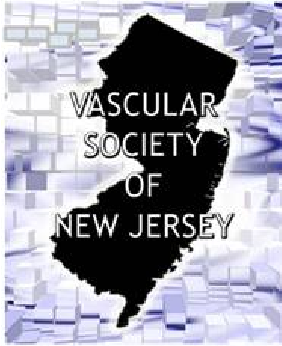

Vascular Society of New Jersey

Monthly Report- March 2011

From the President — Theresa Impeduglia, MD

Dear Colleagues,

Once again, I want to encourage all of our members to attend this year's annual Spring Meeting. Your participation is essential in order to sustain the health and growth of our Society. Scientific forums and the exchange of information are vital to the advancement of our medical education. I look forward to seeing you there.

LAST WEEK TO REGISTER

33rd Annual Scientific Meeting of the Vascular Society of New Jersey

Wednesday, March 9, 2011

at Nanina's In The Park, Belleville, NJ.

download form at www.vascularsocietynj.org

Presentations Include:

Carotid Disease

Brajesh K. Lal, MD

Duplex Guided Office Procedures: Feasibility and Economic Impact

Anil Hingorani, MD

Juxtarenal Aneurysms : The Evidence and Myths

Jose L. Trani, MD

SFA Interventions: Are the Costs Worth the Mediocre Results?

Darren B. Schneider, MD

LEGAL REPORT — MARK E. MANIGAN, ESQ.

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Changes to NJ Hospital Licensing Regulations Impact Facilities and Professionals Alike

On February 22, 2011, the New Jersey Department of Health and Senior Services ("DHSS") re-adopted, with certain amendments, the hospital licensing standards set forth under N.J.A.C. 8:43G. The key amendment related to requiring the "presence" of, rather than the "supervision" by, an anesthesiologist - as opposed to any physician - when an advanced practice nurse ("APN") administers general anesthesia, major regional anesthesia, conscious sedation, or minor regional nerve blocks in a hospital setting. N.J.A.C. 8:43G-6.1 et seq.

Under the amendment, a joint protocol between an anesthesiologist and an APN specializing in anesthesia must include not only a requirement that the anesthesiologist be available on-site, on call, or by electronic means, but also a requirement that the anesthesiologist be physically present during the induction of anesthesia, the emergence from anesthesia, and any critical changes in patient status. There is no requirement as to the specific level of "supervision" required by the anesthesiologist. Rather, the level of "presence" necessary must be clearly defined in the joint protocol depending on the type of procedure and related risk factors.

The amendment is consistent with the re-designation of certified registered nurse anesthestists ("CRNAs") as APNs specializing in anesthesia by the New Jersey Board of Nursing ("BON"). The DHSS was quick to point out, however, that the amended hospital licensing standards does not change the scope of practice of physicians or nurses as defined by the New Jersey Board of Medical Examiners ("BME") and the BON.
Other changes to the hospital licensing standards include:

- Including psychiatric hospitals (in addition to general acute care and special hospitals) as falling under the purview of the DHSS and the new hospital licensing standards. N.J.A.C. 8:43G-1.2.
- Updating patient visitation rights in hospitals such that partners in a civil union or a domestic partner have same rights as spouses. N.J.A.C. 8:43G-4.1
- Updating the underlying requirements and guidance for infection control in the hospital setting. N.J.A.C. 8:43G-14.1
- Requiring hospital to provide patients or the patient's legally authorized representative with copies of medical records within 30 days at a fee based on the hospital's actual cost. N.J.A.C. 8:43G-15.3
- Requiring certain deadlines for medical history/physical examination, updates, and follow-up assessments. N.J.A.C. 8:43G-16.6.

Re-Proposed Medicinal Marijuana Rules Released

After months of political debate, the New Jersey Department of Health and Senior Services (DOH) officially published its reproposed rules on February 22, 2011. The reproposed rules, which have appeared in several unofficial draft forms since November, differ in several key ways from the originally proposed rules.

The reproposed rules clarify that although satellite dispensaries are prohibited, an alternative treatment center (ATC) may cultivate marijuana at a separate location from its dispensary site. Home deliveries are now prohibited and only medical conditions originally named in the New Jersey Compassionate Use Medical Marijuana Act must be resistant to conventional medical therapy in order to qualify as debilitating medical conditions for purposes of a patient obtaining a registry identification card. The cap placed on the potency of the medicinal marijuana, however, remains unchanged.

Importantly, the reproposed rules require that each ATC appoint a "medical advisory board" for the purposes of providing advice to the ATC on "all aspects of its business." The medical advisory board must consist of five members: three New Jersey licensed health care professionals (one of which must be a physician); one patient registered with the ATC; and one business owner from the same region as the ATC. ATC owners, employees, officers, and board members are prohibited from serving on the medical advisory board, which is required to meet two times per calendar year.

Written comments on the reproposed rules are being accepted by the DOH through April 23,

2011 and a public hearing is scheduled for March 7, 2011, between 10:00 A.M. and 12:00 P.M. at the following address: New Jersey Department of Health and Senior Services, First Floor Auditorium, Health and Agriculture Building, 369 South Warren Street (at Market Street), Trenton, New Jersey 08608.

Joint Commission Standards for Patient-Centered Communication

In an effort to promote safe, high quality care for every patient, the Joint Commission has implemented several new accreditation standards that focus on improving communication and cultural competence throughout the healthcare industry. The following standards will apply to language access services:

- HR.01.02.01 instructs hospitals to maintain documented evidence proving language proficiency, education, training and experience for all interpreters on staff, regardless of whether they are full-time, part-time, or provide services through a remote interpreter service provider.
- PC.02.01.21 requires health care providers to identify each patient's communication needs, both oral and written, including the patient's preferred language for discussing healthcare. Providers must communicate with the patient in their preferred language during care and treatment.
- RC.02.01.01 requires medical records to contain information documenting each patient's demographic information, including race, ethnicity, communication needs and preferred language.
- RI.01.01.01 dictates that written policies on patient rights must be translated and made available in common languages. Further, the rule instructs that hospitals be respectful of patients' cultural and personal values, religious and spiritual beliefs, and right to privacy.
- RI.01.01.03 directs healthcare providers to make interpreting and translation services available as necessary and to provide information in a manner tailored to the patient's age, language and ability to understand.

Importantly, the standards also apply to patients who are deaf or hard of hearing. The standards grant the same rights and access to patients who require sign language as they do to patients who require a spoken language interpreter.

As part of a one-year pilot program, the standards were implemented in January 2011 will require healthcare organizations to provide all patients, regardless of language, patient-centered communication. Beginning in 2012, organizations that fail to comply may risk jeopardizing their accreditation.

Lessons Learned from the Cignet Civil Monetary Penalty

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) recently issued a staggering $4.3 million dollar civil monetary penalty against Cignet Health of Maryland (Cignet). HHS stated in its February 22, 2011 announcement that such penalty is the result of multiple violations of the HIPAA Privacy Rule and is based on the penalties authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH Act). As we previously reported in an earlier HIPAA Corner, the HITECH Act, among many other changes, increased the emphasis on enforcement by increasing possible penalties.

In this instance, the OCR found that, between September 2008 and October 2009, Cignet violated over 40 patients' rights by neglecting to provide them with access to their medical

records when requested. (The HIPAA Privacy Rule requires that covered entities provide patients with copies of their medical records within specified time-frames.) These patients individually filed complaints with the OCR. While the OCR imposed a penalty of $1.3 million for Cignet's failure to provide these patients with access to their health information, the lion's share of the penalty, $3 million, was incurred because Cignet failed to respond to the OCR's repeated demands to produce the records and failed to cooperate with the OCR's investigations.

The takeaway from the Cignet matter is that the OCR is becoming much more aggressive in enforcing HIPAA. While in the past the OCR may have been more willing to accept corrective action instead of imposing penalties, this no longer seems to be the case. Therefore, now more than ever, it is important to take HIPAA complaints seriously and respond appropriately and in a timely fashion. Finally, although anyone can become the subject of an OCR investigation, providers should seek to avoid enforcement actions and penalties by having a strong, up-to-date HIPAA plan in place.

From the Statehouse — Beverly J. Lynch

On February 8, 2011, Governor Christie signed new legislation that makes significant changes to the membership terms and duties of the State Board of Medical Examiners (BME). Specifically, the new law requires that:

- A member of the BME is eligible for reappointment for one additional term of office, but no member is to serve more than two consecutive terms. This limitation will apply to any member newly appointed after the effective date of this bill, and any member serving on the effective date of this bill will be limited to two additional consecutive terms.

- The Medical Practitioner Review Panel, established by the BME pursuant to section 8 of P.L.1989, c.300 (C.45:9-19.8), is to investigate referrals (notices or complaints) that it receives from health care facilities and health maintenance organizations regarding a licensee in order to make a recommendation to the BME, <u>and make its recommendation within 90 days after receipt of the referral, rather than investigate "promptly," as the law currently provides.</u>

- The 90-day period is to be tolled, whenever additional time is required: to obtain information, records, or evidence sought pursuant to section 9 of P.L.1989, c.300 (C.45:9-19.9) that is necessary for the review panel to make its recommendation; for the review panel to consider additional information furnished more than 30 days after receipt of the referral; for expert consultation related to the subject matter under investigation; or for other good cause shown due to extraordinary or unforeseen circumstances.

- If the 90-day period is tolled, the review panel is to so notify the BME, indicating the reason and amount of additional time required to make its recommendation, and transmit a copy of the notice to the Attorney General and the referring entity. This time frame is not to be construed to limit or otherwise impair the authority of the BME to take any action against a licensee or applicant for a license, or the authority of the review panel to make a recommendation.

- Upon receipt of notification from a physician of any action taken against the physician's medical license by any other state licensing board or any action affecting the physician's privileges to practice medicine by any out-of-State hospital, health care facility, health maintenance organization or other employer, the BME, within 60 days, is to investigate the information received and obtain any additional information that may be necessary in order to make a determination whether to initiate disciplinary action against the physician. This time frame is not to be construed to limit or otherwise impair the authority of the BME to take any action against a licensee.

For more information, please contact Beverly Lynch, blynch@blynchassociates.com, or 609-392-7553.

SINGER / KEAN BILL ADDRESSES DOCTOR SHORTAGE IN NEW JERSEY
Nation Could Face Shortage of 150,000 Doctors in Next 15 years

A bill sponsored by Senators Robert Singer (R-Ocean) and Sean T. Kean (R-Monmouth) that would assess how to increase the number of teaching hospitals and medical residency programs throughout the State was passed on February 17 by the Senate.

S2613 would require the Commissioner of Health and Senior Services to assess how medical residency programs can be developed in hospitals that currently are community-based, non-teaching hospitals, to increase the number of teaching hospitals and medical residency programs generally throughout the State, and to ensure the existence of medical residency programs in counties in the State that currently have few or no medical residency programs.

The bill also requires that the Commissioner of Health and Senior Services provide a written report with their findings and recommendations to the Governor and Legislature within six months after the effective date.

DHSS Proposes New Medical Marijuana Rules

The Department of Health and Senior Services proposed new rules in the February 22, 2011, edition of the *New Jersey Register* outlining the registration and application process for patients, primary caregivers, physicians and alternative treatment centers to participate in New Jersey's medical marijuana program.

The new rules replace those originally proposed in November that were declared by a legislative resolution as inconsistent with the act. Accordingly, DHSS proposed new rules to implement the provisions of the act in addition to revising the request for applications to establish and operate a medicinal marijuana alternative treatment center.

The proposed new rules include some key changes. Six alternative treatment centers (ATCs) - two each in the north, central and southern regions of the state - will be permitted and each will be able to both dispense and grow medicinal marijuana. In addition, the application process for cultivating and dispensing permits will be combined into one application for an ATC permit. Also, home delivery and satellite locations for the ATCs will no longer be allowed.

The proposed new rules also establish a definition for the term "medical advisory board." Only the debilitating conditions originally contained in the law will be subject to the provision that all conventional therapies have been exhausted before a physician can recommend a patient for medicinal marijuana. The proposed new rules would establish the process by which qualifying patients, their physicians and their primary caregivers would register with DHSS to avail themselves of the Act's protections against civil and criminal sanction.

The rules still require a maximum potency level of 10 percent. Physicians still must have an ongoing relationship with a patient. Over the course of the first two years of the program, DHSS will evaluate many different aspects of the program and consider changes as necessary.
DHSS has scheduled a public hearing on the new rule proposal March 7 at 10 a.m. at the Health and Agriculture Building in Trenton.

Estate Planning Update:
On December 17, 2010, President Obama signed into law the Tax Relief, Unemployment Insurance Authorization, and Job Creation Act of 2010, which includes changes to the federal estate, gift, and generation-skipping transfer (GST) tax laws for 2011 and 2012.

While the new law provides short-term clarity for estate, gift, and GST taxes, the statute is "temporary" and sunsets on December 31, 2012. Therefore, we can expect further changes to the laws in this area sometime within the next 2 years. Here are some of the pertinent changes.

- **For 2011, the federal estate tax, gift tax, and GST exemptions are all increased to $5,000,000. The tax rate for all 3 is now 35%.**
- **For 2012, the exemptions are indexed for inflation.**
- **Starting this year, a surviving spouse may, in many cases, be able to make use of any federal estate tax exemption unused in the estate of the predeceased spouse. The surviving spouse can use this additional exemption either for lifetime gifts or at the surviving spouse's death. This is commonly referred to as portability.**
- **All of these changes are scheduled to end in 2013, when the estate and gift taxes revert to a $1,000,000 exemption with a top rate of 55%, the GST tax reverts to an exemption of about $1,400,000 with a flat tax rate of 55%, and portability expires.**

Generally, the changes to the law should not require significant changes to many current estate plans. However, while there will be exceptions, the following observations are likely to apply in many cases:

- **The increase in the lifetime gift tax exemption to $5,000,000 makes gifting strategies more accessible and potentially more meaningful. In particular, those who had made gifts up to the previous $1,000,000 limit may want to consider opportunities for additional gifts to children and grandchildren**
- **As a NJ resident, your plan should include provisions to account for the now significant difference between the applicable state ($675,000) and federal ($5,000,000) estate tax exemptions.**
- **The new "portability" of the federal estate tax exemption means that married couples may be able to utilize their combined $10,000,000 exemption regardless of the ownership of the assets between them at the time of the first death. However, portability should not be considered a substitute for prudent estate planning. We will review this in more detail in next month's article.**

No matter how the tax law changes, you still need an estate plan. All of the non-tax reasons for having one remain, including seeing that your property passes as you wish after death, naming executors and trustees, naming guardians for minor children, and providing fir the management of your financial and medical affairs if you are unable to take care of yourself.

If you have any questions please contact me at (877)972-7900 or dvargo@varbeco.com.

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President, Varbeco Wealth Management, LLC