This presenter has no conflicts of interest, commercial support, or off-label use to disclose

1. Discuss a nurse practitioner’s legal responsibilities when prescribing
2. Explain how to evaluate an employer request, in light of your state’s scope of practice laws
1. DEA and state requirements for prescribing
2. HIPAA regulations protecting patient privacy
3. What malpractice is and how to avoid it
4. What can be billed, when, by whom
5. NP scope of practice under state law

**DEA registration**

- Rx only the drugs state law authorizes a NP to prescribe
  - IN: 2, 2N, 3, 3N, 4, 5 Prescribe, administer & dispense, procure
- Rx only for a "legitimate medical purpose"
- Attend to signs of abuse

- 7-day supply only, if prescribing opioids for the patient for the first time
- 7-day supply only, for patients under 18
- Above not applicable if
  - Treating cancer
  - Providing palliative care
  - Medication-assisted treatment of substance abuse disorder
  - Some other exemption adopted by medical board
    - Indiana Code 25-1-9.7
An APN who is granted authority by the board to prescribe legend drugs must do the following:

(1) Enter on each prescription form that the APN uses to prescribe a legend drug:
   (A) the signature of the APN;
   (B) initials indicating the credentials awarded to the APN under this chapter; and
   (C) the identification number assigned to the APN under subsection (a).

(2) Comply with all applicable state and federal laws concerning prescriptions for legend drugs.

An advanced practice nurse may be granted authority to prescribe legend drugs under this chapter only within the scope of practice of the advanced practice nurse and the scope of the licensed collaborating health practitioner. IC 25-23-1-19.6(b) and (c)

• Indiana NP accused of phoning in controlled substance prescriptions the name, license number and DEA registration of her collaborating physician without his consent
• NP accused under criminal law of prescribing and dispensing weight loss drugs when there were lapses in her DEA registration
Know the state and federal requirements on prescribing

- Rules change. Review the rules at least twice a year
  - Indiana Board of Nursing at https://www.in.gov/pla/nursing.htm
  - Indiana Medical Board at http://www2.ismanet.org/ISMA/Legal/Prescribing_Controlled_Substances/ISMA/Legal/Prescribing_Controlled_Substances.aspx?hkey=c8861682-84c1-4e6a-865c-d800421a0e30

- HIPAA regulations protecting patient privacy

Issues

- What can I share and with whom?
- What can’t I share?
- What records are patients entitled to?
- What policies need to be in place?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides federal protections for personal health information and gives patients an array of rights with respect to that information

- If federal and state laws conflict, the controlling law is the one that most protects the patient’s privacy
HIPAA basics
• Communicate protected patient information (PHI)
• PHI is individually identifiable health information
• Disclose only the minimum amount of necessary information
• Disclose only to individuals who need to know the information for treatment, payment or operations
• Give patients their records when they request

• "A nurse practitioner who has privileges at a multi-hospital health care system and who is part of the system’s organized health care arrangement impermissibly...

...[T]he [hospital] terminated the nurse practitioner’s access to its electronic records system; reported the nurse practitioner’s conduct to the appropriate licensing authority; and, provided the nurse practitioner with remedial Privacy Rule training."

http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/allcases.html

• "I work in an ICU. I cared for a patient who is a nurse who works at another facility. She OD’d. She was transferred, when stable, to a treatment center. I was told we cannot report her to the board due to HIPAA. I understand that when RNs renew licenses they must answer a question about treatment for use of alcohol or any other drug. But if there is no report of her being in the hospital for treatment, due to HIPAA, it’s possible that she may not answer the question truthfully. Can I report her?”

No.
Another typical HIPAA dilemma

• "I gave a patient a prescription for pain medication and instructed him that once medicated he cannot drive, but he admits he has been driving. Can I call someone and divulge the situation?"

  – HIPAA exception: May disclose if
    – the disclosure is needed to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and
    – the recipient is able to lessen the threat.

Administrative safeguards
• perform annual risk analysis
• training; policies, procedures, monitoring
• business associate agreement guideline

Physical safeguards
• access control — locked doors, cabinets
• non-public positioning of computer screens
• protection of laptops, USB drives, computers, servers, computer data backups

Technical safeguards
• unique user ID/passwords (no generic log-in to EHR)
• automatic computer log off
• identity proofing to authenticate patients
• secure online transmission of electronic PHI (encryptions or equivalent protection)
Federal
• Scalable penalties from $100 - $50,000 per violation, depending on the level of knowledge and intent associated with a violation

• Health Records (IC 16-39-1-9)
• Duty to Warn (IC 34-30-16)
• HIV/AIDS (IC 16-41-7-1)
• Juveniles (IC 12-23-12-1)
• Child Abuse Reporting (IC 31-33-5)

• Information necessary for
  • treatment
  • payment
  • health care operations
  [But not psychotherapy notes]

• A health care provider may disclose information from mental health records, if necessary
  to law enforcement,
  family members of the patient, or
  any other persons who may reasonably be able to
  prevent or lessen the risk of harm  45 CFR § 164.512(j)
Some states require disclosure of patient information to prevent or lessen the risk of harm. 

**Indiana**

- Disclosure not required unless patient has communicated an actual threat
  - Mental health clinicians have civil immunity if they fail to warn a victim, unless the patient has communicated an actual threat
  - IC 34-30-16-1

- Warn a victim if a patient communicates an actual threat

- Make reasonable attempts to communicate the threat to the victim or victims
- Make reasonable efforts to notify a law enforcement agency having jurisdiction in the patient’s or victim’s place of residence
- Seek civil commitment of the patient under IC 12-26
- Take steps reasonably available to the provider to prevent the patient from using physical violence or other means of harm to others until the appropriate law enforcement agency can be summoned and takes custody of the patient

- Report the threat of physical violence or other means of harm, within a reasonable period of time after receiving knowledge of the threat, to a physician or psychologist who is designated by the employer of a mental health service provider as an individual who has the responsibility to warn under this chapter
  - IC 34-30-16-1
• At this point, don’t text patient information
  • Smart phones usually aren’t encrypted
  • SMS usually is not encrypted
  • No password usually is required to access SIM card
  • Joint Commission suggests using mobile applications that incorporate message encryption

• Do I discuss patients only in the work environment (not during breaks or in the elevator)?
• Are discussions in the work environment private?
• Do I safeguard patient records from the eyes of others?
• How securely do I transmit patient information electronically?
• Do my laptop and phone have protected info?
• Do I or my facility give patients their records on request?

1. Duty of care
2. Breach of the standard of care
   What a reasonably prudent clinician of similar education would have done in similar situation
3. Injury
4. Injury was caused by the breach of standard of care
Top 7 conditions that lead to malpractice claims (all providers, all areas of practice)

- Breast cancer
- Pregnancy
- Acute MI
- Displacement of intervertebral disc
- Cancer of bronchus or lung
- Appendicitis
- Colon and rectal cancer

Red flag chief complaints

- Abdominal pain
- Chest pain
- Back pain with neurologic symptoms
- Breast mass
- Hemoptysis

How NPs get into trouble

- Missed diagnosis
- Lapsed follow-up (leading to missed diagnosis)
- Failure to identify and act on change in condition
- Medication errors
• Abnormal lab test results don’t get to NP
• NP fails to fully inform patient of what to do if things get worse after leaving the clinic/facility
• NP fails to refer or otherwise elevate level of care
• People on the team fail to fully communicate

Case: Missed breast cancer

• 60-year-old woman visited her MD’s office
• Was seen by a covering MD
• C/o mass right breast
• MD referred her for mammogram and breast ultrasound

• Mammogram, performed the next day, showed fibroglandular densities, no specific evidence of malignancy
• Prior films were obtained
• Ultrasound showed no mass
• MD recommended clinical follow-up of the palpable mass
• MD testified that she informed the patient of the test results and told her it was important to get yearly mammograms
• Patient did not return for 4 years
• When patient returned, was seen by NP (February)
• NP noted right nipple inverted, palpable density at 2 o'clock
• NP noted the mass had been worked up 4 years earlier
• Patient reported that the mass had enlarged
• NP described the mass as slightly tender and diffuse, with no palpable margins

• NP recommended diagnostic mammogram with follow up in 4 weeks
• Mammogram done same day, suggested malignancy
• Ultrasound the next day did not demonstrate any abnormality, but radiologist advised clinical correlation
• NP saw the patient again in 4 weeks (March)

• Records state the dx mammogram and US showed no change from previously
• NP did not record a physical examination
• No note that the NP discussed the abnormal mammogram report or presence of a persistent breast mass and nipple inversion with a physician
• No note that the NP referred the patient to a surgeon
In October, patient developed a severe, persistent headache.
- Another physician diagnosed sinus infection.
- Antibiotics did not relieve the symptoms and the patient developed a drooping left eye.

In January, a physician noted cervical lymphadenopathy on the right and the drooping left eye. Ordered brain MRI, which revealed several areas of abnormality.

Breast MRI noted significant axillary adenopathy and multiple breast abnormalities.
- B/L breast and axillary node biopsies were ordered.
- Cancer was found in both breasts and axillae.

Diagnosis: Stage IV metastatic breast cancer.
- Underwent palliative brain radiation.
- Patient sued the MDs and NP for failure to diagnose breast cancer.
- Defendants argued patient care was proper.
  - Argued the metastases occurred during the 4-year lapse between visits.
  - Argued the time delay in the second round of evaluations made no difference in the outcome.
Parties settled for $500,000

• Neither the original examining physician nor the NP followed the standard of care for evaluation of breast mass.

• Algorithms for evaluation of breast mass
  • https://qap.sdsu.edu/screening/breastcancer/bda/index.html
  • http://www.rmf.harvard.edu/files/documents/crcormf_bca.pdf

• Know the standard of care for the evaluations and treatments you offer

• A mass always deserves close follow up, until it is gone

• Patient non-compliance with instructions doesn’t release the clinician from liability
Case: Missed diagnosis

- Infant saw NP for well child visits, birth to 9 months
- Mother pointed out that one pupil was larger
- Mother told NP child's eyes did not move in tandem
- NP: "These things aren't important"

Missed diagnosis

- NP tested for red reflex at about 9 months; no light reflected; NP referred patient to ophthalmologist
- Diagnosis: Retinoblastoma
- One eye removed 3 months later; the other eye removed 3 years later
- Parties settled for $2 million

Standard of care

- Know the schedule and what is to be performed at well child visits
- Perform red reflex exam at every well child visit until a child can read
- Exam is normal when reflections of 2 eyes viewed both individually and simultaneously are equivalent in color, intensity, and clarity and there are no opacities or white spots within the area of either or both red reflexes
What we learn from this case

• Know the appropriate screening for your population
• Perform the screening on schedule

Risk avoidance strategies

• Know the risky areas – chest pain, abdominal pain, neurologic symptoms, breast mass, eye signs in infant/child
• Follow guidelines/standards/protocols for the complaint
• Follow through until the problem is ruled out or ruled in and treated

What can be billed, when, by whom?

• What
  • Physician services -- Procedures/services with a CPT or HCPCS code
• When
  • When the service is within the NP’s scope of practice under state law
  • When the service is medically necessary
• By whom
  • See next slide
• Credentialed providers
• Medicare rules
  • Bill under the name of rendering provider, unless
  • Follow "incident to rules" or "shared visit rules"
• Medicaid rules
  • Bill under rendering provider
• Commercial payer rules
  • Ask each payer who they want NPs’ services billed under
    and then follow their rules

• Incident-to billing
  – Allows NP work to be billed under MD name
  – Only in office setting
  – Get 100% of MD fee schedule
  – MD must be in the suite
  – MD must perform initial service
  – MD must remain involved in care of pt

• Shared billing
  – Allows NP and MD work to be combined into one
    CPT code, billed under MD name
  – In hospital
    – Includes ER and OPD
  – MD must have had face-to-face visit with the
    patient that day
  – Applies only to E&M

"Local physician, clinic and nurse practitioner
indicted on health care fraud charges"

"FOR IMMEDIATE RELEASE, July 18, 2013
St. Louis, MO – Dr. M__l__ and nurse practitioner R__ l__
were indicted on multiple health care fraud related
charges for their alleged false billing for services never
rendered and false statements in patients’ medical
records...."

Source:
• From June 2008 to June 2011...Dr. L__ billed for his services on 573 occasions when he was actually out of town or in Cabo San Lucas, Mexico.

• Insurers were also billed for L__’s services on Fridays, when he did not come into the clinic. Instead the patients were seen by medical assistants, who took their vital signs and drew their blood or gave them an injection.
  — The doctor reviewed the records when he returned and billed insurers as if he had actually examined the patients.

• Bill under your own name, unless following incident to rules
• Know Medicare’s rules on choice of CPT code and the documentation that supports the codes
  • Take a class on coding once a year

• I just graduated. A neurology practice wants to hire me to provide in-office and in-hospital evaluation of patients with possible stroke and/or seizure. I may be rounding on patients receiving TPA, titrate 3% saline or mannitol, etc. Is this an acceptable position for an AGPCNP even with signed agreements with the neurologist for skills outside of my scope?
• "I am an NP working in a Physical Medicine office (chiropractor and medical) and the owner wants me to perform stem cell therapy. I am presently performing trigger point and joint injections and he is mandating that performing stem cells (from umbilical cord) injections is not any different than doing trigger point or joint injections using any other medications and I should not need additional training...."

“I believe that performing these injections would imply acquiring additional skills as required by the BON with lecture and hands-on training on models followed by competency evaluation in form of returned demonstration. Would the BON accept as valid the fact that I have a trigger point and joint injections experience and training? I am wondering if I am the only one responsible in case a patient has a bad reaction despite the fact that my employer demands that I do these injections? Are there negative implications for me?”

• I am a FNP. Can I work in an ICU?
• I am a geriatric NP. Can I evaluate and manage a 40-year old?
• I am an adult NP. Can I see and treat a 13-year old? How about a 10-year-old?
• I am a FNP. Can I prescribe for those with major mental illnesses?
• I am a pediatric NP. One of my patients is now 22 but I know his complicated history better than anyone. Can I continue to see him?
• WHCNP took a job at an STD clinic. Clinic managers expected her to treat men (for STDs) as well as women’s primary care complaints. BON refused to approve her collaborative agreement. Said she could treat women’s health issues only. NP was out of a job

• WHCNP had own practice. Started providing primary care as well as women’s health. Soon, 70% of her 1500 patients were primary care. BON told her to stop providing primary care and reprimanded her

• Is the activity, intervention, or role prohibited by the NPA and rules/regulations or any other applicable laws, rules/regulations, or accreditation standards or professional nursing scope and standards?

• Is performing the activity, intervention, or role consistent with evidence-based nursing and health care literature?

• Are there practice setting policies and procedures in place to support performing the activity, intervention, or role?

• Has the nurse completed the necessary education to safely perform the activity, intervention, or role?

• Is there documented evidence of the nurse’s current competence (knowledge, skills, abilities, and judgments) to safely perform the activity, intervention, or role?

• Does the nurse have the appropriate resources to perform the activity, intervention, or role in the practice setting?
• Would a reasonable and prudent nurse perform the activity, intervention, or role in this setting?
• Is the nurse prepared to accept accountability for the activity, intervention, or role and for the related outcomes?

If sued, the first thing the plaintiff’s attorney will ask is "What are your qualifications to provide this care?"

How will you respond?

A nurse practitioner shall perform as an independent and interdependent member of the health team. The following are standards for each nurse practitioner:
(1) Assess clients by using advanced knowledge and skills to:
(A) identify abnormal conditions;
(B) diagnose health problems;
(C) develop and implement nursing treatment plans;
(D) evaluate patient outcomes; and
(E) collaborate with or refer to a practitioner, as defined in IC 25-23-1-19.4, in managing the plan of care.
(2) Use advanced knowledge and skills in teaching and guiding clients and other health team members.

(3) Use appropriate critical thinking skills to make independent decisions, commensurate with the autonomy, authority, and responsibility of a nurse practitioner.

(4) Function within the legal boundaries of their advanced practice area and shall have and utilize knowledge of the statutes and rules governing their advanced practice area, including the following:
   (A) State and federal drug laws and regulations.
   (B) State and federal confidentiality laws and regulations.
   (C) State and federal medical records access laws.

(5) Consult and collaborate with other members of the health team as appropriate to provide reasonable client care, both acute and ongoing.

(6) Recognize the limits of individual knowledge and experience, and consult with or refer clients to other health care providers as appropriate.

(7) Retain professional accountability for any delegated intervention, and delegate interventions only as authorized by IC 25-23-1 and this title.

(8) Maintain current knowledge and skills in the nurse practitioner area.

(9) Conduct an assessment of clients and families which may include health history, family history, physical examination, and evaluation of health risk factors.

(10) Assess normal and abnormal findings obtained from the history, physical examination, and laboratory results.

(11) Evaluate clients and families regarding development, coping ability, and emotional and social well-being.

(12) Plan, implement and evaluate care.
(13) Develop individualized teaching plans with each client based on health needs.
(14) Counsel individuals, families, and groups about health and illness and promote attention to wellness.
(15) Participate in periodic or joint evaluations of service rendered, including, but not limited to, the following:
(A) Chart reviews
(B) Client evaluations.
(C) Outcome statistics.

(16) Conduct and apply research findings appropriate to the area of practice.
(17) Participate, when appropriate, in the joint review of the plan of care.
• IAC 848, r. 4-2-1

• Credentials must be consistent with practice
  • Only see patients in the age group for which you are certified
  • If a specialist NP — psych, women’s health — only see patients with complaints in that specialty
  • If a primary care NP, don’t take jobs where acute care knowledge and credentials are required
  • If you want to add skills to your portfolio, get the level of didactic and supervised hands-on training that a similar professional would consider sufficient
Thank you for coming!

• U.S. Health and Human Services, Office of Civil Rights web site at www.hhs.gov/ocr/privacy/index.html
• Toevs, CC and Toevs, B. "Text messages in the ICU: Are they secure?" Society of Critical Care Medicine Critical Connections, February/March 2014, p. 14

• NSO, Legal case studies at www.nso.com
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• Snyder, K. Legal Eagle Eye Newsletter for the Nursing Profession from www.nursinglaw.com
• Buppert, C. Advanced practice providers: Top 3 compliance problems, *Compliance Today*, April 2014 (Health Care Compliance Association)
