Some Medico-Legal Aspects of COVID-19

During this pandemic, rules and regulations are ever-changing.

BY LAWRENCE F. KOBAK, DPM, JD

As I sit here writing this, some of my friends and neighbors have been infected and even died since the COVID-19 outbreak. They had no proper funeral. Our family had a "virtual" religious celebration. Social distancing has become the norm where once there was a kiss and hug. Except via Facetime, and similar video conferencing, we cannot enjoy our grandchildren. It is important never to forget the human aspects of this scourge. This is truly a plague, as much as the other ten that are talked about in the Passover Haggadah.

An important place to start this column is to look at the players and our form of government. Every day, we see the President, Vice-President and representatives from the CDC and NIH holding press conference after press conference.

1) Federal vs. State

Without getting into a long lesson about the 10th Amendment to the U.S. Constitution, let's just say that whatever the federal government cannot do is reserved for the states. Both entities share in healthcare rules and policy. COVID-19 did not change this dynamic. On television, we see this dynamic playing out between the President and various governors. It usually consists of governors asking/begging for supplies and manpower from the federal government. Other times, the governors are ordering the federal government to stay out of its business and prerogatives. Usually, it is a question of financial resources and political power.

HIPAA, OSHA, CLIA are federal laws and programs; the same is true with Medicare. The Anti-Kickback Laws are federal. However, most states have their versions of the Anti-Kickback Laws. Medicaid has federal and state components. Most states have their own version of HIPAA. If it is stricter than the federal version, that is the version that applies for the residents of that state. The point is that neither the state nor federal government exists in a vacuum. They-co-exist, often with different rules. It gets confusing.

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2) CDC

The Center for Disease Control was founded after World War II. It grew out of an organization that helped fight malaria in war areas. It is part of the U.S. Public Health Services. It focuses on aspects of communicable diseases of all kinds as well as drug abuse, birth defects, obesity, and bioterrorism. Part of it consists of a Center for State, Tribal, Local and Territory Support. In other words, the CDC does also work with the states.

The CDC does not promulgate laws and they are not a police force. Their guidelines and publications are often persuasive and guide both federal and state law-makers and agency regulations. An example of this is the rather controversial CDC Guidelines for Chronic Pain. Although often misunderstood and misapplied, various state professional licensing agencies have adopted its conclusions and recommendations. They are enforced as the standard of care, often as if it were the law. Likewise, negligence attorneys from many states quote from it as if it were the Bible.

3) NIH

The National Institute of Health is the pre-eminent federal agency involving research for public health. It is a part of the United States Department of Health and Human Services. It consists of 27 different institutes made up of different medical disciplines.

The collective research accomplishments of the NIH include the first human trial of gene therapy, a treatment for mercury poisoning, as well as the discovery that rats helped spread the bubonic plague. The list of their discoveries is almost endless.

Like the CDC, the NIH does not pass any laws or regulations. They

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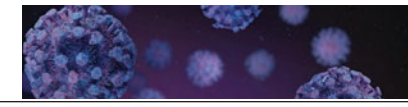

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do not act as a police force. However, the results of their research have helped change the accepted standard of care in virtually all medical disciplines, including podiatry. Their research protocols are often adopted by the various medical specialties. Certainly, the NIH research prestige, by definition, can be quite persuasive to the medical community. The results of their research have revolutionized the practice of medicine in both this country and the world. Look for the NIH to spearhead various research projects into the prevention, treatment, and cure for COVID-19. Both the Center for Disease Control and the National Institute of Medicine have great influence with the President, governors, and the Congress and state legislatures.

Podiatry and COVID-19

First, the podiatrist must be careful to neither contract nor impart the COVID-19 virus through interaction with patients. The CDC is "asking for" a delay in all ambulatory provider visits. They want you to reschedule any non-urgent hospital admissions. They want elective surgical procedures delayed. Routine podiatric visits should be postponed. Notice, the CDC has not stated that these "suggestions" are the law. However, flouting of this advice could be considered punishable by various state licensure boards. The reason for these "suggestions" is that they do not want hospital facilities potentially used during this pandemic for complications from bunion and hammertoe surgeries that can wait until this pandemic has subsided. The CDC is asking no more from us than they are asking of MDs, dentists, and other healthcare providers. It must also be stated that various states may adopt these regulations and enforce them as if they are law.

If you are treating patients who cannot wait, such as post-operative patients, wound care patients, and the like, treat each of them as if they are COVID-19 positive. Take universal precautions. Do not allow patients or relatives to congregate in the waiting room. In fact, caution would dictate that nobody accompanies the patient into the waiting room or treatment room if physically possible. Make sure your medical assistants and personnel keep their distance from each patient whenever possible. If not possible, any personnel should be gloved and appropriately masked.

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Not performing these precautions might be considered not only negligent, but "reckless". While some states, such as New York, are passing laws that shield healthcare providers from negligence in the malpractice arena, they will not shield the provider from reckless treatment. They will not shield the employer from the consequences of providing unsafe working conditions.

As of the beginning of April, a podiatrist may provide and bill for telephone services and online digital evaluation and management services by authority of just passed and signed federal legislation. This is also known as telemedicine. This ability applies only to Medicare Part B and Medicare Advantage plans. Individual insurance policies have their own rules. Call your local insurance representatives for each individual plan's regulations in this area. Under the Medicare version of telehealth, the services still must be medically necessary to be reimbursed. A reimbursable telecommunication cannot solely consist of a phone call bearing greeting. The HIPAA privacy law will not be enforced with these telemedicine interactions if the communications are provided "in good faith". Recording any of these interactions and publishing them later on social media would certainly constitute a lack of good faith. A complete and accurate chart must be kept on all such interactions.

Please note that while many health insurance plans are waiving co-payments and deductibles for COVID-19 tests and treatment, it does not mean that you can waive these components for your *unrelated* treatment of the foot and ankle. It would still be a violation of both federal and state law and be considered fraudulent billing!

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Additionally, note that if you volunteer to help with medical care at a local facility, some states may allow you to perform treatment that would normally be out of scope. Please call your malpractice carrier to see if your current coverage is adequate, the facility is providing coverage (obtain it in writing), or the state has waived your liability. If you are volunteering in a state where you are not licensed, make sure the state has some sort of waiver to your lack of licensure. The answer to these important questions may vary from state to state, plan to plan, and from facility to facility.

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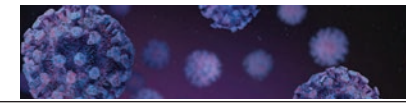

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Please record any patient cancellation of an office visit. It is your protection against any claim of patient abandonment. The current pandemic cannot be used as an excuse to lower the standard of patient charting. You can continue to make house calls if the patient needs a house call. Of course, universal precautions still apply. Charting requirements have not changed. Always keep identification on you. You may be required to demonstrate that you are an essential worker. That too will vary by the state.

Finally, use this time as a gut check. Why did you become a podiatric physician? You must balance your duty as a healer and your responsibility to leave your family safe. There are no easy answers. On a personal note, consider using this time to be kinder to all. That includes your colleagues, staff, and patients. Your kindness will not only reflect well upon yourself but will reflect well on your profession. We will come out on the other side of this stronger and better prepared. I also hope we become even more humane. Be safe out there.

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A word of caution; the COVID-19 pandemic is a rapidly changing situation, and the federal/state rules and regulations as well as recommendations may change, almost from day to day. Keep current with federal and state laws, rules, and regulations. **PM**

Dr. Kobak is Senior Counsel in Frier Levitt's Healthcare Department in the Uniondale, New York. Larry has extensive experience representing physicians in connection with licensure issues, as well as successfully defending physicians before Medical Boards, OPMC, OPD investigations, as well as Medicare Fraud, Fraud & Abuse, Hospital Actions, RAC Audits, Medicare Audits, OIG Fraud, Health Care Fraud, Medical Audits, and Health Plan Billing Audits. As a licensed podiatrist prior to becoming an attorney, he served as the international president of the Academy of Ambulatory Foot and Ankle Surgery.