paid in money, need value of consideration
    - Nonprofit to nonprofit — will receive an enforceable commitment for fair and reasonable benefits for its assets.

*The Acquisition Act does not require a fairness opinion.*

---

**W. Wright Banks, Jr.**

**Georgia Office of Attorney General**

W. Wright Banks, Jr. is a Deputy Attorney General with the Office of the Georgia Attorney General. He serves as the Director of the Commercial Transactions and Litigation Division which includes three sections: Business and Finance; Real Property, Construction, Transportation and Authorities; and Tax. From 2007 to 2012, he served as the Section Leader of the Business and Finance Section. Prior to the time that he served as Section Leader, he worked in the Business and Finance Section practicing in a number of areas of law, including alcoholic beverage regulation, bankruptcy, insurance, and procurements handling both transactions and litigation matters. He has provided general representation to a number of entities of the State, including the Department of Administrative Services, the Alcohol and Tobacco Division of the Department of Revenue, the Georgia Lottery Corporation, the Financing and Investment Division of the Georgia State Financing and Investment Commission and the Georgia Superior Court Clerks’ Cooperative Authority.

He graduated from the University of Georgia with an A.B. degree in Political Science in 1990. He received his law degree from Mercer University cum laude in 1993 where he was a member of the Mercer Law Review and Phi Kappa Phi and received three American Jurisprudence Awards.

Among other responsibilities, the Commercial Transactions and Litigation Division is charged with administering the responsibilities of the Attorney General under the Hospital Acquisition Act, O.C.G.A. §§ 31-7-400 through 31-7-412. Wright has served in a variety of roles related to a number of hospital transactions including serving as hearing officer in four recent transactions involving hospitals ranging from twenty-five to in excess of three hundred beds.
Bridget Bourgeois, CPA
Partner

Profile
Bridget Bourgeois is the firm’s Healthcare Valuation and Fair Market Value Leader serving health and life science companies including academic health systems, hospitals, physician entities and managed care companies as well as pharmaceutical, biotech, medical technology and clinical research organizations for strategic planning, transaction support, financial reporting, tax planning and corporate compliance needs. Bridget is a frequent speaker at national and international meetings on valuation and fair market value topics.

Overview of Experience
- Bridget has conducted numerous valuations and analyses of deal structures involving for-profit and not-for-profit organizations, health science companies, health systems, and physician entities performed for a variety of reasons, including affiliations, joint ventures, acquisitions, divestiture, and compliance with healthcare laws and regulations (e.g. FCPA, anti-kickback, Stark laws, tax-exempt rules on private inurement and private benefit).
- Bridget educates and advises clients such as health and life science companies and government regulators on methods used to determine and support fair market value. Bridget also regularly advises state attorneys general on valuation matters to assist with regulatory review and approval of health care transactions. This experience includes analyses of measuring community benefit value.
- Bridget has significant experience assisting multi-national companies with developing standard FMV processes, methods, and tools, and providing valuation education and guidance on how to build and sustain FMV processes helping companies to manage compliance risks globally.
- Bridget has conducted numerous international engagements for health and life science companies valuing business enterprises, equities, and intangible assets such as branded and generic products, drug development and delivery technologies, patents, trademarks, contracts, customer relationships and restrictive covenants.

Education and professional affiliations
- Bridget received a BA in accounting from Lamar University. She is a Certified Public Accountant licensed in Georgia and Texas, and has memberships in the AIPCA, American Society of Appraisers, and previously served on the ASA’s Healthcare Special Interest Group.

Michelle A. Williams, JD
Partner

Michelle Williams practices health care law and is a member of the Firm’s Regulatory Health Care Group and the Products Liability Group. Ms. Williams concentrates her practice on the regulatory aspects of health law and handles Medicare/Medicaid termination actions, EM TALA defense and peer review organization hearings, professional agency actions and administrative agency proceedings including those involved in food poisonings and infectious disease look backs. She also works with the Corporate Health Care Practice Group advising on hospital sales and acquisitions, fraud and abuse and Stark, and qui tam actions.

Prior to law school, Ms. Williams completed her Medical Technologist internship at Butterworth Hospital, an affiliate of Michigan State University, where she received a B.S. in microbiology and public health and a B.S. in animal husbandry.

Ms. Williams was a medical technologist at University Hospitals of Cleveland, Lansing General Hospital and Baystate Medical Center and a laboratory assistant at Michigan State University where she worked on vaccine projects for Brucellosis and Marek’s Disease Herpes Virus. While an undergraduate, she worked at the Michigan State University abattoir in all phases of meat production.

She received her J.D. in 1986 from Case Western Reserve University School of Law where she was the Executive Editor of Health Matrix: Quarterly Journal of Health Services Management.

Following law school, she served as assistant counsel of University Hospitals of Cleveland, Ohio, a teaching hospital of Case Western Reserve University School of Medicine, and then as associate general counsel of The Mt. Sinai Medical Center, Cleveland, Ohio.

She is a member of the American Health Lawyers Association (AHLLA), past Vice Chair of the AHLLA Hospitals and Health Systems Practice Group, past Chair of the American Red Cross Blood Services Southern Region Life Board, past Chair of the Board of Directors of the American Red Cross Southern Region Blood Services, and was first selected to Best Lawyers in America 2006.
THE TOP THREE HEALTHCARE ISSUES FOR VARIOUS SUB-SPECIALISTS

- Hospitals
  Christie D. Jordan, Southeast Georgia Healthcare System, Brunswick

- Mental Health
  Robert B. Remar, Rogers & Hardin LLP, Atlanta

- Long Term Healthcare
  Brittany H. Cone, Hall Booth Smith PC, Atlanta
ISSUES OF SPECIAL IMPORTANCE TO MENTAL HEALTH PROFESSIONALS

Robert B. Remar
Rogers & Hardin LLP
2700 International Tower
229 Peachtree Street, N.E.
Atlanta, Georgia 30303
(404) 522-4700
rremar@rh-law.com
ISSUES OF SPECIAL IMPORTANCE TO MENTAL HEALTH PROFESSIONALS

Robert B. Remar
Rogers & Hardin LLP
Atlanta, Georgia

TABLE OF CONTENTS

I. INTRODUCTION .............................................................................................................. 1

II. THE PATIENT-THERAPIST PRIVILEGE ........................................................................ 1
    A. DETERMINING WHEN THE PRIVILEGE APPLIES .............................................. 3
       1. Is Treatment Given Or Contemplated .............................................................. 3
       2. Does The Privilege Extend To Communications With A Physician ...................... 6
    B. DETERMINING WHEN THE PRIVILEGE IS WAIVED ........................................ 7
    C. THE PRIVILEGE SURVIVES DEATH .................................................................. 10
    D. RESPONDING TO DISCOVERY REQUESTS ....................................................... 13
    E. HIPAA PROTECTION FOR PSYCHOTHERAPY NOTES ....................................... 15
       1. HIPAA And Protected Health Information ....................................................... 15
       2. Consent vs. Authorization ............................................................................. 17
       3. Psychotherapy Notes .................................................................................... 19
       4. Individuals’ Rights To Access Protected Health Information ............................ 22
       5. No Private Right Of Action Under HIPAA ....................................................... 26
    F. ISSUES RELATED TO WORKERS’ COMPENSATION .......................................... 27

III. DAMAGES CLAIMS PARTICULARLY RELEVANT TO MENTAL HEALTH PROFESSIONALS ................................................................................................. 29
    A. INVOLUNTARY DETENTION / FALSE IMPRISONMENT .................................... 29
    B. UNAUTHORIZED DISCLOSURE OF PRIVILEGED RECORDS .............................. 33
    C. PATIENT CAUSES HARM TO THIRD PARTIES ................................................. 36
       1. Duty To Control ............................................................................................ 37
       2. Duty To Warn .............................................................................................. 40
       3. Liability For Warning ................................................................................ 43
       4. Liability For Emotional Distress ................................................................. 44
I. INTRODUCTION

Mental health professionals (“MHP”) face special legal challenges not usually encountered by the other health care professions. Unlike physical health care, mental health treatment frequently involves the disclosure of the patient’s most intimate, secret and personal thoughts, fantasies and conduct. MHPs are also called upon to treat patients who, because of mental illness, may have the potential to injure themselves or others.1 MHPs also have the ability to involuntarily commit patients and to treat them without their consent. The law therefore imposes special obligations on MHPs as it relates to the confidentiality of patient information and the potential personal liability arising out of the conduct of their patients. This paper addresses the challenges that MHPs face in dealing with the patient-therapist privilege, including responding to discovery and requests for information, and the potential liability arising out of the patient-therapist relationship.

II. THE PATIENT-THERAPIST PRIVILEGE

Unique among the health care professions in Georgia, communications between a patient and a mental health professional are privileged as a matter of Georgia law. O.C.G.A. § 24-5-501, which provides for the attorney-client, spousal, grand jury and state secret privileges, also provides for privileged communications between patient and psychiatrist, psychologist, clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist, and licensed

1 As discussed below, in 2017 the Georgia Court of Appeals decided one case involving patient suicide and another involving a patient killing two persons.
I. INTRODUCTION

Mental health professionals (“MHP”) face special legal challenges not usually encountered by the other health care professions. Unlike physical health care, mental health treatment frequently involves the disclosure of the patient’s most intimate, secret and personal thoughts, fantasies and conduct. MHPs are also called upon to treat patients who, because of mental illness, may have the potential to injure themselves or others.¹ MHPs also have the ability to involuntarily commit patients and to treat them without their consent. The law therefore imposes special obligations on MHPs as it relates to the confidentiality of patient information and the potential personal liability arising out of the conduct of their patients. This paper addresses the challenges that MHPs face in dealing with the patient-therapist privilege, including responding to discovery and requests for information, and the potential liability arising out of the patient-therapist relationship.

II. THE PATIENT-THERAPIST PRIVILEGE

Unique among the health care professions in Georgia, communications between a patient and a mental health professional are privileged as a matter of Georgia law. O.C.G.A. § 24-5-501, which provides for the attorney-client, spousal, grand jury and state secret privileges, also provides for privileged communications between patient and psychiatrist, psychologist, clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist, and licensed

¹ As discussed below, in 2017 the Georgia Court of Appeals decided one case involving patient suicide and another involving a patient killing two persons.
professional counselor. Communications between and among the listed MHPs who are providing psychotherapy to the patient regarding the patient’s communications are also privileged. O.C.G.A. § 24-5-501(a)(8). In Gwinnett Hospital Systems, Inc. v. Hoover, 337 Ga. App. 87, 785 S.E.2d 918 (2016) the issue was whether a grief journal maintained by the plaintiff in a wrongful death suit on the recommendation of a licensed associate professional counselor who was acting as agent of a licensed professional counselor was absolutely privileged. The plaintiff (Hoover) maintained a “grief journal” that she started after it was recommended to her during a counseling session. Hoover attended counseling sessions with a licensed associate professional counselor (“LAPC”) who was supervised outside of the patient’s sessions by a licensed professional counselor (“LPC”). The defendant sought production of the journal claiming that it was not privileged because it was made under the direction of an LAPC and not an LPC and that it did not qualify as a communication within the meaning of O.C.G.A. § 24-5-501(a). The court held that the LAPC was working for and under the direct supervision of the LPC in providing care and treatment to Hoover. The court, analogizing to the attorney-client privilege, found that communications with the agent of a licensed professional counselor are privileged. The court distinguished cases which had addressed communications with individuals such as nurses or attendants who support the qualified professional but were not acting as their agents. The court further found that the contents of the grief journal were communicated to the LAPC as part of the treatment plan and therefore qualified as a privileged communication under the statute.

---

2 The psychologist-patient privilege is also recognized in the Psychology Practice Act, O.C.G.A. § 43-39-16.
Neither the patient nor the MHP may be compelled to disclose privileged communications except in narrowly defined circumstances. Moreover, the MHP has an affirmative duty to assert the privilege on behalf of the patient and has no authority to waive the privilege without patient consent. The obligations imposed by the privilege raise difficult and often conflicting duties for the MHP that are not applicable to other health care professionals.

Among the issues that MHP’s and the Courts must wrestle with are: determining when the privilege is applicable; determining when the privilege is deemed waived; determining if there are exceptions to the privilege; responding to requests for records that contain privileged communications or the product of privileged communications; complying with HIPAA’s psychotherapy notes requirements; and resolving conflicting obligations that arise from the duty to maintain privileged communications with duties to the patient and to third parties.3

A. Determining When The Privilege Applies

1. Is Treatment Given Or Contemplated

MHP’s frequently act in different roles: treating therapist, retained expert or court appointed evaluator. However, the patient-MHP privilege applies only “to the extent that treatment was given or contemplated.” Mrozinski v. Pogue, 205 Ga. App. 731, 732, 423 S.E.2d 405, 407 (1992) (emphasis omitted) (quoting Massey v. State, 226 Ga. 703, 704, 177 S.E.2d 79, 81 (1970)). Thus, if an individual sees an MHP for a non-treatment related evaluation, such as fitness for duty, fitness for custody or emotional distress damages, no privilege attaches because the patient is not seeking treatment and


The confusion that can arise in distinguishing between treatment and evaluation is exemplified by the Supreme Court’s decision in State v. Herendeen, 279 Ga. 323, 613 S.E.2d 647 (2005). Herendeen involved a subpoena served on two licensed psychologists who were treating two children pursuant to a Juvenile Court Order that the children receive therapy. The State sought the treatment records for use in a criminal prosecution against the childrens’ parents. The State argued that since the treatment was not voluntarily sought, the privilege did not apply. The Court of Appeals, citing Lucas v. State, 274 Ga. 640, 645, 555 S.E.2d 440, 446 (2001), concluded that because treatment was given, the privilege applied regardless of whether the treatment was voluntarily sought. Herendeen v. State, 268 Ga. App. 113, 601 S.E.2d 372 (2004), aff’d, 279 Ga. 323, 613 S.E.2d 647 (2005).

The Georgia Supreme Court affirmed. State v. Herendeen, 279 Ga. 323, 613 S.E.2d 647 (2005). The trial court had held that the childrens’ records were not subject to the privilege because the counseling "was done pursuant to court order with express contemplation of recommendations to the court based upon that therapy." Id. at 324,
FUNDAMENTALS OF HEALTH CARE LAW
215 of 278

613 S.E.2d at 649. Noting that Georgia, along with the other 49 States, the District of Columbia and all federal courts protect psychotherapist-patient communications, the Supreme Court held that where “the requisite relationship [between mental health provider] and patient” exists, the privilege applies. Id. at 326, 613 S.E.2d at 650. In contrast “[t]he requisite professional relationship does not exist when the mental health provider is appointed by the court to conduct a preliminary examination to evaluate a person's mental state because, in such a situation, mental health treatment is not given or contemplated.” Id. In addition, “no professional relationship is formed because no mental health treatment is given or contemplated when a court . . . orders a plaintiff in a tort action to undergo a psychiatric examination . . . or . . . orders persons involved in a parental rights' termination action to undergo a mental evaluation.” Id.

However, the Court rejected the argument that the privilege exists only when the patient voluntarily seeks treatment. Rather, the defining test for whether the privilege exists is whether treatment (as opposed to evaluation or assessment) was provided or contemplated. Because treatment was provided in Herendeen, the privilege applied and the communications between the children and the mental health professional were privileged. The Court remanded to the trial court for a determination of whether there was any material contained in the records that did not originate in communications between the children and their mental health providers and to determine whether a guardian ad litem should be appointed to decide whether the children should invoke the privilege.

The Herendeen decision was applied by the Court of Appeals in a contentious child custody dispute case. Gottschalk v. Gottschalk, 311 Ga. App. 304, 715 S.E.2d 715 (2011). The trial court ordered Mr. Gottschalk to enter therapy with a specified
psychologist. After six sessions the psychologist was directed to issue a report to the children’s guardian ad litem with respect to continuation of supervised visitation. In issuing its order the trial court stated:

There is to be no privilege with regard to this therapy as it is court-ordered and is ordered for the benefit of the minor children in this matter as well as the [appellant]. [The therapist] may share the results of this therapy with the guardian ad litem and the court, and the [appellant] is specifically required to follow the recommendations of [the therapist] as a condition of his visitation.

Id. at 315, 715 S.E.2d at 724. The Court of Appeals agreed with Mr. Gottschalk that the trial court erred when it concluded that the privilege did not apply because the treatment was court-ordered. Because the court-ordered relationship with the therapist involved or contemplated treatment, Mr. Gottschalk’s communications with the therapist were privileged. However, the Court concluded that the error was harmless because the therapist was directed to only report her conclusions regarding visitation to the guardian ad litem and the court and not the communications themselves. The Court did not address the fact that the therapist’s conclusions were necessarily the product of the privileged communications.

2. Does The Privilege Extend To Communications With A Physician

Another area of potential confusion is whether the privilege extends to a physician who does not practice the specialty of psychiatry. Georgia law does not contain a statutory definition of the term “psychiatrist,” and there is no separate licensing designation for psychiatrists. The Georgia Supreme Court considered the issue in Wiles v. Wiles, 264 Ga. 594, 448 S.E.2d 681 (1994). Wiles was a child custody dispute. The wife, Dr. Wiles, was a physician. The husband sought the medical records
of one of Dr. Wiles’s patients. Dr. Wiles was an internist who testified that she treated one-third of her patients for mental health problems, that providing counseling was part of her practice, and that she had treated the patient in question for a mental condition. The Court concluded that Dr. Wiles was a physician who spent a substantial portion of her time treating mental and emotional problems and that the privilege was therefore applicable. Id. at 598, 448 S.E.2d at 684. The difficulty with the Wiles test is that it is an after-the-fact assessment based upon the nature of the physician’s practice and the amount of time that the physician devotes to mental health treatment during any particular time. Thus, a patient may confide in her physician only to learn after the fact that the communications are not privileged because of the nature of the physician’s practice.

B. Determining When The Privilege Is Waived


4 In Jaffee v. Redmond, 518 U.S. 1 (1996), the Supreme Court resolved a conflict among the circuits by holding that confidential communications between a licensed psychotherapist and patient in the course of diagnosis and treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence.
However, when a party calls his or her mental health professional to testify when the party’s mental status is at issue, this constitutes a clear intent to waive the privilege. *Trammel v. Bradberry*, 256 Ga. App. 412, 568 S.E.2d 715 (2002). Also see *Griggs v. State*, 241 Ga. 317, 245 S.E.2d 269 (1978) (defendant who called his psychiatrist to bolster his insanity defense waived the privilege); see also *Armstead v. State*, 293 Ga. 243, 744 S.E.2d 774 (2013) (defendant waived state constitutional right of privacy and statutory privilege in his mental health records when he filed notice of intent to pursue defense of not guilty by reason of insanity and put his mental capacity at issue).

In contrast, in *Neuman v. State*, 297 Ga. 501, 773 S.E. 2d 716 (2015) (the “Dunwoody Day Care” case) the court held that merely raising an insanity defense does not waive the attorney-client privilege as it relates to MHPs engaged to evaluate the defendant’s mental state. In order to evaluate his client’s mental state at the time of the shooting, Neuman’s defense counsel engaged a psychologist and a psychiatrist to evaluate Neuman. The MPH then provided reports to defense counsel. The State sought to obtain the MHP’s records of their evaluation of Neuman. The trial court ordered the records turned over to the State. The Supreme Court reversed, holding that because the doctors were engaged by defense counsel to aid in his representation of Neuman, the attorney-client privilege protected both Neuman’s communications to the doctors and the doctors’ reports to counsel. The Court noted that the doctors were retained to evaluate a possible insanity defense and not as testifying experts. If they had been called to testify the privilege would have been waived.

In the absence of an express waiver of the privilege, one seeking the disclosure of privileged communications must establish a waiver by decisive, unequivocal conduct reasonably showing the intent to waive the privilege. *Mincey v. Ga. Dep’t of Cmty.*
However, when a party calls his or her mental health professional to testify when the party's mental status is at issue, this constitutes a clear intent to waive the privilege. Trammel v. Bradberry, 256 Ga. App. 412, 568 S.E.2d 715 (2002). Also see Griggs v. State, 241 Ga. 317, 245 S.E.2d 269 (1978) (defendant who called his psychiatrist to bolster his insanity defense waived the privilege); see also Armstead v. State, 293 Ga. 243, 744 S.E.2d 774 (2013) (defendant waived state constitutional right of privacy and statutory privilege in his mental health records when he filed notice of intent to pursue defense of not guilty by reason of insanity).

In contrast, in Neuman v. State, 297 Ga. 501, 773 S.E. 2d 716 (2015) (the "Dunwoody Day Care" case) the court held that merely raising an insanity defense does not waive the attorney-client privilege as it relates to MHPs engaged to evaluate the defendant's mental state. In order to evaluate his client's mental state at the time of the shooting, Neuman's defense counsel engaged a psychologist and a psychiatrist to evaluate Neuman. The MPH then provided reports to defense counsel. The State sought to obtain the MHP's records of their evaluation of Neuman. The trial court ordered the records turned over to the State. The Supreme Court reversed, holding that because the doctors were engaged by defense counsel to aid in his representation of Neuman, the attorney-client privilege protected both Neuman's communications to the doctors and the doctors' reports to counsel. The Court noted that the doctors were retained to evaluate a possible insanity defense and not as testifying experts. If they had been called to testify the privilege would have been waived.

In the absence of an express waiver of the privilege, one seeking the disclosure of privileged communications must establish a waiver by decisive, unequivocal conduct reasonably showing the intent to waive the privilege. Mincey v. Ga. Dep't of Cmty. Affairs, 308 Ga. App. 740, 708 S.E.2d 644 (2011). Mincey was a personal injury action against the Department of Community Affairs ("DCA"). Mincey failed to disclose her prior mental health treatment in response to various discovery requests. As a discovery sanction the court held that Mincey had waived her mental health privilege and ordered Mincey to execute a release authorizing the disclosure of her mental health records.

The Court of Appeals reversed, holding that Mincey's discovery conduct did not constitute a decisive and unequivocal waiver of the privilege. While the Court held that the trial court erred in concluding that Mincey had waived the privilege, the Court did find that DCA was entitled to discovery of information regarding whether and when Mincey was treated for mental health related issues. This finding was based on the well established rule that the privilege protects communications, not the fact of treatment or the dates of treatment.

In addition, the failure to object to an O.C.G.A. § 9-11-34 third party request for production of psychiatric records does not waive the privilege. Hopson v. Kennestone Hosp., 241 Ga. App. 829, 526 S.E.2d 622 (1999). In connection with a dispute over a divorce settlement agreement, the former husband served a § 9-11-34 discovery request on Kennestone Hospital seeking his ex-wife's psychiatric records. The ex-wife did not object and the hospital subsequently produced the records to the ex-husband. Kennestone later sued the ex-wife for $704 for medical expenses. The ex-wife counterclaimed asserting various tort theories based on the improper release of the psychiatric records. The trial court granted summary judgment to Kennestone on the counterclaim, relying on Price v. State Farm Mutual Automobile Insurance Co., 235 Ga. App. 792, 510 S.E. 582 (1998). In Price, the Court held that the failure to object to a third party discovery request constituted a waiver of the privilege. Overruling Price, the
Court held that because communications between a patient and a psychiatrist are absolutely privileged, the failure to object to a non-party discovery request is not a waiver of the privilege. In order to waive the privilege, the patient must take an affirmative step, such as calling the mental health professional as a witness. Here the failure to object waived only objections to the non-privileged portions of the record.

The Supreme Court affirmed. *Kennestone Hosp. v. Hopson*, 273 Ga. 145, 538 S.E.2d 742 (2000). The Court emphasized the strong public policy behind the privilege and held that the failure to object was not the type of decisive and unequivocal conduct that justifies inferring an intent to waive the privilege.

It is also well established that the presence of a third party not necessary for the treatment process waives the privilege. However, the privilege extends to participants in joint therapy sessions, such as family therapy and marital therapy. There is no waiver of the privilege where persons are being treated jointly or are participants in therapy which is primarily for the benefit of another. *See Odom v. Odom*, 291 Ga. 811, 814, 733 S.E.2d 741, 744 (2012) (“Communications between a treating psychologist and a patient are privileged . . . and do not lose their privileged status because patients may have been treated jointly or because they were referred by a guardian ad litem.”); *Mrozinski v. Pogue*, 205 Ga. App. 731, 423 S.E.2d 405 (1992); *Brown v. Howard*, 334 Ga. App. at 186, 778 S.E.2d at 814.

C. The Privilege Survives Death

The strength of the privilege under Georgia law is demonstrated by the Supreme Court’s opinion in *Cooksey v. Landry*, 295 Ga. 430; 761 S.E.2d 61 (2014). Twenty-two year-old Christopher Landry had been under the care of Dr. Cooksey, a psychiatrist, for several years before he committed suicide in September 2012. His parents began
investigating a potential malpractice claim against Dr. Cooksey. They requested Christopher’s psychiatric records from Dr. Cooksey, who refused to produce the records on the basis of the patient-psychiatrist privilege.

The Landreys then filed an action seeking an injunction directing Dr. Cooksey to turn over the records. They argued that without the records they would be unable to adequately investigate a potential claim against Dr. Cooksey. The trial court agreed and, without reviewing the record, ordered Dr. Cooksey to provide all of Christopher’s psychiatric records to the Landreys. The Supreme Court reversed.

The Court first discussed the strength of the privilege under Georgia law, including that the privilege is not waived even though the patient’s care and treatment may be at issue and that the privilege can only be waived by the express action of the patient. 295 Ga. At 432-433. Most importantly, the Court affirmed earlier decisions that the privilege survives death and that a deceased patient’s representative cannot waive the privilege. The Court then reversed, directing the trial court to review the files to determine whether there is any non-privileged information and whether, as to privileged information, there was a waiver by Christopher. In reaching its conclusion the Court emphasized the nature of the privilege under Georgia law:

We conclude by emphasizing that it is no small matter for a court, given its focus on the pursuit of truth and justice, to hold that potentially relevant evidence is shielded from disclosure. Our legislature, however, has determined that the public policies supporting the creation of a mental health privilege necessitated enactment of a nearly absolute privilege, one without exception if the patient is deceased or the nature of the patient’s mental condition is put at issue. As explained by the United States Supreme Court when it recognized a psychiatrist-patient privilege under its own federal evidentiary rules,

If the purpose of the privilege is to be served, the participants in the confidential conversation “must be
able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.”

*Jaffee v. Redmond* (citations omitted). Likewise, to allow a trial court, through the exercise of its equitable powers and its own notion of what is right, to require disclosure of privileged communications would bring uncertainty to Georgia’s well-defined psychiatrist-patient privilege and eviscerate its effectiveness. The interests protected by O.C.G.A. § 24-5-501 are weighty and cannot simply be set aside in even the most sympathetic of circumstances to allow individuals to search through psychiatric records with the hope of discovering evidence.

*Id.* at 435-436.

In its opinion in *Cooksey*, the Court cited *Sims v. State*, 251 Ga. 877, 311 S.E.2d 161 (1984). In *Sims* the defendant wife was on trial for the murder of her husband and sought to introduce statements made by the deceased husband during joint counseling sessions which both she and her deceased husband had attended. The Court found that the defendant and her husband were jointly seeking counseling for marital problems and that the deceased husband was a necessary participant in the sessions. As a result, the husband’s communications to the psychiatrist were entitled to protection. *Id.* at 881, 311 S.E.2d at 165-66. Since the privilege survives the death of the communicant, there was no one who could waive the privilege and the Court found that the trial court did not err in refusing to allow the psychiatrist to testify as to the deceased victim’s communications during marital therapy. *Id.*

In *Alvista Healthcare Center, Inc. v. Miller*, 286 Ga. 122, 122, 686 S.E.2d 96, 97 (2009), a surviving spouse requested copies of her deceased husband’s medical records because she was investigating a potential wrongful death action involving a nursing care
facility owned and operated by Alvista. Alvista denied the surviving spouse’s requests for records on the basis that HIPAA and its accompanying privacy regulations provided that the records could only be released to a permanent executor or administrator of the deceased spouse’s estate, which was not represented when the widow requested the decedent’s medical records. [See Part II, Section E for a discussion of HIPAA requirements.]

The Georgia Supreme Court held that O.C.G.A. § 31-33-2(a)(2) authorizes a surviving spouse to act on behalf of the decedent or his estate in obtaining medical records only if an executor or an administrator has not been appointed and, therefore, the surviving spouse was entitled to access the decedent’s protected health information under 45 C.F.R. § 164.502(g)(4) of the HIPAA Privacy Rule, which looks to the applicable state law to determine who has authority to act on behalf of the decedent or his estate. Alvista Healthcare Center, 286 Ga. at 123-24, 686 S.E.2d at 97. However, the Court specifically stated that under O.C.G.A. § 31-33-4, mental health records are excepted from the provisions of the Health Records Act.

**D. Responding To Discovery Requests**

Another area that presents potential minefields to MHPs is responding to discovery requests. O.C.G.A. § 9-11-26(b)(1) provides that “[p]arties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action.” Therefore, the service of a subpoena, notice to produce discovery or deposition notice does not, by itself, constitute an exception to the

---

5 Section 164.502(g)(4) requires a covered entity like Alvista to treat a person who has authority to act on behalf of a deceased individual or his estate under an applicable law as a “personal representative . . . with respect to protected health information relevant to such personal representation.” 45 C.F.R. § 164.502(g)(4).

In addition, records maintained by mental health facilities under the Mental Health Code “shall be produced in response to a valid subpoena or order of any court of competent jurisdiction, except for matters privileged under the laws of this state.” O.C.G.A. § 37-3-166(a)(8) (emphasis added); O.C.G.A. § 37-4-125(a)(8). See also O.C.G.A. § 37-7-166(a)(7) (relating to treatment records of alcoholics and drug dependent individuals). Therefore, MHPs may not disclose privileged communications nor produce records containing privileged materials but must assert the patient-MHP privilege. Cooksey v. Landry, 295 Ga. 430, 761 S.E.2d 61 (2014).

Breach of the duty to protect the patient’s privacy and confidences can give rise to an action for damages. Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982). MHPs should not produce privileged materials except in response to a court order or the express written authorization of the patient, even in the absence of an objection from the patient. See Jones v. Abel, 209 Ga. App. 889, 434 S.E.2d 822 (1993). In Jones, the Court of Appeals affirmed a jury verdict in favor of a psychiatrist who produced his patient’s records in response to a third party request for production of documents on the fifteenth day after receipt of the request. With three justices vigorously dissenting, the Court affirmed the jury verdict in favor of the psychiatrist on the basis of expert testimony that the standard of care required production of the records because no objection had been filed by the patient. Id. at 896, 434 S.E.2d at 828. The decision is questionable given the Court of Appeals and Supreme Court opinions in Hopson v. Kennestone Hospital, Inc., 241 Ga. App. 829 (1999), aff’d, 273 Ga. 145, 538 S.E.2d 742 (2000). See p. 8, supra. In Hopson, a tort claim was asserted against Kennestone for releasing Sherri Hopson’s psychiatric records. The Court of Appeals reversed the trial court’s grant of summary judgment to Kennestone, finding that Hopson’s failure to object to a O.C.G.A. § 9-11-34 request for production of records did not constitute a waiver of the patient-psychiatric privilege. The decision is questionable given the Court of Appeals and Supreme Court opinions in Hopson v. Kennestone Hospital, Inc., 241 Ga. App. 829 (1999), aff’d, 273 Ga. 145, 538 S.E.2d 742 (2000). See also Bala v. Powers Ferry Psychological Assocs., 225 Ga. App. 843, 491 S.E.2d 380 (1997) (concluding that an expert affidavit opining that a psychologist had improperly disclosed information concerning the plaintiff to the plaintiff’s former husband’s attorney was sufficient to state a claim for malpractice); Jones v. Thornton, 172 Ga. App. 412, 323 S.E.2d 217 (1984) (patient sued a physician for invasion of privacy and libel on the basis of compliance with a discovery request prior to the expiration of the objection period provided in the Civil Practice Act). Accord Sletto v. Hosp. Auth., 239 Ga. App. 203, 521 S.E.2d 199 (1999).

E. HIPAA Protection For Psychotherapy Notes

1. HIPAA And Protected Health Information. HIPAA’s Privacy Standards, 45 C.F.R. § 164.500, et seq., generally prohibit “covered entities” from using or disclosing “protected health information” (“PHI”), absent the consent of the patient, records of a drug and alcohol abuse treatment facility can be disclosed only by court order following notice and hearing based upon the determination that other ways of obtaining the information are not available and that the public interest and need for disclosure outweigh the harm to the patient, the physician-patient relationship and the treatment service. See 42 C.F.R. § 2.64 (new version effective 2-17-17); see also Carr v. Farmer, 213 Ga. App. 568, 445 S.E.2d 350 (1994).
response to a third party request for production of documents on the fifteenth day after receipt of the request. With three justices vigorously dissenting, the Court affirmed the jury verdict in favor of the psychiatrist on the basis of expert testimony that the standard of care required production of the records because no objection had been filed by the patient. Id. at 896, 434 S.E.2d at 828. The decision is questionable given the Court of Appeals and Supreme Court opinions in Hopson v. Kennestone Hospital, Inc., 241 Ga. App. 829 (1999), aff’d, 273 Ga. 145, 538 S.E.2d 742 (2000). See p. 8, supra. In Hopson, a tort claim was asserted against Kennestone for releasing Sherri Hopson’s psychiatric records. The Court of Appeals reversed the trial court’s grant of summary judgment to Kennestone, finding that Hopson’s failure to object to a O.C.G.A. § 9-11-34 request for production of records did not constitute a waiver of the patient-psychiatric privilege. The Supreme Court granted certiorari and affirmed. See also Bala v. Powers Ferry Psychological Assocs., 225 Ga. App. 843, 491 S.E.2d 380 (1997) (concluding that an expert affidavit opining that a psychologist had improperly disclosed information concerning the plaintiff to the plaintiff’s former husband’s attorney was sufficient to state a claim for malpractice); Jones v. Thornton, 172 Ga. App. 412, 323 S.E.2d 217 (1984) (patient sued a physician for invasion of privacy and libel on the basis of compliance with a discovery request prior to the expiration of the objection period provided in the Civil Practice Act). Accord Sletto v. Hosp. Auth., 239 Ga. App. 203, 521 S.E.2d 199 (1999).

E. HIPAA Protection For Psychotherapy Notes

1. HIPAA And Protected Health Information.

HIPAA’s Privacy Standards, 45 C.F.R. § 164.500, et seq., generally prohibit “covered entities” from using or disclosing “protected health information” (“PHI”),
unless a specific exception in the Privacy Standards applies. Moreover, state laws that are more stringent than the Privacy Standards in protecting medical and health information are not preempted. Therefore, the strong protection that Georgia law affords to the patient-therapist privilege is not diluted by HIPAA.

A “covered entity” generally may not use or disclose covered health information, except: (1) for treatment, payment, or health care operations; (2) upon the individual’s agreement in certain limited circumstances (after an opportunity to agree or object); (3) to the individual; (4) pursuant to an authorization from an individual (unless the authorization is for the use or disclosure of genetic information for underwriting purposes); or (5) as permitted or required by HIPAA for governmental or other purposes. 45 C.F.R. § 164.502(a). Even when the use or disclosure of PHI is permitted, in most circumstances, a “minimum necessary” disclosure standard applies. 45 C.F.R. § 164.502(b).

HIPAA has an expansive definition of protected “health information.” It applies to oral or recorded information that is created or received by a health care provider or plan and that relates to the past, present, or future health or condition of an individual, the provision of health treatment to an individual, or payments for health treatments. 42 U.S.C. § 1320d(4). Thus, even enrollment forms, claim forms, and bills for medical treatment include protected health information.

---

2. **Consent vs. Authorization.**

The Privacy Rules do not generally require that a covered entity obtain patient consent for use and disclosure of protected health information for specified purposes, including treatment, payment, and health care operations. See 45 C.F.R. § 164.502. (One notable exception is for psychotherapy notes, discussed below.) Nevertheless, the regulations permit and encourage health care providers to obtain consent for such purposes. The requirements for patient consent are set forth generally in Section 164.506.

By contrast, an “authorization” is required by the Privacy Rules for uses and disclosures of protected health information not otherwise permitted, even with consent. An authorization is a detailed document that gives covered entities permission to use protected health information for specified purposes other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual. Where the Privacy Rules require patient authorization, voluntary consent is not sufficient to permit a use or disclosure of protected health information unless it meets the Privacy Rules’ requirements for a valid authorization.

A valid authorization must specify a number of elements, including, but not limited to, (1) a specific description of the protected health information to be used and disclosed, (2) the person authorized to make the use or disclosure, (3) the person to whom the covered entity may make the disclosure, (4) the purpose of the disclosure, (5) an expiration date, (6) the right to revoke authorization (with certain limited exceptions); (7) a statement regarding the ability or inability to condition treatment, payment, enrollment or eligibility on the authorization; and (8) the potential for additional disclosure by the recipient. See 45 C.F.R. § 164.508.
In *Allen v. Wright*, 282 Ga. 9, 644 S.E.2d 814 (2007), the Georgia Supreme Court held that the medical release authorization requirement of O.C.G.A. § 9-11-9.2 is preempted by HIPAA. Section 9-11-9.2 requires that, in any action alleging medical malpractice, the plaintiff is required to file a medical authorization form which authorizes defendant’s counsel to obtain and disclose protected health information and to discuss the plaintiff’s case and treatment with his/her treating physicians. The Court concluded that the required authorization does not satisfy HIPAA requirements because it does not contain a sufficiently specific identification of the information to be disclosed, does not provide for an expiration date, and does not contain a notice of the right to revoke the authorization. The 9-11-9.2 authorization was therefore preempted by HIPAA and not enforceable. See also *Northlake Med. Ctr., LLC v. Queen*, 280 Ga. App. 510, 634 S.E.2d 486 (2006).

In *Gerguis v. Statesboro HMA Medical Group*, 331 Ga. App. 867, 772 S.E. 2d 227 (1995), the Court addressed a dispute over access to patient medical records. Statesboro HMA purchased a physician practice group. Under the purchase agreement HMA owned the records. When members of the physician practice group left to start their own practice they requested access to the patient records, which HMA declined to provide except upon a HIPAA compliant patient authorization. The Court of Appeals sided with HMA. The Court first noted that personal medical records are protected by the Georgia constitutional right to privacy and cannot be disclosed except by patient consent or as otherwise required by law. The Court then concluded that under HIPAA HMA, as the custodian of the records, could only disclose the records pursuant to a valid patient authorization even if the patient had previously seen the requesting physician.
3. Psychotherapy Notes.

In addition to the general protections for PHI, HIPAA's Privacy Rule extends special protection to psychotherapy notes. 45 C.F.R. § 164.508(a)(2) states that “[n]otwithstanding any provision of this subpart, . . . a covered entity must obtain an authorization for use or disclosure of psychotherapy notes . . .” (emphasis added).

“Psychotherapy notes” are defined as:

Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

45 C.F.R. § 164.501 (emphasis added). Therefore, psychotherapy notes should be maintained in a separate file from the rest of the patient’s record.

The regulations provide that, with limited exceptions (which exceptions do not apply to psychotherapy notes), a covered entity “may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization.” 45 C.F.R. § 164.508(b)(4).

The regulations recognize several exceptions to the authorization requirement for psychotherapy notes. See 45 CFR § 164.508(a)(2). Those exceptions include:

- Use by the originator of the psychotherapy notes for treatment;
- Use or disclosure by the covered entity in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;
- Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual;
• Use with respect to the oversight of the originator of the psychotherapy notes, such as peer review;

• Disclosures required by law (45 C.F.R. § 164.512(a)) and certain disclosures about decedents (45 C.F.R. § 164.512(g)); and

• Disclosures required to avert a serious threat to health or safety. 45 C.F.R. § 164.512(j).


In response to the tragedies at Newtown, Connecticut and Aurora, Colorado, the Director of the Office for Civil Rights of the Department of Health and Human Services (DHHS) confirmed in a January 15, 2013 open letter to the nation’s health care providers that HIPAA’s privacy rules (45 C.F.R. § 164.512(j)) allow for the disclosure of “necessary information about a patient to law enforcement, family members of the patient, or other persons, when [the provider] believe[s] the patient presents a serious danger to himself or other people.” Open Letter from Leon Rodriguez, Director of Office of Civil Rights for the Department of Health and Human Services, to United States Health Care Providers (January 15, 2013), http://www.hhs.gov/ocr-office/lettertonationhcp.pdf. The letter notes that disclosure is allowed to any “persons whom the provider believes are reasonably able to prevent or lessen the threat,” including “the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm.” See Section III, C. 3 regarding liability for warning.

Additionally, Section 164.512 specifically allows disclosures to “[a] public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect.” 45 C.F.R. § 164.512(b)(1)(ii); see also 45 C.F.R. § 160.203(a)(iv) and (c) (HIPAA’s confidentiality provisions do not preempt state laws
that provide “for the reporting of disease or injury [or] child abuse”; O.C.G.A. § 19-7-5 (requiring MHPs to report child abuse). Section 512(c) allows a health provider to report other suspected abuse, but places limitations on such reporting. It states that:

Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

45 C.F.R. 164.512(c).
4. **Individuals’ Rights To Access Protected Health Information.**

HIPAA’s Privacy Standards provide an individual with the right to inspect and obtain copies of his/her protected health information. That right, however, is not unqualified. A covered entity may refuse to disclose psychotherapy notes to the patient without any right of review under 45 C.F.R. § 164.524(a)(1). Moreover, access to other protected health information may be denied if the health care professional exercising his/her professional judgment determines that granting the patient “the access requested” would “reasonably likely” endanger the life or physical safety of the individual or another person. However, the patient has a right to have such a denial reviewed by a licensed health care professional who is designated by the covered entity as a reviewing official and who did not participate in the initial decision to deny. 45 C.F.R. § 164.524(a)(3)(i).

The Georgia Mental Health Code\(^8\), on the other hand, grants patients access to their entire mental health record, including psychotherapy notes. Specifically, under the Mental Health Code, current patients may examine all their mental health records unless the Chief Medical Officer or the treating physician or psychologist determines that disclosure of the record would be detrimental to the patient’s physical or mental health and a notation of that determination is included in the patient’s record. O.C.G.A. §§ 37-3-162(b) and 37-3-167(a); Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). Former patients, however, have unqualified access to their mental health records and the

---

\(^8\) O.C.G.A. § 37-3-101 et seq.
 Individuals' Rights To Access Protected Health Information.

HIPAA's Privacy Standards provide an individual with the right to inspect and obtain copies of his/her protected health information. That right, however, is not unqualified. A covered entity may refuse to disclose psychotherapy notes to the patient without any right of review under 45 C.F.R. § 164.524(a)(1). Moreover, access to other protected health information may be denied if the health care professional exercising his/her professional judgment determines that granting the patient "the access requested" would "reasonably likely" endanger the life or physical safety of the individual or another person. However, the patient has a right to have such a denial reviewed by a licensed health care professional who is designated by the covered entity as a reviewing official and who did not participate in the initial decision to deny. 45 C.F.R. § 164.524(a)(3)(i).

The Georgia Mental Health Code grants patients access to their entire mental health record, including psychotherapy notes. Specifically, under the Mental Health Code, current patients may examine all their mental health records unless the Chief Medical Officer or the treating physician or psychologist determines that disclosure of the record would be detrimental to the patient's physical or mental health and a notation of that determination is included in the patient's record. O.C.G.A. §§ 37-3-162(b) and 37-3-167(a); Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). Former patients, however, have unqualified access to their mental health records and the exception for withholding on the basis of potential harm is not applicable. Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a).9

Georgia law has no similar statutory provisions for mental health professionals in the private practice setting to assist them in determining what rights patients have to access their mental health records. The Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists has adopted rules as part of the Code of Ethics which state, in part, that licensees must “provide information regarding a client’s evaluation or treatment, in a timely fashion and to the extent deemed prudent and clinically appropriate by the licensee, when that information has been requested and released by the client.” Ga. Comp. R. & Regs. § 135-7-.01(2)(m). Therefore, professional counselors, social workers, and marriage and family therapists follow a standard that is similar to the rules governing mental health facilities.10

Georgia courts have not considered the question of whether mental health professionals must follow HIPAA or Georgia law when assessing patients’ rights of access to their protected health information. HIPAA and its related regulations do not preempt any state law that provides more stringent requirements for the access of protected health information. Alvista Healthcare Ctr., 286 Ga. at 126, 686 S.E.2d at 99 (citing Moreland v. Austin, 284 Ga. 730, 733, 670 S.E.2d 68, 71-72 (2008)); Allen v. Wright, 282 Ga. 9, 12, 14, 644 S.E.2d 814, 816-18 (2007). According to 45 C.F.R. § 160.202, a state law is more stringent if it provides the patient greater rights of access to

---

9 Importantly, Georgia law does not address the question of whether a mental health professional may refuse a former patient access to mental health records if the mental health professional determined that releasing those records would be detrimental to the former patient’s mental or physical health.

10 The Rules of the State Board of Examiners of Psychologists do not directly address the patient’s right of access to his/her records but, by implication, a patient does have a right of access. Ga. Comp. R. & Regs § 510-4-.02(e)(4.05).
his/her protected health information. See Moreland v. Austin, 284 Ga. at 733, 644 S.E.2d at 71 (“More stringent’ means laws that afford patients more control over their medical records”); Tender Loving Health Care Serv. of Ga., LLC v. Ehrlich, 318 Ga. App. 560, 734 S.E.2d 276, 279 (Ga. Ct. App. 2012) (HIPAA preempts state law when it “affords patients more control over their medical records”) overruled on other grounds by Wellstar Health Sys., Inc. v. Jordan, 293 Ga. 12, n. 6, 743 S.E.2d 375 (2013) (holding in part that HIPAA did not entitle an individual to access protected work product in the possession of a covered entity simply by virtue of the fact that it contained protected health information). Section 164.524(a)(1) of the HIPAA rules allows a covered entity to deny a patient complete access to psychotherapy notes without specifying a reason and without the requirement for review of the decision. However, under the Georgia Mental Health Code, current patients of a mental health facility have an absolute right of access to their entire mental health records, unless a mental health professional determines that disclosure of any portion of the records would harm the patient mentally or physically. O.C.G.A. §§ 37-3-162(b) and 37-3-167(a); Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). Therefore, when current patients request their mental health records, including psychotherapy notes, a Georgia facility may only withhold psychotherapy notes if there is a finding that disclosure would be detrimental to the patient.

In contrast, former patients have an unfettered right of access to their records maintained by the facility. Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). There is thus a potential conflict between the HIPAA provisions which provide no right of access to psychotherapy notes and the Mental Health Code, which clearly grants a right of access. Since the Mental Health Code provides the patient with greater rights than are provided by HIPAA, the Mental Health Code would likely preempt HIPAA’s provision permitting
a facility to deny a patient right of access to psychotherapy notes. This conflict should not be an issue in the context of current patients, since access can be denied if it is determined that access would be detrimental to the patient. While the state regulations grant a former patient access without exception, the Code Section (O.C.G.A. § 37-3-162 (b)) provides for access subject to a finding of potential harm and makes no distinction between current and former patients. Since the primary duty imposed on any health care professional is to do no harm, the prudent course of action would be for a mental health professional in charge of patient records at a facility to review those records to determine whether disclosure to the patient would likely cause harm to the patient. If it is determined in good faith that disclosure would likely cause the patient harm, then the record should not be disclosed (and a notation to that effect should be made in the patient’s record).

As to mental health professionals in private practice, other than licensed professional counselors, social workers and marriage and family therapists, there are no statutes or rules specifically governing a patient’s right of access to their records. Since HIPAA explicitly provides that a mental health professional may refuse to disclose psychotherapy notes to the patient, the prudent course of action would be for the mental health professional to determine whether disclosure of psychotherapy notes to the patient or to any other entity that the patient requests would be detrimental to the patient. If so then those portions of the record which could cause the patient harm should be withheld. If there is no likelihood of harm then the mental health professional would have no reason not to provide the records to the patient.
5. No Private Right Of Action under HIPAA

HIPAA’s penalty provisions authorize the Secretary of Health and Human Services to impose significant monetary penalties for any violation of the Act. The civil monetary penalty escalates based on the provider’s increasing level of culpability. Any person that violates HIPAA is liable for a penalty ranging from $100 to $50,000 per violation (where the covered entity did not know of the violation and would not have known of it with the exercise of due diligence) to a minimum of $50,000 per violation (where the violation was due to willful neglect and was not corrected in a timely fashion). The total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $1,500,000.

While the civil monetary penalties can be substantial, the federal courts have found that HIPAA does not create a private right of action. In Acara v. Banks, 470 F.3d 569 (5th Cir. 2006), the Fifth Circuit affirmed the dismissal on subject matter jurisdiction grounds of an action against a physician for the unconsented disclosure of medical information during a deposition. The Court found that HIPAA’s delegation of enforcement authority to the Secretary of Health and Human Services was strong evidence of Congress’s intent to preclude private enforcement. Every other Circuit Court that has analyzed the issue has come to the same conclusion. See Miller v. Nichols, 586 F.3d 53, 59 (1st Cir. 2009) (“No Private Right of Action under HIPAA”); Carpenter v. Phillips, 419 F. App’x 658, 659 (7th Cir. 2011) (“HIPAA does not furnish a private right of action”); Dodd v. Jones, 623 F.3d 563, 569 (8th Cir. 2010) (“HIPAA does not create a private right of action”); Seaton v. Mayberg, 610 F.3d 530, 533 (9th Cir. 2010).

HIPAA’s penalty provision now incorporates the increased and tiered civil money penalty structure provided by the Health Information Technology for Economic and Clinical Health (HITECH) Act.
5. No Private Right Of Action under HIPAA

HIPAA's penalty provisions authorize the Secretary of Health and Human Services to impose significant monetary penalties for any violation of the Act. The civil monetary penalty escalates based on the provider's increasing level of culpability. Any person that violates HIPAA is liable for a penalty ranging from $100 to $50,000 per violation (where the covered entity did not know of the violation and would not have known of it with the exercise of due diligence) to a minimum of $50,000 per violation (where the violation was due to willful neglect and was not corrected in a timely fashion). The total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $1,500,000.

While the civil monetary penalties can be substantial, the federal courts have found that HIPAA does not create a private right of action. In Acara v. Banks, 470 F.3d 569 (5th Cir. 2006), the Fifth Circuit affirmed the dismissal on subject matter jurisdiction grounds of an action against a physician for the unconsented disclosure of medical information during a deposition. The Court found that HIPAA's delegation of enforcement authority to the Secretary of Health and Human Services was strong evidence of Congress's intent to preclude private enforcement. Every other Circuit Court that has analyzed the issue has come to the same conclusion. See Miller v. Nichols, 586 F.3d 53, 59 (1st Cir. 2009) ("No Private Right of Action under HIPAA"); Carpenter v. Phillips, 419 F. App'x 658, 659 (7th Cir. 2011) ("HIPAA does not furnish a private right of action"); Dodd v. Jones, 623 F.3d 563, 569 (8th Cir. 2010) ("HIPAA does not create a private right of action"); Seaton v. Mayberg, 610 F.3d 530, 533 (9th Cir. 2010) ("HIPAA itself provides no private right of action."); Wilkerson v. Shinseki, 606 F.3d 1256, 1267 (10th Cir. 2010) ("HIPAA does not create a private right of action for alleged disclosures of confidential medical information"); Bradley v. Pfizer, Inc., 440 F. App’x 805, 809 (11th Cir. 2011) ("there is no private right of action for a violation of HIPAA’s confidentiality provisions"); see also Swift v. Lake Park High Sch. Dist. 108, No. 03-C-5003, 2003 WL 22388878, at *4 (N.D. Ill. Oct. 21, 2003) ("No federal court reviewing the matter has ever found that Congress intended HIPAA to create a private right of action."); Hudes v. Aetna Life Ins. Co., 806 F. Supp. 2d 180, 196 (D.D.C. 2011) (concluding that “[i]n light of the statutory language of [applicable enforcement provision 42 U.S.C. §] 1320d-5 and the apparent consensus among the courts that have considered the question, . . . Plaintiff has no private HIPAA right of action”), aff’d, 493 F. App’x 107 (D.C. Cir. 2012); Spore v. Rogers, Civil No. 5:14-CV-025-CAR-MSH, 2015 WL 5046582 M.D. Ga. Aug. 26, 2015). Also see Saldena-Fountain v. United States, No. EP-15-CV-39-KC, 2016 WL 626573 (W.D. Tex. Feb. 26, 2016) (discussing right of action cases), aff’d, 693 F. App’x 295 (5th Cir. 2017).

**Issues Related To Workers’ Compensation**

Although Section 164.508(a)(1) requires authorization before a covered entity may use or disclose protected health information, there is an exception for disclosure for use in a workers’ compensation proceeding. Under Section 164.512, a covered entity may use or disclose protected health information without written authorization or an opportunity to object “as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs . . .” 45 C.F.R. § 164.512(l). Similarly, the regulations allow disclosures to an employer to evaluate whether an individual has a work-related illness, 45 C.F.R. § 164.512(b), or to determine eligibility
for government benefits, 45 C.F.R. § 164.512(d). Thus, as a general matter, PHI may be disclosed to determine eligibility for benefits.

In addition, with respect to workers’ compensation, O.C.G.A. § 34-9-207(a) provides that “[w]hen an employee has submitted a claim for workers’ compensation benefits . . . , that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury . . . , including, but not limited to, communications with psychiatrists or psychologists.” In other words, by submitting a claim for workers’ compensation benefits, an employee waives any claim of privilege or confidentiality he may have with regard to his medical records under Georgia law to the extent that they relate to his claim. See Arby’s Rest. Group, Inc. v. McRae, 292 Ga. 243, 244, 734 S.E.2d 55, 56-57 (Ga. 2012) (“The occurrence of any one of [the] triggering events [in O.C.G.A. § 34-9-207] waives the employee’s privilege in confidential health information”). Therefore, given the Privacy Rule’s incorporation of state law when addressing workers’ compensation, a covered entity is generally permitted to disclose an individual’s protected health information related to a workers’ compensation claim without prior authorization.

However, as previously noted, the Privacy Rule extends special protection to psychotherapy notes (45 C.F.R. § 164.508(a)(2)). Although several provisions of 45 C.F.R. § 164.512 are specifically exempt from the authorization requirement (§ 164.512(a), (d) as it relates to oversight of the health care provider, (g)(1) and (j)(1)(i)), Section 164.512(l)—addressing workers’ compensation—is not among them. 45 C.F.R. § 164.508(a)(2)(ii). Moreover, although on its face the “disclosures required by law” provision might seem to apply, the specific discussion of disclosures allowed under this
provision would not appear to cover workers’ compensation proceedings, particularly in light of the specific workers’ compensation provision contained in Section 512(l). Therefore, using basic rules of construction, it appears that psychotherapy notes may not be disclosed without authorization in a workers’ compensation proceeding because workers’ compensation is not one of the listed exceptions under Section 508(a)(2)(ii).

III. DAMAGES CLAIMS PARTICULARLY RELEVANT TO MENTAL HEALTH PROFESSIONALS

A. Involuntary Detention / False Imprisonment

The Georgia Code defines false imprisonment as “the unlawful detention of the person of another, for any length of time, whereby such person is deprived of his personal liberty.” O.C.G.A. § 51-7-20. The Georgia Court of Appeals provided a good statement of the elements of the tort in Hampton v. Norred & Associates, Inc.:

The essential elements of the cause of action for false imprisonment are a detention of the person of another for any length of time, and the unlawfulness of that detention. A detention need not consist of physical restraint, but may arise out of words, acts, gestures, or the like, which induce a reasonable apprehension that force will be used if plaintiff does not submit; and it is sufficient if they operate upon the will of the person threatened, and result in a reasonable fear of personal difficulty or personal injuries. . . . A person need not make an effort to escape or to resist until an application of open force results, thereby risking possible physical injury, before he can recover; however, an actual detention must have occurred whether caused by force or fear.

216 Ga. App. 367, 368, 454 S.E.2d 222, 223 (1995) (citations omitted). The tort thus has two central elements: (1) detention of the person (for any length of time), and (2) unlawfulness of the detention. Scott Hous. Sys., Inc. v. Hickox, 174 Ga. App. 23, 24, 329 S.E.2d 154, 155 (1985) (“In an action to recover damages for . . . false imprisonment the only essential elements are the arrest or detention and the unlawfulness thereof.”)
Cases alleging false imprisonment by mental health professionals generally focus on the “unlawfulness” of the detention.

A mental health professional who in good faith executes a procedurally valid certificate authorizing involuntary detention under the Georgia Mental Health Code does not act “unlawfully” and is insulated from a false imprisonment claim. Williams v. Smith, 179 Ga. App. 712, 715, 348 S.E.2d 50, 53 (1986). The Williams court, relying on the immunity provisions of the Mental Health Code for the admission and release of patients under O.C.G.A. § 37-3-4, applied a two-part test to determine a psychiatric clinic’s immunity from a false imprisonment claim. First, so long as a patient’s detention is predicated upon procedurally valid process, the detention is not “unlawful,” and the remedy of false imprisonment is unavailable. Second, even if the detention is secured by procedurally void or defective process, false imprisonment is available only if the process was secured in bad faith. Id.

O.C.G.A. § 37-3-4 provides civil and criminal immunity to a person authorized to involuntarily commit patients so long as she “acts in good faith in compliance with the admission and discharge provisions of this chapter” and does not “fail[] to meet the applicable standard of care in the provision of treatment to [the] patient.” This immunity provision provides an affirmative defense that the defendant has the burden

---

12 O.C.G.A. § 37-3-41 allows any physician, psychologist, clinical social worker, or clinical nurse specialist in psychiatric/mental health within the state to execute a certificate stating that he has personally examined a person within the preceding forty-eight hours and found that the person appears to be a mentally ill person requiring involuntary treatment. O.C.G.A. § 37-3-81 allows for the involuntary detention of a patient beyond the evaluation period upon recommendation of the chief medical officer of an evaluating facility supported by the opinions of two physicians or a physician and a psychologist who have personally examined the patient within the preceding five days and who agree that the patient is a mentally ill person requiring involuntary treatment.

Heath reached the Court of Appeals twice. In its first review, the Court reversed summary judgment in the defendants’ favor on the plaintiff’s false imprisonment claim because the defendants produced no evidence that the plaintiff’s three-day detention was pursuant to valid procedural process. Heath v. Peachtree Parkwood Hosp., Inc., 200 Ga. App. 118, 119, 407 S.E.2d 406, 407 (1991).

Upon remand, the plaintiff argued she was not a voluntary patient who could be lawfully detained against her volition. The patient testified that she believed she was checking herself into a weight loss clinic and that she was never notified of her statutory rights as a voluntary mental health patient and thus had no knowledge that she was, instead, checking into a mental health facility in which she could be held against her will. The jury returned a verdict of $25,000 on the false imprisonment claim in the plaintiff’s favor.

On appeal, the defendants asserted as an affirmative defense that they were immune from liability, as provided by O.C.G.A. § 37-3-4, because they acted in good faith in compliance with the admission and discharge provisions of the statutes governing the admission of voluntary patients to a mental health facility. The Court held that, in order to assert the affirmative defense of immunity under O.C.G.A. § 37-3-4, the defendants first had to show the plaintiff was, in fact, a voluntary patient subject to the Mental Health Code. The Court held that the trial court did not err in instructing
the jury that the defendants had the burden of proving these facts and upheld the jury verdict in the plaintiff’s favor. Heath v. Emory Univ. Hosp., 208 Ga. App. at 631-32, 431 S.E.2d at 429-30.

The affirmative defense of immunity provided under O.C.G.A. § 37-3-4 does not extend to hospitals or other mental health facilities, but only to the employees of such entities. Krachman v. Ridgeview Inst., Inc., 301 Ga. App. 361, 687 S.E.2d 627 (2009). In Krachman, the plaintiff conceded that she was lawfully admitted to Ridgeview as a voluntary patient, but she contended that she was unlawfully detained after Ridgeview staff members did not comply with the discharge procedures under O.C.G.A. § 37-3-22(a). Reversing the trial court’s grant of summary judgment in favor of the mental health facility, the Court held that the plain language of O.C.G.A. § 37-3-4 extends immunity only to designated individuals and “does not evidence a legislative intent to confer immunity on hospitals or other mental health facilities.” Id. at 364, 687 S.E.2d at 629. Furthermore, because the plaintiff sued Ridgeview under a respondeat superior theory of liability, Ridgeview had no defense based on its agent’s immunity from civil liability for acts committed in the course of employment as “[i]mmunities, unlike privileges, are not delegable and are available as a defense only to persons who have them.” Id. at 364, 687 S.E.2d at 630 (quoting Gilbert v. Richardson, 264 Ga. 744, 754, 452 S.E.2d 476, 483-84 (1994) (citing Restatement (Second) of Agency § 217(b)(ii) (1958))). Finally, the Court found that material issues of fact existed as to plaintiff’s false imprisonment claim. Because there was evidence that the plaintiff orally expressed her desire for discharge to Ridgeview staff members on numerous occasions, the Court concluded that jury questions remained regarding whether Ridgeview demonstrated its “objective compliance” with the discharge procedures set forth in O.C.G.A. § 37-3-22 (a).

In addition to compliance with procedural requirements, Georgia law provides a defense to a false imprisonment claim based on the existence of a medical emergency or the consent of a substituted decision maker. In Davis v. Charter-By-The-Sea, Inc., 183 Ga. App. 213, 358 S.E.2d 865 (1987), two adult children brought their intoxicated mother to the hospital. The mother had to be bodily carried by her children due to her condition, and two doctors who attended her determined she was “medically unstable” and should be admitted. One of the children also signed a consent form authorizing treatment of her mother.

The Court, distinguishing Williams because that case involved delivery of a patient to a facility by a peace officer pursuant to a valid certificate, found evidence of “other legal justification for receiving, examining, and treating [the mother].” 183 Ga. App. at 216, 358 S.E.2d at 868. The Court found sufficient evidence in the record to support a defense to the plaintiff’s false imprisonment charge based on (1) the existence of a medical emergency and (2) valid consent given by a substituted decision maker or the implied consent of the incapacitated plaintiff. Id. at 216-17, 358 S.E.2d at 868.

B. Unauthorized Disclosure Of Privileged Records

Georgia law recognizes a cause of action for damages for the breach of the duty to protect a patient’s privacy and confidentiality. See generally Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982). In Mrozinski, a father participated in the psychiatric treatment of his minor daughter. The father contended that the treating psychiatrist provided privileged information to the attorney of his former wife for use in a custody suit. The information
provided included a “discharge summary” and an affidavit. The information described
the father’s conduct and reactions during family therapy, contained the psychiatrist’s
observations and conclusions as to the interaction between the father and his daughter
during family therapy, and expressed negative criticism of the father's conduct and
reactions during therapy. The affidavit recommended that custody of the child be
returned to the former wife.

The father claimed (1) wrongful disclosure of privileged information, and (2)
breach of confidential relations for both his and his daughter’s records. The psychiatrist
contended that the father was not a patient, and thus no privilege existed between
himself and the father, and that any communications lost their privileged status when
the psychiatrist treated the father and daughter jointly. The psychiatrist also argued
that the father lacked standing to raise these claims on behalf of his minor daughter.

Referencing strong public policy interests, the Court held that if multiple persons
participate in joint therapy, the psychiatrist-patient privilege extends to the
communications of all participants. Mrozinski, 205 Ga. App. at 733, 423 S.E.2d at 408.
The Court held that genuine issues of material fact existed, precluding summary
judgment, on whether the psychiatrist gave or contemplated psychiatric assistance to
the father so that the father would be a patient and the privilege would exist, and on
whether the psychiatrist breached a confidential relationship during the custody dispute
and disclosed the father’s privileged information. Id. at 734, 423 S.E.2d at 409. The
Court also held that the father had standing to file suit for unauthorized disclosure of his
minor daughter's clinical records and for unauthorized release of privileged material
regarding his minor daughter. Id. at 736-37, 423 S.E.2d at 411.
Georgia law also recognizes a claim for invasion of privacy for the unauthorized disclosure of privileged records. The right of privacy in Georgia is a “fundamental constitutional right.” \textit{Cornelius v. Hutto}, 252 Ga. App. 879, 883, 558 S.E.2d 36, 40 (2001) (citations omitted). To bring a successful invasion of privacy claim, a plaintiff must prove: (1) the defendant made a disclosure to the public; (2) the facts disclosed were private, secluded or secret facts and not public ones; and (3) that the matter made public was offensive and objectionable to a reasonable man of ordinary sensibilities under the circumstances. \textit{Cabaniss v. Hipsley}, 114 Ga. App. 367, 372, 151 S.E.2d 496, 501 (1966). For a thorough discussion of the right to privacy under Georgia law, including public records that may contain privileged communications, see \textit{Phillips v. Consol. Publ’g Co.}, Civil Action No. CV 213-069, 2015 WL 5821501 (S.D. Ga. Sept. 14, 2015).

\textit{Cornelius} is one of the few Georgia cases involving an invasion of privacy claim against a mental health professional. In \textit{Cornelius}, a father brought a breach of confidentiality and invasion of privacy action against his former psychiatrist for giving an affidavit regarding custody of his son. Before the father divorced his ex-wife, the psychiatrist had treated them both. The allegedly offending affidavit did not expressly mention the psychiatrist’s treatment of the father, but concluded that the son “would best be served by having limited contact with his father,” and that “[the ex-wife] is the more psychologically fit and nurturing parent . . . .” \textit{Cornelius}, 252 Ga. App. at 880-81, 558 S.E.2d at 39.

The Court found sufficient evidence in the record to send the question of breach of confidentiality to the jury, and thus upheld the denial of a directed verdict in the
father's favor.13 Id. at 882-83, 558 S.E.2d at 39-40. On the invasion of privacy claim, the Court rejected the defense that because the communications were revealed in an affidavit filed with the Court they were privileged under O.C.G.A. § 51-5-8 (providing a limited privilege in defamation cases). Citing “strong public policy against releasing mental health records,” the Court refused to allow “circumvent[ion]” of the psychiatrist-patient privilege merely by filing an affidavit in a lawsuit. Id. at 883-84, 558 S.E.2d at 40-41. The Court thus held that the father’s invasion of privacy claim presented a jury question, and reversed a directed verdict in the psychiatrist’s favor. Id.

C. Patient Causes Harm To Third Parties

Georgia law creates seemingly conflicting duties on mental health professionals regarding the duty to warn identifiable third parties of foreseeable potential harm from a patient. On the one hand, Georgia law places a well-established duty on mental health professionals to maintain the confidentiality of patient communications. Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982); see also supra, Part II, Section B. On the other hand, Georgia law imposes duties on mental health professionals both to their patients and to third parties that may require the disclosure of confidential and privileged communications. Under some circumstances, the duty to warn an identifiable third party of potential harm from a patient may outweigh the mental health professional’s obligation to maintain the privileged and confidential nature of patient communications.

13 The father contended that testimony by the psychiatrist at trial contradicted the psychiatrist’s affidavit and should therefore have been excluded, entitling the father to a directed verdict. The Court held that the testimony did not necessarily contradict the affidavit, and, even if it did, additional evidence in the record supporting the psychiatrist’s defense precluded granting a directed verdict in the father’s favor. Id. at 882-83, 558 S.E.2d at 39-40.
1. Duty To Control

Georgia courts have not explicitly adopted the classic duty to warn concept set forth in the seminal case of Tarasoff v. Regents of University of California, 551 P.2d 334 (Cal. 1976). Nevertheless, the Georgia courts have held that a duty to prevent harm to others may arise out of the special nature of the therapist/patient relationship. At the very least, mental health professionals in Georgia have a duty to exercise reasonable care to control a patient to prevent him from doing bodily harm to a third person. Bradley Ctr., Inc. v. Wesner, 161 Ga. App. 576, 287 S.E.2d 716, aff'd, 250 Ga. 199, 296 S.E.2d 693 (1982).

In Bradley Center, the patient of a mental health facility shot and killed his ex-wife and her lover while the patient was on an unrestricted weekend pass from the hospital. The hospital argued that it owed no duty to the ex-wife because she was outside the professional-client relationship. The Court disagreed, holding that where the course of treatment of a mental patient involves an exercise of control over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises, requiring the physician to exercise that control with such reasonable care as to prevent the patient from causing harm to others. Id. at 581, 287 S.E.2d at 721.

In 1992, the Georgia Court of Appeals described the Bradley Center decision as establishing a “two-part test” for determining under what circumstances a physician may be liable to a third party: “(1) the physician must have control over the mental patient; and (2) the physician must have known or reasonably should have known that the patient was likely to cause bodily harm to others.” Ermutlu v. McCorkle, 203 Ga. App. 335, 336, 416 S.E.2d 792, 794 (1992). Thus, Bradley Center is expressly limited to
cases in which the mental health professional has taken charge or otherwise assumed control of the patient. As such, if no right of control exists, a plaintiff cannot state a claim. See generally Ward v. Emmanuel Cty. Bd. of Health, 218 Ga. App. 382, 461 S.E.2d 559 (1995); Ermutlu, 203 Ga. App. 335, 416 S.E.2d 792 (1992). For example, a mental health professional cannot be held liable for the release of a voluntary outpatient, since the professional does not exercise control over such a patient. Id. at 337, 416 S.E.2d at 794-95 (holding that patient must meet involuntary commitment standard before psychiatrist’s duty arises).

In Curles v. Psychiatric Solutions, Inc., 808 S.E.2d 237 (2017) the Georgia Court of Appeals reversed a dismissal of plaintiff’s wrongful death action alleging ordinary and medical negligence against the owners, operators and employees of a psychiatric treatment facility that treated and released a patient who later killed two persons. The case arose from the deaths of Donna Kern and William Chapman at the hands of Amy Kern. Amy Kern had an extensive mental health history dating back to 1999 and she suffered from psychotic episodes which resulted in violent conduct. Between November 2008 and January 2009 Amy was an involuntary patient at Focus by the Sea, a private psychiatric facility, on three separate occasions. Her first involuntary commitment came after she attempted suicide. She remained at Focus for ten days and upon release she voluntarily sought outpatient psychiatric treatment. A month later she was arrested after she chased her boyfriend around their home with an axe. As a condition of her release from custody she was ordered to return to Focus for psychiatric treatment, where she remained for seven days. Seven days later she was involuntarily committed for a third time after threatening violence against her boyfriend. 14 days after her
commitment she was discharged from Focus and 12 days later she killed her grandmother and her aunt’s boyfriend.

Count II of the Complaint alleged that Focus and its employees failed to comply with the statutory notification and discharge requirements pursuant to O.C.G.A. §§ 37-3-4, 37-3-24 and 37-3-95. The trial court dismissed that Count on the basis that it sounded in medical malpractice and that it was barred by the medical malpractice statute of repose and the expert affidavit requirement. The Court of Appeals reversed, finding that the underlying negligent or wrongful act upon which Count II was based did not arise out of care or treatment for the benefit of Amy nor did it involve the exercise of professional judgment. Rather, it arose out of a statutory duty to give notice. The Court further found that the allegations of the Complaint were sufficient to establish that the victims were within the class of individuals that the notice provision was designed to protect.

Count III of the Complaint was based upon the duty to control principal enunciated in the Bradley Center case. Given Amy’s repeated instances of violence and the fact that she was involuntarily committed to the care of Focus were sufficient to establish both a special relationship between Focus and Amy and that she posed a threat of danger to herself and others. The Court then reversed the trial court on the basis that it had erred in construing Count III as a claim for medical malpractice. The Court found that the allegations of the Complaint that Amy was discharged based on a corporate policy of releasing patients when their insurance ran out, did not sound in malpractice.
2. **Duty To Warn**

The Georgia Court of Appeals has addressed a second exception to the general rule that a doctor has no duty to prevent a third person from harming others. That exception “requires a special relationship between the doctor and the injured party which would confer a right to protection to the injured party.” Bruscato v. Gwinnett-Rockdale-Newton Cmty. Serv. Bd., 290 Ga. App. 638, 640, 660 S.E.2d 440, 443 (2008) (citing Gilhuly v. Dockery, 273 Ga. App. 418, 419, 615 S.E.2d 237, 239 (2005); Restatement (Second) of Torts § 315(b)).

Bruscato involved a psychiatric patient who was being cared for and monitored at home, at his parents’ request and upon condition that the parents would provide 24-hour monitoring of the patient. The patient ultimately killed his mother, and the patient’s father sued the patient's treating psychiatrist, alleging, in part, that the psychiatrist had a duty to the mother by virtue of the mother’s special relationship with the psychiatrist. Id. at 641, 660 S.E.2d at 443. Relying on Swofford v. Cooper, 184 Ga. App. 50, 360 S.E.2d 624 (1987), aff’d, 258 Ga. 143, 368 S.E.2d 518 (1988), the father contended that the mother “was conferred ‘patient-like’ status and had privity with [the treating psychiatrist] since she ‘necessarily [and] customarily participated in the consultation and treatment of [the patient].’” Bruscato, 290 Ga. App. at 641, 660 S.E.2d at 443. The Court of Appeals rejected both the “patient-like status” argument and the privity argument, concluding that no special relationship existed between the treating psychiatrist and the mother. Id. at 641-42, 660 S.E.2d at 443-44. The Court rejected the argument, as had the Swofford court, that the mere taking of advice regarding the treatment of a patient can convert a caretaker into a patient. Id. The Bruscato court also rejected the argument that the mother had been in privity of contract with the psychiatrist by virtue of her agreement with the psychiatrist to provide 24-hour supervision and that this privity gave rise to a special relationship. Distinguishing cases in which decedent patients had sued physicians and hospitals based on duties to aid or protect arising from privity of contract, the Court refused to extend that privity to a “third party who was never the patient of the physician or hospital.” Id. at 642, 660 S.E.2d at 444. The Court, accordingly, declined to extend the duties owed to third parties beyond that set forth in Bradley Center based on the facts of Bruscato, wherein the parents had supervised the patient at home for over three years prior to the attack. Id. at 643, 660 S.E.2d at 444. The Court stated further policy bases for its reticence, noting first that “extending a physician’s duty of care to third parties beyond the provisions of the Bradley Center test mandating that the physician exercise control over the patient could discourage outpatient care to the detriment of the state’s express policy of providing the ‘least restrictive alternative,’ ‘least restrictive environment,’ or ‘least restrictive appropriate care and treatment’ to mental patients.” Id. The Court further noted that “the imposition of liability for an outpatient under these circumstances could discourage physicians from including the relative of any

---

14 The comments to Section 315 indicate that such relationships would include, for example, common carriers, innkeepers, possessors of land, and individuals who are required by law or who voluntarily take custody of another. Bruscato, 290 Ga. App. at 642 n.7, 660 S.E.2d at 444 n.7. “[T]he comments to [Section 315] suggest that special relationships are based upon a duty to control.” Id.

15 Swofford presented the issue of whether a patient’s caretakers became “patients” of the defendant physician by receiving advice as to how best to assist with the patient’s care. Swofford, 184 Ga. App. at 53, 360 S.E.2d at 627. Citing Sims v. State, 251 Ga. 877, 881, 311 S.E.2d 161, 165 (1984), wherein the Supreme Court of Georgia held that when a third-party family member participates in joint therapy sessions, the third party is a "necessary or customary participant" and is deemed a patient to whom the privilege applies, the Court of Appeals concluded that the caretakers were not patients because they did not “necessarily or customarily participate[] in the consultation and treatment of [the patient].” Swofford, 184 Ga. App. at 53, 360 S.E.2d at 627.
Duty To Warn

The Georgia Court of Appeals has addressed a second exception to the general rule that a doctor has no duty to prevent a third person from harming others. That exception “requires a special relationship between the doctor and the injured party which would confer a right to protection to the injured party.” Bruscato v. Gwinnett-Rockdale-Newton Cmty. Serv. Bd., 290 Ga. App. 638, 640, 660 S.E.2d 440, 443 (2008) (citing Gilhuly v. Dockery, 273 Ga. App. 418, 419, 615 S.E.2d 237, 239 (2005); Restatement (Second) of Torts § 315(b)).

Bruscato involved a psychiatric patient who was being cared for and monitored at home, at his parents’ request and upon condition that the parents would provide 24-hour monitoring of the patient. The patient ultimately killed his mother, and the patient’s father sued the patient’s treating psychiatrist, alleging, in part, that the psychiatrist had a duty to the mother by virtue of the mother’s special relationship with the psychiatrist. Id. at 641, 660 S.E.2d at 443. Relying on Swofford v. Cooper, 184 Ga. App. 50, 360 S.E.2d 624 (1987), aff’d, 258 Ga. 143, 368 S.E.2d 518 (1988), the father contended that the mother “was conferred ‘patient-like’ status and had privity with [the treating psychiatrist] since she ‘necessarily [and] customarily participated in the consultation and treatment of [the patient].’” Bruscato, 290 Ga. App. at 641, 660 S.E.2d at 443 (citation omitted). The Court of Appeals rejected both the “patient-like status” argument and the privity argument, concluding that no special relationship existed between the treating psychiatrist and the mother. Id. at 641-42, 660 S.E.2d at 443-44. The Court rejected the argument, as had the Swofford court, that the mere taking of advice regarding the treatment of a patient can convert a caretaker into a patient. Id.

The Bruscato court also rejected the argument that the mother had been in privity of contract with the psychiatrist by virtue of her agreement with the psychiatrist to provide 24-hour supervision and that this privity gave rise to a special relationship. Distinguishing cases in which decedent patients had sued physicians and hospitals based on duties to aid or protect arising from privity of contract, the Court refused to extend that privity to a “third party who was never the patient of the physician or hospital.” Id. at 642, 660 S.E.2d at 444. The Court, accordingly, declined to extend the duties owed to third parties beyond that set forth in Bradley Center based on the facts of Bruscato, wherein the parents had supervised the patient at home for over three years prior to the attack. Id. at 643, 660 S.E.2d at 444. The Court stated further policy bases for its reticence, noting first that “[e]xtending a physician’s duty of care to third parties beyond the provisions of the Bradley Center test mandating that the physician exercise control over the patient could discourage outpatient care to the detriment of the state’s express policy of providing the ‘least restrictive alternative,’ ‘least restrictive environment,’ or ‘least restrictive appropriate care and treatment’ to mental patients.” Id. The Court further noted that “the imposition of liability for an outpatient under these circumstances could discourage physicians from including the relative of any
mental health patient—or for that matter, the relative of a minor—in the treatment process out of concern that the physician would be exposed to greater liability.”  

Finally, the Court held that there was no duty to warn the mother of dangers and tendencies of which she was already fully aware by virtue of her care for the patient.  

Interestingly, Bruscato made a second appearance in the Court of Appeals in 2010.  As discussed at page 41 below, the patient sued his psychiatrist for malpractice alleging claims for emotional distress.  The Court reversed the dismissal of the case holding, in part, that the impact rule was not applicable to emotional distress claims in medical malpractice actions.

The Court of Appeals had addressed similar issues in Jacobs v. Taylor, 190 Ga. App. 520, 379 S.E.2d 563 (1989), a case in which the Court of Appeals appeared to assume that an assertion of breach of duty to warn identifiable parties of a patient’s threats of violence stated a claim for relief.  Jacobs involved a patient (Murray) who killed his ex-wife and two strangers five months after his release from a state hospital to the county jail.  Following his acquittal on terrorist threat charges, Murray was released from custody and two months later murdered Taylor’s decedents.  The children of the decedents brought suit alleging, inter alia, that the defendants-physicians breached a duty to warn the decedents of their patient’s murderous tendencies.  The Court upheld summary judgment in favor of the physicians, finding that the ex-wife “was fully cognizant of the danger [the patient] presented,” and that Georgia law imposes no duty to warn of that which the plaintiff already knew or should have known.  

In at least one case, Garner v. Stone,16 a jury returned a substantial damages award for a plaintiff who alleged the defendant-psychologist’s decision to warn a third party of harm posed by the patient breached the psychologist’s duty of care to the plaintiff.  The psychologist made his decision to warn after consultation with an attorney, who informed him that he did have such a duty.  The jury returned the verdict against the psychologist notwithstanding instructions informing the jury that a psychologist incurs an obligation to use reasonable care to protect the intended victim if the psychologist determines, pursuant to the standards of his profession, that the patient presents a “serious danger of violence.”  The case settled before appeal and therefore serves no precedential value in Georgia.

Given the proliferation of mass shootings by mentally-ill individuals, it is likely that, when squarely presented with the issue, the Georgia courts will find that a mental health professional has a duty to warn readily identifiable targets of her patient’s threats.

of the general public . . . of the risk posed by . . . a patient with a history of violence who made generalized threats . . .” Id.

3. Liability For Warning

Since Georgia has yet to specifically adopt the duty to warn under Tarasoff, a mental health professional could potentially face liability to the patient for breach of the duty of privacy and confidentiality if she does warn a third party of harm. Furthermore, even if Georgia law imposes a duty to warn third parties on mental health professionals, many open issues concerning the application of the duty remain. For example, is an “express threat” required before the duty is triggered as it is in several other jurisdictions? Is “imminent danger” required?

In at least one case, Garner v. Stone, a jury returned a substantial damages award for a plaintiff who alleged the defendant-psychologist’s decision to warn a third party of harm posed by the patient breached the psychologist’s duty of care to the plaintiff. The psychologist made his decision to warn after consultation with an attorney, who informed him that he did have such a duty. The jury returned the verdict against the psychologist notwithstanding instructions informing the jury that a psychologist incurs an obligation to use reasonable care to protect the intended victim if the psychologist determines, pursuant to the standards of his profession, that the patient presents a “serious danger of violence.” The case settled before appeal and therefore serves no precedential value in Georgia.

Given the proliferation of mass shootings by mentally-ill individuals, it is likely that, when squarely presented with the issue, the Georgia courts will find that a mental health professional has a duty to warn readily identifiable targets of her patient’s threats.

---

of bodily harm even if the information was acquired in the course of a privileged communication. As discussed above, the Office of Civil Rights within HHS has affirmed in an open letter to the health community that the HIPAA privacy rules allow an MHP to warn of a readily identifiable threat, even if that warning discloses protected health information. While HIPAA does not preempt state law, it is persuasive public policy. Mental health professionals must therefore make a judgment as to whether the risk to a third party outweighs the patient’s right to privacy.

4. Liability For Emotional Distress

In 2010, the Georgia Court of Appeals carved out an exception in medical malpractice actions to the rule prohibiting recovery for emotional distress damages in negligence actions in the absence of physical injury. In Bruscato v. O’Brien, 307 Ga. App. 452, 705 S.E.2d 275 (2010), aff’d, 289 Ga. 739, 715 S.E.2d 120 (2011), the Court of Appeals concluded that a plaintiff alleging medical malpractice no longer has to show physical injury to recover for emotional distress caused by the alleged malpractice. The Court also ruled that the plaintiff was not barred by public policy from pursuing a malpractice claim against his psychiatrist even though the alleged malpractice ultimately led to the plaintiff murdering his mother. Also see Howell v. Normal Life of Ga., 337 Ga. App. 774, 788 S.E.2d 840 (2016).


---

17 New York has amended its mental hygiene law by providing that if a mental health professional determines that a patient is likely to engage in conduct that would result in serious harm to the patient or others, the professional shall make a report which can be used to revoke the patient’s firearms license or make him ineligible for a license. New York Secure Ammunitions and Firearms Enforcement (SAFE) Act of 2013, S. 2230 (signed Jan. 15, 2013).
(2008), discussed at pages 36-37. Bruscato killed his mother after the defendant psychiatrist discontinued certain prescriptions, allegedly causing the patient to revert into a psychotic, homicidal state. Bruscato’s father, as guardian, filed a malpractice action against the psychiatrist seeking damages for the emotional distress resulting from the alleged negligence in discontinuing his son’s medication. The trial court granted summary judgment to the psychiatrist, concluding that 1) Georgia’s Impact Rule barred the medical malpractice claim, and 2) that the patient could not recover damages due to Georgia’s longstanding public policy of prohibiting wrongdoers from profiting from their misdeeds. On appeal, the Court of Appeals reversed.

The Court of Appeals outlined the origins of the Impact Rule, highlighting the concerns in emotional distress cases of frivolous litigation and the difficulties in proving causation between the negligence and the distress. The Court concluded that “[t]he above-stated policy concerns, however, are not present in medical malpractice cases.” 307 Ga. App. at 457, 705 S.E.2d at 280. According to the Court, the requirements of medical malpractice claims, especially the presence of a physician-patient relationship and O.C.G.A. § 9-11-9.1’s expert affidavit requirement, provide built-in safeguards to these policy concerns.  Id. 18

The fact that Bruscato was mentally incompetent to stand trial and had not yet been convicted of a crime was central to the Court’s decision not to invoke Georgia’s longstanding policy of prohibiting wrongdoers from benefiting from their wrongdoing. The Court concluded that Bruscato had not yet been found guilty of murder and, even if found competent to stand trial, could still be found not guilty by reason of insanity. Moreover, Bruscato claimed distress arising from the alleged malpractice—not the

18 The same rationale would apply to other mental health professionals.
murder—so that “even if Bruscato is characterized as an intentional ‘wrongdoer,’ his status as such would not be a bar to his recovering for those damages that are not attributable to the alleged immoral or illegal act.” Id. at 459, 705 S.E.2d at 281.

The Supreme Court granted certiorari to determine whether the Court of Appeals properly ruled that Bruscato’s damages claims were not barred by public policy barring a wrongdoer from profiting from his wrongful acts. The Court affirmed, adopting the Court of Appeals analysis. O’Brien v. Bruscato, 289 Ga. 739, 715 S.E.2d 120 (2011). The Court concluded that while one who knowingly commits a wrongful act cannot use the act for personal gain, an individual’s psychiatric condition may preclude him from knowingly committing a wrongful act. Because Bruscato had been found incompetent to stand trial, there had not been a finding that he knowingly committed a wrongful act. The Court also noted that Bruscato was not seeking to profit from the murder of his mother; rather, he was seeking damages for the suffering the alleged malpractice caused him. 19

In summary, Bruscato v. O’Brien effectively abrogates the Impact Rule in the medical malpractice context. Moreover, wrongful acts by the plaintiff do not necessarily provide an absolute bar to recovery where the Complaint alleges that the emotional distress arose from the malpractice and not from the wrongful act itself and/or the plaintiff did not knowingly commit the wrongful act.

D. Patient Suicide And Harm To Self

19 A Superior Court in Connecticut recently followed Bruscato holding that lack of mental capacity to commit a crime can be an exception to the wrongful conduct rule. Tonucci v. Gaylord Hosp., Inc., No. CV13602144, 2015 WL 6405691 (Conn. Super. Ct. Sept. 22, 2015).
Unlike third-party-harm claims, which involve non-patients, suicide cases are based on a duty of care to the patient. Georgia first recognized liability for patient suicide in 1933. See Emory Univ. v. Shadburn, 47 Ga. App. 643, 643, 171 S.E. 192, 193 (1933) (holding that hospital has duty to “safeguard[] and protect[] the patient from any known or reasonably apprehended danger from himself . . . and to use ordinary and reasonable care to prevent it”), aff’d, 180 Ga. 595, 180 S.E. 137 (1935). Until recently—and for the same reasons as articulated in the third-party cases—liability for suicide claims in Georgia was predicated on the mental health professional’s right to “control” the conduct of his or her patient and thereby prevent the suicide. See Keppler v. Brunson, 205 Ga. App. 32, 33, 421 S.E.2d 306, 307 (1992) (citing Ermutlu, 203 Ga. App. 335, 336, 416 S.E.2d 792 (1992), for proposition that control required for liability in suicide claim). A 2012 decision by the Georgia Court of Appeals, however, casts doubt on the former “control” standard and suggests that an MHP can be liable for suicide claims under any circumstance, regardless of control, where the treatment of the patient “fell below the requisite standard of care, and this failure proximately caused [the] injury.” Peterson v. Reeves, 315 Ga. App. 370, 375, 727 S.E.2d 171, 175 (2012) (citing O.C.G.A. § 51-1-27).

In Peterson, the patient, Reeves, brought a medical malpractice action against one of her treating psychiatrists for injuries sustained in a suicide attempt. Id. at 370, 727 S.E.2d at 172. During a tumultuous month of involuntary and voluntary treatments for psychotic behavior, Reeves was admitted for a second time to a voluntary treatment facility where Peterson, the psychiatrist, diagnosed her with several mental disorders and prescribed medication. Three days later, and without additional contact with Peterson, Reeves was discharged from the facility. Two days later she poured gasoline
over herself and set herself on fire. Id. at 371-372, 727 S.E.2d at 173. Surviving the attempt, Reeves alleged that Peterson committed malpractice by failing to subject her to a suicide or self-injury risk assessment and for failing to involuntarily commit her. Id. at 372, 727 S.E.2d at 173. Peterson moved for summary judgment, asserting first that “Georgia law requires a psychiatrist to have control over a patient before he can be held liable” and second that “no duty should be placed on a psychiatrist in a voluntary, outpatient facility to involuntarily commit any patient.” Id. at 372-373, 727 S.E.2d at 173-174.

The trial court rejected Peterson’s arguments and the Court of Appeals affirmed. The Court of Appeals dismissed the “control” line of cases as inapplicable to malpractice actions; i.e., a medical practitioner, regardless of whether the patient is under the practitioner’s control, has a “long-recognized duty inherent in the doctor-patient relationship to exercise the applicable degree of care and skill in the treatment of [the] patient.” Id. at 375, 727 S.E.2d at 175. And if the applicable degree of care and skill in the treatment of the patient requires the patient’s involuntary commitment, then failing to commit the patient may amount to malpractice. The court stressed that it was “not creating[] a new ‘duty to commit.’ Rather, [it was] simply recognizing that, under some circumstances, the failure to commit may constitute a breach of the well-established duty of care physicians owe patients.” Id. at 378, 727 S.E.2d at 177.

In Everson v. Phoebe Sumter Medical Center, 341 Ga. App. 182, 798 S.E.2d 667 (2017) the Court of Appeals applied the medical negligence standard of care to a claim arising out of a patient’s suicide. 27 year-old Benjamin Everson went to Sumter Regional Hospital complaining that he was hallucinating and hearing voices. Dr. Brian Jordan, the emergency room physician, diagnosed Everson with obsessive compulsory
disorder and discharged him with an appointment to see a mental healthcare provider two days later at a nearby facility. Instead, his father decided to have him evaluated at a facility associated with Duke University. On the way to the appointment Everson leapt from a moving car driven by his father and ran in front of another vehicle which struck and killed him. Everson’s parents brought an action for medical malpractice against the hospital and Dr. Jordan alleging that they failed to properly evaluate and treat Everson’s condition when he went to the emergency room, misdiagnosed him and failed to recognize that he needed a psychiatric evaluation. The trial court dismissed the action as to the hospital, finding that the Plaintiff’s expert’s testimony regarding the attending nurses failed to meet the requirements of O.C.G.A. § 24-7-702. As to Dr. Jordan, the court found that it was a jury question as to whether Everson’s condition met the requirements of the definition of emergency medical care so as to trigger the gross negligence standard or whether the ordinary negligence standard of care would apply. The Court further found that it was a jury question as to whether Everson’s suicide was a reasonable foreseeable consequence of Dr. Jordan’s failure two days earlier to properly diagnose and treat his psychosis.

After Peterson and Everson both physicians and MHPs should be aware that failing to involuntarily commit a patient, or failing to properly assess whether a patient should be involuntarily committed, may constitute malpractice regardless of whether the patient is under the practitioner’s control. But the practitioner must also be cognizant that involuntarily committing patients may “expose doctors to an increased
risk of liability in suits for false imprisonment.” Id. at 387, 727 S.E.2d at 181 (J. Andrews, dissenting). 20

Unresolved are several possible defenses to patient suicide claims. Among the least developed are defenses based on contributory or comparative negligence and lack of proximate causation. 21 Georgia’s contributory negligence statute reduces a claimant’s recovery by the degree of his negligence, and bars a claimant from any recovery if the claimant bears fifty percent or more of the responsibility for the negligent act. O.C.G.A. § 51-11-7. The Georgia Court of Appeals has rejected the theory that suicide bars recovery as a matter of law as an act of contributory negligence where a special relationship exists between the patient and the defendant. Brandvain v. Ridgeview Inst., Inc., 188 Ga. App. 106, 119, 372 S.E.2d 265, 275 (1988) (holding that defenses of contributory or comparative negligence are matters for jury consideration and are not determinable as matter of law), aff’d, 259 Ga. 376, 382 S.E.2d 597 (1989); see also Peterson, 315 Ga. App. At 376, 727 S.E.2d at 176 (“proximate cause is undeniably a jury question and is always to be determined on the facts of each case upon mixed considerations of logic, common sense, justice, policy, and precedent” (citation omitted)). But see City of Richmond Hill v. Maia, 301 Ga. 257, 800 S.E.2d 573 (2017) (holding that absent a special relationship between the defendant and the decedent, such as where the defendant owes a duty to prevent the decedent from harm, suicide is

20 The precedential value of Peterson is limited. Of the seven judges deciding the appeal, two joined the opinion, two concurred specially, and one concurred in the judgment only. Such a combination should be physical precedent only. Court of Appeals Rule 33(a). Nevertheless, the special concurrence mirrors the majority opinion, entirely agreeing with it in substance and only adding clarifications. While not binding precedent, Peterson is strong persuasive authority.

21 Lack of proximate cause is not truly a defense, as proximate causation is part of a plaintiff’s prima facie case for negligence.
an intervening cause that absolves the defendant of liability). The Court in Brandvain also rejected the theory that suicide acts as an intervening cause, cutting off proximate causation. Id. at 116, 372 S.E.2d at 273 (suicide not an intervening cause if reasonably foreseeable to the defendant).

In Miranda v. Fulton DeKalb Hospital Authority, 284 Ga. App. 203, 664 S.E.2d 164 (2007), the Court of Appeals found that the alleged failure to properly monitor a suicidal patient was not the proximate cause of the patient’s suicide. The patient was placed in restraints with an order that he be monitored every 15 minutes. He managed to escape and committed suicide 15 hours later. Plaintiff’s expert witness testified that had the patient been continually monitored his escape would have been much more difficult. The Court concluded as a matter of law that this testimony failed to establish proximate cause.

Finally, Georgia law provides qualified statutory immunity to mental health professionals’ decisions to admit or discharge. O.C.G.A. § 37-3-4. This immunity can insulate these professionals if a patient is discharged and subsequently commits suicide, so long as the professional acted in good faith. See generally Poss v. Ga. Reg’l Hosp., 676 F. Supp. 258, 262 (S.D. Ga. 1987), aff’d sub nom., Poss v. Azar, 874 F.2d 820 (11th Cir. 1989). But that immunity is unavailable if the health professional “fail[ed] to meet the applicable standard of care in the provision of treatment to a patient.” O.C.G.A. § 37-3-4.

E. Sexual Relations With A Patient

As a general rule, licensing board rules and ethical principles governing mental health professionals impose an absolute ban on sexual relations between mental health professionals and their patients. 22 See also supra, Part II, Section A.
professionals and their current patients. In Georgia, such conduct can expose the professional to criminal prosecution and disciplinary sanctions by the appropriate licensing board,\(^{23}\) as well as substantial civil liability. These rules also generally prohibit a practitioner from entering into a professional relationship with a patient with whom the practitioner has had a sexual relationship.

Under Georgia law, a psychotherapist who engages in sexual relations with a patient is deemed to have committed the felony of sexual assault, consent of the victim is not a defense. O.C.G.A. § 16-6-5.1(e).\(^ {24}\) The rationale for the Code section appears to be that a person under the care of a therapist is deemed to be in the “custody” of the therapist such that the patient cannot legally and knowingly consent to a sexual relationship with the therapist. Cf. Howard v. State, 272 Ga. 242, 243, 527 S.E.2d 194, 195 (2000) (“We observed that, to fulfill its role, the State can protect the public by enacting legislation which criminalizes various forms of sexual conduct, including sexual conduct which can be said to take place in private, between consenting adults: e.g., sexual contact with prisoners, the institutionalized, and the patients of psychotherapists (O.C.G.A. § 16-6-5.1); incest (O.C.G.A. § 16-6-22); and solicitation of sodomy (O.C.G.A. § 16-6-15).”). Apparently no Georgia appellate court has interpreted this Code section as it applies to mental health professionals, although there have been prosecutions of mental health professionals under the statute. See Demetrios v. State, 246 Ga. App. 506, 541 S.E.2d 83 (2000) (prosecution for rape, sexual assault and violation of § 16-6-5.1(c)). The Code may also allow for a private right of action. Cf. Am. Home Assurance Co. v. Smith, 218 Ga. App. 536, 538, 462 S.E.2d 441, 444 (1995) (“A civil remedy may also be available [under § 16-6-5.1], although Georgia’s criminal statute does not directly contemplate one”) (dictum).

A mental health professional who ignores § 16-6-5.1 and the many ethical and professional rules proscribing sexual relationships with a patient likely faces a cause of action for medical malpractice, fraud, assault, battery, and intentional infliction of emotional distress. See, e.g., Hickey v. Askren, 198 Ga. App. 718, 403 S.E.2d 225 (1991) (decided on statute of limitation grounds). Furthermore, most insurers now expressly exclude such claims from coverage or limit the amount of coverage. Even absent such an exclusion, an insurer may take the position that such claims are not covered or are excluded by a general fraudulent or intentional acts exclusion. See Am. Home Assurance Co., 218 Ga. App. at 536, 462 S.E.2d at 444 (upholding provision in malpractice liability insurance policy limiting coverage to $25,000 in lawsuits involving sexual misconduct by the insured).

\(^{23}\) Virtually all the licensing boards in Georgia governing mental health professionals now have disciplinary rules prohibiting sexual relations between the professional and a patient or client, as do the ethical codes of most national medical and mental health professional organizations.

\(^{24}\) An employee or volunteer at a mental health facility who engages in sexual contact with a patient is also guilty of sexual assault. O.C.G.A. § 16-6-5.1(d).
professionals and their current patients. In Georgia, such conduct can expose the professional to criminal prosecution and disciplinary sanctions by the appropriate licensing board, as well as substantial civil liability. These rules also generally prohibit a practitioner from entering into a professional relationship with a patient with whom the practitioner has had a sexual relationship.

Under Georgia law, a psychotherapist who engages in sexual relations with a patient is deemed to have committed the felony of sexual assault, consent of the victim is not a defense. O.C.G.A. § 16-6-5.1(e). The rationale for the Code section appears to be that a person under the care of a therapist is deemed to be in the “custody” of the therapist such that the patient cannot legally and knowingly consent to a sexual relationship with the therapist. Cf. Howard v. State, 272 Ga. 242, 243, 527 S.E.2d 194, 195 (2000) (“We observed that, to fulfill its role, the State can protect the public by enacting legislation which criminalizes various forms of sexual conduct, including sexual conduct which can be said to take place in private, between consenting adults: e.g., sexual contact with prisoners, the institutionalized, and the patients of psychotherapists (O.C.G.A. § 16-6-5.1); incest (O.C.G.A. § 16-6-22); and solicitation of sodomy (O.C.G.A. § 16-6-15).”). Apparently no Georgia appellate court has interpreted this Code section as it applies to mental health professionals, although there have been prosecutions of mental health professionals under the statute. See Demetrios v. State, 246 Ga. App. 506, 541 S.E.2d 83 (2000) (prosecution for rape, sexual assault and violation of § 16-6-5.1(c)).

A mental health professional who ignores § 16-6-5.1 and the many ethical and professional rules proscribing sexual relationships with a patient likely faces a cause of action for medical malpractice, fraud, assault, battery, and intentional infliction of emotional distress. See, e.g., Hickey v. Askren, 198 Ga. App. 718, 403 S.E.2d 225 (1991) (decided on statute of limitation grounds). Furthermore, most insurers now expressly exclude such claims from coverage or limit the amount of coverage. Even absent such an exclusion, an insurer may take the position that such claims are not covered or are excluded by a general fraudulent or intentional acts exclusion. See Am. Home Assurance Co., 218 Ga. App. at 536, 462 S.E.2d at 444 (upholding provision in malpractice liability insurance policy limiting coverage to $25,000 in lawsuits involving sexual misconduct by the insured).

F. Child Abuse Reporting

The Georgia Child Abuse Reporting Act requires that healthcare professionals, including psychologists, nurses, professional counselors, social workers and marriage and family therapists, report suspected child abuse. Such a report is required notwithstanding “that the reasonable cause to believe such abuse has occurred or is occurring is based in whole or in part upon any communication to that person which is otherwise made privileged or confidential by law.” O.C.G.A. § 19-7-5(g). No private right of action exists against healthcare professionals who fail to report. The Georgia
courts have also held that healthcare professionals enjoy good faith immunity for incorrect reports of child abuse.

1. **No Private Right Of Action For Failure To Report**

O.C.G.A. § 19-17-5(f) provides that anyone who in good faith makes a report of child abuse is immune from civil or criminal liability. In addition, the Georgia courts have held that there is no private cause of action against a healthcare professional who fails to report suspected child abuse in violation of O.C.G.A. § 19-7-5(g). See *Cechman v. Travis*, 202 Ga. App. 255, 414 S.E.2d 282 (1991) (O.C.G.A. § 19-7-5 does not create private right of action against a physician who failed to identify and/or report abuse); *Vance v. TRC*, 229 Ga. App. 608, 494 S.E.2d 714 (1997) (reaffirming *Cechman* and holding that O.C.G.A. § 19-7-5(g) does not create a private right of action even where a physician failed to report possible sex abuse of a minor); *Fulton-DeKalb Hosp. Auth. v. Reliance Trust Co.*, 270 Ga. App. 822, 608 S.E.2d 272 (2004) (O.C.G.A. § 19-7-5(g) does not create private right of action against a hospital for failing to identify and/or report evidence of suspected child abuse); see also, e.g., *Anthony v. Am. Gen. Fin. Servs.*, 287 Ga. 448, 456, 697 S.E.2d 166, 172 (2010) (citing favorably to *Cechman* and *Vance* for the proposition that “the public policy advanced by a penal statute, no matter how strong, cannot support the implication of a private civil cause of action that is not based on the actual provisions of the relevant statute” (emphasis in original)).

In 2006, the Georgia Court of Appeals reaffirmed that mental health providers have no duty to the victim to report suspected child abuse. *McGarrah v. Posig*, 280 Ga. App. 808, 635 S.E.2d 219 (2006). In *McGarrah*, a mother and guardian of a minor child brought an action against a licensed psychologist, who provided therapy and treatment to the plaintiff’s son, and the psychologist’s practice, alleging that the psychologist
courts have also held that healthcare professionals enjoy good faith immunity for incorrect reports of child abuse.

1. No Private Right Of Action For Failure To Report

O.C.G.A. § 19-17-5(f) provides that anyone who in good faith makes a report of child abuse is immune from civil or criminal liability. In addition, the Georgia courts have held that there is no private cause of action against a healthcare professional who fails to report suspected child abuse in violation of O.C.G.A. § 19-7-5(g). See Cechman v. Travis, 202 Ga. App. 255, 414 S.E.2d 282 (1991) (O.C.G.A. § 19-7-5 does not create private right of action against a physician who failed to identify and/or report abuse); Vance v. TRC, 229 Ga. App. 608, 494 S.E.2d 714 (1997) (reaffirming Cechman and holding that O.C.G.A. § 19-7-5(g) does not create a private right of action even where a physician failed to report possible sex abuse of a minor); Fulton-DeKalb Hosp. v. Reliance Trust Co., 270 Ga. App. 822, 608 S.E.2d 272 (2004) (O.C.G.A. § 19-7-5(g) does not create private right of action against a hospital for failing to identify and/or report evidence of suspected child abuse); see also, e.g., Anthony v. Am. Gen. Fin. Servs., 287 Ga. 448, 456, 697 S.E.2d 166, 172 (2010) (citing favorably to Cechman and Vance for the proposition that “the public policy advanced by a penal statute, no matter how strong, cannot support the implication of a private civil cause of action that is not based on the actual provisions of the relevant statute” (emphasis in original)).

In 2006, the Georgia Court of Appeals reaffirmed that mental health providers have no duty to the victim to report suspected child abuse. McGarrah v. Posig, 280 Ga. App. 808, 635 S.E.2d 219 (2006). In McGarrah, a mother and guardian of a minor child brought an action against a licensed psychologist, who provided therapy and treatment to the plaintiff's son, and the psychologist’s practice, alleging that the psychologist breached a professional standard of care by her failure to detect and report alleged sexual abuse. The mother attempted to distinguish Chechman, Vance, and Fulton-DeKalb Hospital on the grounds that in those decisions the plaintiffs’ common-law claims failed, not because no cause of action at common law existed, but because the injury to the plaintiff was not the proximate result of the breach of any legal duty owed by the defendants. Id. at 809-810, 635 S.E.2d at 221. The Court disagreed, reaffirming that the legal duty to report child abuse is imposed by Georgia statute, which does not give rise to a private cause of action for damages.25 Id. at 810, 635 S.E.2d at 222.

2. Good Faith Immunity For Reports

The Georgia Child Abuse Reporting Act provides broad immunity for anyone who reports suspected child abuse. Under the Act, any person who participates in the making of a report of suspected child abuse is immune from civil or criminal liability that would otherwise be incurred, “provided such participation . . . is made in good faith.” O.C.G.A. § 19-7-5(f). In 2003, the Supreme Court of Georgia clarified the immunity provision of the Act in O’Heron v. Blaney, 276 Ga. 871, 583 S.E.2d 834 (2003).

The Court in O’Heron held that the Act’s immunity provision allows immunity to attach in two ways, either by showing that “reasonable cause” exists, or by showing “good faith.” Id. at 873, 583 S.E.2d at 836. The Court explained that the Act requires a reporter who has reasonable cause to suspect child abuse to report to avoid facing criminal penalties. The trigger for the duty to report is a “reasonable cause to believe,”

25 The Court acknowledged that, at least in Fulton-DeKalb Hosp., lack of proximate causation was an additional ground for denying the plaintiff’s recovery for damages resulting from failure to report suspected child abuse. McGarrah, 280 Ga. App. at 810, 635 S.E.2d at 222.
which requires an objective analysis. Id. at 872, 583 S.E.2d at 836. The relevant question, therefore, is “whether the information available at the time would lead a reasonable person in the position of the reporter to suspect abuse.” Id. at 873, 583 S.E.2d at 836. If an objective analysis supports the reporter’s conclusion that child abuse has occurred, then immunity attaches and there is no need to further examine the reporter’s good faith. Id.

If, on the other hand, the information would not lead a reasonable person to suspect child abuse under an objective standard, then the reporter may still enjoy immunity if she made the report in good faith. The Court described the Act’s good faith statute as a subjective one. It described the relevant question as “whether the reporter honestly believed she had a duty to report.” Id. A reporter acting in good faith enjoys immunity under the Act even if she is negligent or exercises bad judgment. Id. at 873-74, 583 S.E.2d at 836-37.
which requires an objective analysis. Id. at 872, 583 S.E.2d at 836. The relevant question, therefore, is "whether the information available at the time would lead a reasonable person in the position of the reporter to suspect abuse." Id. at 873, 583 S.E.2d at 836. If an objective analysis supports the reporter's conclusion that child abuse has occurred, then immunity attaches and there is no need to further examine the reporter's good faith. Id.

If, on the other hand, the information would not lead a reasonable person to suspect child abuse under an objective standard, then the reporter may still enjoy immunity if she made the report in good faith. The Court described the Act's good faith statute as a subjective one. It described the relevant question as "whether the reporter honestly believed she had a duty to report." Id. A reporter acting in good faith enjoys immunity under the Act even if she is negligent or exercises bad judgment. Id. at 873-74, 583 S.E.2d at 836-37.
TOP THREE ISSUES FACING LONG TERM CARE PROVIDERS IN 2018

Brittany H. Cone
Hall Booth Smith, PC
Atlanta, GA

TABLE OF CONTENTS
I. Introduction to Long Term Care………………………………………………….....1
   A. What is Long Term Care?...............................................................................1
   B. What is the cost of Long Term Care?..............................................................1
   C. What laws govern Long Term Care Providers?...............................................1

II. Opioid Crisis and the Impact on Long Term Care Providers…………………….2
   A. What is the Opioid Crisis?..............................................................................2
   B. Impact on Long Term Care Providers………………………………...………..2
      1. Drug Diversion…………………………………………………...……..2
      2. Best Practices for Long Term Care Providers……………………….…3
   C. Applicable Laws and Regulations…………………………………………..….3

III. Reimbursement Backlog and the Uncertain Future……………………………….4
   A. Medicare Appeals and Medicaid Backlog………………………………….….4
   B. Skilled Nursing Facility Value Based Purchasing……………………………..4

IV. Electronic Surveillance (Granny Cams)………………………………………….…5
   A. Introduction and Technological Advances……………………………………..5
   B. Legal Considerations……………………………………………………………5
      1. Resident Privacy………………………………………………………...5
      2. Staff Privacy………………………………………………………….…6
   C. Practical Tips……………………………………………………………………6
TOP THREE ISSUES FACING LONG TERM CARE PROVIDERS IN 2018

Brittany H. Cone
Hall Booth Smith, PC
Atlanta, GA

TABLE OF CONTENTS

I. Introduction to Long Term Care ................................................................. 1
   A. What is Long Term Care? ..................................................................... 1
   B. What is the cost of Long Term Care? .................................................. 1
   C. What laws govern Long Term Care Providers? ...............................1

II. Opioid Crisis and the Impact on Long Term Care Providers .............. 2
   A. What is the Opioid Crisis? ................................................................. 2
   B. Impact on Long Term Care Providers ............................................ 2
      1. Drug Diversion ........................................................................ 2
      2. Best Practices for Long Term Care Providers ............................ 3
   C. Applicable Laws and Regulations .................................................. 3

III. Reimbursement Backlog and the Uncertain Future ............................ 4
   A. Medicare Appeals and Medicaid Backlog ....................................... 4
   B. Skilled Nursing Facility Value Based Purchasing ............................ 4

IV. Electronic Surveillance (Granny Cams) .................................................. 5
   A. Introduction and Technological Advances ....................................... 5
   B. Legal Considerations ..................................................................... 5
      1. Resident Privacy ........................................................................ 5
      2. Staff Privacy ............................................................................ 6
   C. Practical Tips .............................................................................. 6
THREE OF THE TOP ISSUES FACING LONG TERM CARE PROVIDERS IN 2018

BRITTANY H. CONE
HALL BOOTH SMITH, PC
ATLANTA, GA

I. Introduction to Long Term Care

A. What is Long Term Care?

When a medical condition, trauma, or illness limits an individual's ability to perform basic personal health maintenance tasks (activities of daily living or ADLs), the individual may be in need of long term care ("LTC"). Unlike other forms of health care, the goal of LTC is not to cure any particular health condition, but rather to allow an individual to attain and maintain an appropriate level of functioning. As of 2014, about 1.4 million people received LTC services in certified nursing facilities. See https://www.cdc.gov/nchs/fastats/nursing-home-care.htm (accessed on January 19, 2018). As the United States population continues to age (baby boomers), the number of people in need of LTC services will continue to rise.

B. What is the cost of Long Term Care?

Staying in a LTC facility can be rather expensive. In fact, in 2016, the average annual cost of a semi-private room in a Georgia nursing home was approximately $75,000. See https://www.genworth.com/about-us/industry-expertise/cost-of-care.html (accessed on January 19, 2018). The total cost of LTC spending exceeds $339 Billion, with Medicare and Medicaid accounting for over $242 Billion. See https://fas.org/sgp/crs/misc/R43483.pdf (accessed on January 19, 2018). Medicaid is the primary payment source for LTC, totaling approximately forty-three percent (43%) of all LTC spending. Id. Medicare, on the other hand, does not pay for usual LTC services, but rather provides reimbursement for short-term skilled nursing services.

C. What laws govern Long Term Care Providers?

The laws governing LTC providers come from several different sources. First, the Federal Omnibus Budget Reconciliation Act ("OBRA") Regulations, found at 42 C.F.R. § 483 et seq., provide the "Conditions of Participation" for skilled nursing facilities that receive federal and state funding. Second, each state has its own rules and regulations governing nursing facilities. Georgia's regulations are found at Ga. Comp. R. & Regs. § 111-8-50 et seq. and Ga. Comp. R. & Regs. § 111-8-56 et seq. Third, the Medicare and Medicaid manuals provide additional guidance for LTC providers.
II. **Opioid Crisis and Drug Diversion**

The Opioid Crisis has led to increased scrutiny on health care providers to not only increase monitoring of prescriptions and patient use, but also to enhance security of drug storage areas.

A. **What is the Opioid Crisis?**

Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, and morphine. While usually safe when taken for a short period of time and as prescribed by a doctor, these drugs are often misused due to the euphoria produced and the pain relief provided. Regular use, even as prescribed by a doctor, can lead to dependence. Abuse of prescription opioids in particular have made a significant contribution to the severity of the Opioid Crisis. See [https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse](https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse) (accessed January 19, 2018). One factor possibly contributing to the widespread abuse of prescription opioids is the drastic increase in the number of prescriptions written across the last few decades. Id. When misused, opioid pain relievers can lead to overdose incidents and deaths. In fact, approximately 116 people die per day from opioid-related drug overdoses (over 42,000 per year). See [https://www.hhs.gov/opioids/](https://www.hhs.gov/opioids/) (accessed January 19, 2018). This problem ultimately resulted in a determination on October 26, 2017, that a Public Health Emergency exists. See [https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf](https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf) (accessed January 19, 2018). As investigations continue into the root causes of this crisis, LTC providers can expect changes to existing requirements and the implementation of new rules and regulations.

B. **Impact on Long Term Care Providers**

One such concern facing health care providers, as a whole, is the risk of drug diversion, which is particularly high in the LTC setting.

1. **Drug Diversion**

Drug diversion is the distribution or abuse of prescription drugs from legal and medically necessary uses towards uses that are illegal and typically not medically authorized or necessary. See [https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/provider-education-toolkits/downloads/prescriber-role-drugdiversion.pdf](https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/provider-education-toolkits/downloads/prescriber-role-drugdiversion.pdf) (accessed January 19, 2018). Diversion can occur at any time drugs are distributed, from the manufacturer to chain store distribution centers and general wholesale distributors, to pharmacies and clinical settings, and ultimately to the patient. Id. Risk of diversion is universal across the spectrum of health care providers and there is generally no true profile of who, when, where, or even how diversion takes places. This risk includes members of the medical profession and other nursing facility staff members.
In the LTC setting, drug diversion creates a variety of risks, including the possibility of patients not receiving appropriate pain relief or other medications, the falsification of medical records, and the misappropriation of the resident's property. Such risks open the door to civil and regulatory liability, licensure and reimbursement (Medicare and Medicaid) issues, and damage to reputation and brand.

2. **Best Practices for Long Term Care Providers**

Dealing with an opioid issue and/or possible drug diversion begins before allegations or concerns ever arise. A Compliance and Ethics Program may help prevent and detect any possible criminal, civil, and administrative violations. In addition, policies and procedures regarding proper documentation of prescription medication and storage/controlled access is essential to early detection. It is also crucial to have an established investigation protocol.

Once concerns related to opioid abuse or diversion arise, the investigation protocol should begin immediately due to the applicable reporting deadlines. First, it must be determined whether an initial report needs to be filed with the Georgia Department of Community Health. If the issue constitutes abuse or serious bodily injury, a report must be made immediately, but no later than two hours. See 42 C.F.R. § 483.12. If there is no abuse or serious bodily injury, a report must be made within 24 hours. Id. This investigation should focus on the 5 Ws (who, what, when, where, and why) and include staff and resident interviews, review of drug records and patient charts, and the preparation of written statements. Following the facility investigation, a report must generally be filed within 5 working days. Id. Depending on the conclusions of the investigation, there may be additional entities that require reports, such as the Drug Enforcement Administration and the Department of Community Health. Discussions should be had with counsel as soon as possible to determine whether these investigations should proceed under Attorney/Client privilege.

C. **Applicable Laws & Regulations**

Laws and regulations applicable to the Opioid Crisis and drug diversion in the LTC setting are as follows:

- Controlled Substances Act, 21 U.S.C. § 801 et seq;
- Title 21 C.F.R. Chapter II – Drug Enforcement Administration;
- False Claims Act, 31 U.S.C. § 3729 et seq;
- Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq;
- Georgia Controlled Substance Act, O.C.G.A. § 16-13-20 et seq;
- Georgia False Medicaid Claims Act, O.C.G.A. § 49-4-168 et seq;
- Long-term Care Facility Resident Abuse Reporting Act, O.C.G.A. § 31-8-80 et seq;
- Conditions of Participation: Patient's Rights, 42 C.F.R. § 483 et seq.
- The Joint Commission, High Alert, Storage, Control, Dispense, and manage Return of Medications;
- Bill of Rights for Resident of Long Term Care Facilities, O.C.G.A. § 31-8-100 et seq;
III.  Reimbursement Backlog and the Uncertain Future

A.  Medicare Appeals and Medicaid Backlog

Currently, LTC providers in Georgia are enduring severe wait times related to its two primary payment sources, Medicare and Medicaid. Both Levels 3 and 4 of the Medicare appeals process are also suffering from a severe backlog. As of the end of FY 2015, the pending workload before the Office of Medicare Hearings and Appeals (“OMHA”) (Level 3) exceeded 880,000 appeals, while the annual adjudication capacity was approximately 75,000 appeals. See https://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf (accessed January 19, 2018). The pending workload before the Medicare Appeals Council (Level 4) exceeded 14,000 appeals as of the end of FY 2015, yet claims were only being adjudicated at a rate of 2,300 per year. Id. In order to address these severe processing delays, the U.S. Department of Health and Human Services (“HHS”) issued a final rule to improve the Medicare appeals process. See https://www.hhs.gov/sites/default/files/medicare-appeals-final-rule-factsheet-jan2017.pdf (accessed January 19, 2018). However, in the early stages of this final rule, HHS expressed its inability to effectively reduce the backlog by the established deadline. See http://www.modernhealthcare.com/article/20170308/NEWS/170309902 (accessed January 19, 2018). Because the appeals of beneficiaries are prioritized, providers are forced to endure longer than average wait times for their own appeals. See https://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf (accessed January 19, 2018).

Georgia LTC providers are also enduring significant delays in receiving Medicaid payments from the state for services rendered to eligible patients. Due to a recent overhaul of the Georgia Medicaid system vis-à-vis the transfer to the GATEWAY system, providers are seeing processing time outside of the 45-day timeframe required by the Georgia Medicaid rules. In addition, LTC providers across the state have reported difficulties reaching Medicaid caseworkers to confirm receipt of applications or determine the status of already pending applications. Once an application is approved, there have also been system errors preventing providers from being properly paid for the care and services provided. These delays have placed some LTC providers in temporary financial straits and at odds with how to handle the accruing balances owed by Medicaid-pending patients.

B.  Skilled Nursing Facility Value Based Purchasing

In general, healthcare reimbursement is slowly moving from the fee-for-service model to a “value-based” model. Under the fee-for-service model, health care providers generally bill for each individual procedure. Under the “value-based” model, health care providers bill for episodes of care. The difference between these two payments structures makes it essential for providers to coordinate with one another in order to avoid unnecessary medical utilization. Beginning October 1, 2018, Medicare claims for skilled nursing services will be subject to a two percent (2%) withhold as a part of the new value based purchasing program. See https://www.gpo.gov/fdsys/pkg/FR-2015-08-04/pdf/2015-18950.pdf (accessed January 19, 2018). LTC providers will have the opportunity to recoup the withheld funds depending on how well the providers do in managing hospital readmissions compared to average performance
standards. Id. The two percent (2%) withheld of all Medicare payments will be placed in a separate incentive pool. Id. Fifty (50) to seventy (70) percent of this incentive pool will be redistributed based on the 30-day "All-Cause Readmission Measure" and related performance measures. Id. LTC providers will be ranked annually with the highest ranked receiving the highest incentive payment and vice-versa. Id. The remaining thirty (30) to fifty (50) percent will be retained by the Centers for Medicare & Medicaid Services ("CMS"). Id. The 30-day All-Cause Readmission Measure estimates a risk-standardized rate of all cause, unplanned hospital readmissions of Medicare SNF beneficiaries within 30 days of discharge from a prior acute hospitalization. This calculation is risk adjusted based on a variety of factors and has multiple exclusions. Id. The financial impact of this program on LTC providers varies widely depending on two primary factors: (1) the average number of Medicare patients the provider has and (2) the average rate of Medicare reimbursement of the provider.

IV. Electronic Surveillance (Granny Cams)

A. Introduction and Technological Advances

“Granny Cams” are video cameras that have been placed in patient ("resident") rooms within LTC facilities, usually by the resident or the resident’s family. Due to lowered costs, increased access, and technological advances, this form of video surveillance has dramatically increased in nursing homes across the country. Use of these granny cams, the presence of smartphones, and the rise of social media have significantly increased LTC providers' liability risks due to care concerns, resident privacy, HIPAA, and staff privacy. State attorney generals across the country have started using such cameras to investigate allegations of abuse, neglect, mistreatment, falsified medical records, and the failure to administer medications. At least one state attorney general has even provided these granny cams to family members who suspected nursing home abuse. See http://nj.gov/oag/newsreleases17/pr20170509a.html (accessed January 20, 2018). As granny cams and related technology have become more popular, state laws have slowly developed to address the many issues presented by them.

B. Legal Considerations

1. Resident Privacy

General privacy law with regard to electronic surveillance revolves around the Fourth Amendment and the reasonable expectation of privacy, as well as the protections granted by the Health Insurance Portability and Accountability Act ("HIPAA"). While both Federal and Georgia law provide for the privacy of nursing home residents, expectations of privacy in LTC facilities can be more complicated due, in part, to shared living spaces. 42 C.F.R. 483.10(h); Ga. Comp. R. & Regs § 111-8-50-.05. Common areas, such as hallways and dining areas, are generally not considered private, while a resident’s room is. Tracey Kohl, Watching Out for Grandma: Video Cameras in Nursing Homes May Help to Eliminate Abuse, 30 Fordham Urban Law Journal 2083, 2093 (2002). The existence of a roommate also further complicates the expectation of privacy. By agreeing to have a roommate, one impliedly consents to a lower level of privacy, but this is not sufficient to allow electronic monitoring without the roommate’s consent. Id. at 2097.

LTC facilities are considered covered entities under HIPAA. As such, facilities must keep Protected Health Information (“PHI”) confidential. Images and recordings of LTC residents are considered PHI. See 45 C.F.R. § 483.164. Therefore, permitting a resident to be recorded without his/her permission could be a HIPAA violation. One additional concern related to video surveillance in LTC facilities is abuse. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident, regardless of consent or cognitive status, it may be considered abuse. See https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-33.pdf (accessed January 20, 2018). If deemed to be abuse, the facility is under an obligation to report. Id.

2. Staff Privacy

As LTC facilities nationwide deal with staffing issues, the rise of electronic surveillance has only exasperated staffing concerns. Federal regulations generally provide very little protection for video surveillance of employees. As a result, arguments for staff privacy typically turn to the Fourth Amendment and the existence of a reasonable expectation of privacy. With that said, it is highly unlikely that a staff member’s expectation of privacy within a resident’s room is deemed reasonable. A notice placed conspicuously on a monitored resident’s room generally serves to place any staff members on notice of the surveillance, which effectively eliminates any expectation of privacy the staff member may hold.

C. Practical Tips

Going forward, LTC providers should take several practical considerations into account. First, it is essential to train staff to provide care as if they are under surveillance because they very well may be. Second, documentation of medication administration and services provided is also critically important. As the adage goes, “do what you document and document what you do.” LTC providers should also consider implementing a policy against staff members capturing and sharing video surveillance within the facility. Last, fostering the relationship between the facility and the resident/resident’s family should increase the odds that the use of granny cams are disclosed such that proper measures can be implemented. It is also important to look forward and consider the impact of ongoing technological advances on resident privacy and develop plans to address the resulting issues. One such example is the use of smart speakers, such as
Google Home and the Amazon Echo, in resident rooms. Regardless, LTC providers can expect the development and implementation of new laws addressing electronic surveillance within resident rooms and elsewhere in the facility.

V. Conclusion

LTC providers face numerous obstacles on a day-to-day basis in their delivery of care to residents. Attorneys representing LTC providers must understand the obligations placed on these providers from both a civil and regulatory standpoint.
Appendix
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Term Expires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carol V. Clark</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Harold T. Daniel, Jr.</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Laverne Lewis Gaskins</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Allegra J. Lawrence</td>
<td>Member</td>
<td>2020</td>
</tr>
<tr>
<td>C. James McCallar, Jr.</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Jennifer Campbell Mock</td>
<td>Member</td>
<td>2020</td>
</tr>
<tr>
<td>Patrick T. O'Connor</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Kenneth L. Shigley</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>A. James Elliott</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Buddy M. Mears</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Dean Daisy Hurst Floyd</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Carol Ellis Morgan</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Hon. Harold David Melton</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Jeffrey Reese Davis</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Tangela Sarita King</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Cassady Vaughn Brewer</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Emory University Liaison</td>
<td>Liaison</td>
<td></td>
</tr>
<tr>
<td>John Marshall</td>
<td>Liaison</td>
<td></td>
</tr>
<tr>
<td>Mercer University Liaison</td>
<td>Liaison</td>
<td></td>
</tr>
<tr>
<td>University of Georgia Liaison</td>
<td>Liaison</td>
<td></td>
</tr>
<tr>
<td>Staff Liaison</td>
<td>Staff Liaison</td>
<td>2018</td>
</tr>
<tr>
<td>Staff Liaison</td>
<td>Staff Liaison</td>
<td>2018</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Term Expires</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Cassady Vaughn Brewer</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Carol V. Clark</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Harold T. Daniel, Jr.</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>Laverne Lewis Gaskins</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Allegra J. Lawrence</td>
<td>Member</td>
<td>2019</td>
</tr>
<tr>
<td>C. James McCallar, Jr.</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Jennifer Campbell Mock</td>
<td>Member</td>
<td>2020</td>
</tr>
<tr>
<td>Patrick T. O’Connor</td>
<td>Member</td>
<td>2018</td>
</tr>
<tr>
<td>Kenneth L. Shigley</td>
<td>Member</td>
<td>2020</td>
</tr>
<tr>
<td>A. James Elliott</td>
<td>Emory University</td>
<td>2019</td>
</tr>
<tr>
<td>Buddy M. Mears</td>
<td>John Marshall</td>
<td>2019</td>
</tr>
<tr>
<td>Dean Daisy Hurst Floyd</td>
<td>Mercer University</td>
<td>2019</td>
</tr>
<tr>
<td>Carol Ellis Morgan</td>
<td>University of Georgia</td>
<td>2019</td>
</tr>
<tr>
<td>Hon. Harold David Melton</td>
<td>Liaison</td>
<td>2018</td>
</tr>
<tr>
<td>Jeffrey Reese Davis</td>
<td>Staff Liaison</td>
<td>2018</td>
</tr>
<tr>
<td>Tangela Sarita King</td>
<td>Staff Liaison</td>
<td>2018</td>
</tr>
</tbody>
</table>
GEORGIA MANDATORY CLE FACT SHEET

Every “active” attorney in Georgia must attend 12 “approved” CLE hours of instruction annually, with one of the CLE hours being in the area of legal ethics and one of the CLE hours being in the area of professionalism. Furthermore, any attorney who appears as sole or lead counsel in the Superior or State Courts of Georgia in any contested civil case or in the trial of a criminal case in 1990 or in any subsequent calendar year, must complete for such year a minimum of three hours of continuing legal education activity in the area of trial practice. These trial practice hours are included in, and not in addition to, the 12 hour requirement. ICLE is an “accredited” provider of “approved” CLE instruction.

Excess creditable CLE hours (i.e., over 12) earned in one CY may be carried over into the next succeeding CY. Excess ethics and professionalism credits may be carried over for two years. Excess trial practice hours may be carried over for one year.

A portion of your ICLE name tag is your ATTENDANCE CONFIRMATION which indicates the program name, date, amount paid, CLE hours (including ethics, professionalism and trial practice, if any) and should be retained for your personal CLE and tax records. DO NOT SEND THIS CARD TO THE COMMISSION!

ICLE will electronically transmit computerized CLE attendance records directly into the Official State Bar Membership computer records for recording on the attendee’s Bar record. Attendees at ICLE programs need do nothing more as their attendance will be recorded in their Bar record.

Should you need CLE credit in a state other than Georgia, please inquire as to the procedure at the registration desk. ICLE does not guarantee credit in any state other than Georgia.

If you have any questions concerning attendance credit at ICLE seminars, please call: 678-529-6688