# Health Law Developments

*The Newsletter of the Health Law Section*
*State Bar of Georgia*
*Summer 2020*

## Inside This Issue



## From the Chair

Dear Health Law Section Members, Friends and Colleagues,

In the first part of this year we have experienced challenges unlike any we have ever faced. The global pandemic is affecting all of us, including our families, our communities, our work and most aspects of our daily life. The tragic death of George Floyd, Rayshard Brooks, and so many others have highlighted the long-standing divisions in our society. We acknowledge the pain and suffering that has been inflicted on the African American community and must work to end racism, violence and the unacceptable abuse of power. I echo the words of the immediate, past President of State Bar of Georgia, Darrell Sutton, that "[t]here is much work to be done. . . . to deliver on the promise of equal justice for all people." I believe, however, that with great challenges come the opportunity for change and growth and hope that we, as a Section, use this time to come together, to form connections and support one another.

In this time of need, I wanted to bring your attention that all members of the State Bar of Georgia in good standing are entitled to up to six (6) appointments (through telephone or telehealth during the pandemic) per calendar year with a licensed clinical counselor. The Lawyer Assistance

Program is a confidential service to help members with life's difficulties. This is a confidential service through CorpCare Associates, Inc., a Georgia-headquartered national counseling agency. For more information you can call the hotline at (800) 327-9631 or go to https://www.gabar.org/committeesprogramssections/programs/lap/index.cfm.

As with most programs, we are all adjusting to the new world of conducting life through virtual means. We are disappointed that we cannot hold our usual in-person events where we have an opportunity to connect with one another and meet new people. We hope to resume in-person programs soon. In the meantime, the Executive Committee is currently planning the annual Advanced Health Law Program, which will be held virtually this fall and cover a wide range of current health law topics. Please be on the look-out for details as we work to plan this event. We invite your input on the program, including format, topics and speakers.

The Section sponsored the Fundamentals of Health Law Program in February. Thank you to the Program Chair, Rich Sanders, along with everyone who participated for another successful program. We provided student sponsorships for local law school students attending the Fundamentals of Health Law Seminar and awarded the Alan Rumph Memorial Fellowship to two deserving law school students. We would have completed the second year of our new mentorship program in May 2020 but have pushed the program back due to COVID-19 and will resume the program as soon as it is safe to do so. A special thanks to Lynn Adam and the Advisory Board for all their work on this meaningful program.

On behalf of the Executive Committee, I would like to thank each of the authors that contributed to the Health Law Section Newsletter. We are truly grateful for your contributions to our section. We also would like to thank Beth Stephens and Scott Grubman for their time spent recruiting authors and editing and publishing the newsletter. I would like to give thanks to our Immediate Past Chair, "Superwoman" Lynnette Rhodes, who led our Section while assuming her responsibilities as the Executive Director of the Medical Assistance Plans Division with the Department of Community Health. Additionally, I would like to thank our current officers, Rebecca Merrill, Keri Conley and Bob Brennan for their contributions and tireless efforts for the Section.

As always, we invite all of you to submit articles, reports, and proposals for presentations that would be informative to the membership.

Thank you for the opportunity to serve as the 2019 to 2020 Chair of the Health Law Section. We will get through this year together.

Amy Fouts, Chair
BakerHostetler

*Amy E. Fouts is the current Chair of the HLS and a partner with BakerHostetler in the Healthcare group.*

# Summer 2020 Alan Rumph Memorial Fellowships

## Raneem Ashrawi

- University of Georgia School of Law, JD Candidate Spring 2021
- Internship Organization: Health Law Partnership (HeLP)

## Yasamine Jalinouszadeh

- Georgia State University College of Law, JD Candidate Spring 2021
- Internship Organization: Georgia Health Policy Center and Harvard Law's Systemic Justice Project

# Managing the Legal and Regulatory Risks of Locum Tenens Physicians

**by Raj Shah and Baylee Culverhouse**

Due to a physician shortage in the United States and a growing turnover of employed physicians, the use of locum tenens physicians continues to rise.[1] Hiring locum tenens ("locum") physicians gives healthcare organizations flexible options to fill absences for a variety of reasons, including illnesses, vacations, pregnancies, and continuing medical education opportunities. Because bringing on a new physician for a short period of time can expose a healthcare organization to certain legal and regulatory risk management issues, this article provides the following legal and risk management best practices for healthcare organizations who employ locum physicians at their healthcare organizations.

**Selecting a Locum Tenens Physician Within the Same Specialty**

Choosing a locum tenens physician within the same specialty as the absentee physician can reduce exposure to liability. Especially in rural areas where locum tenens providers may be hard to come by, a healthcare organization can be tempted to fill a position with a *similar* specialty in hopes that the skills are generally transferable or that other physicians in the healthcare organization can step in if needed. For example, if the healthcare organization generally treats large numbers of pediatric patients and the healthcare organization genuinely needs a family practice physician to fill the vacancy, advise the healthcare organization against accepting an internist physician in hopes that other physicians in the healthcare organization can cover the pediatric patients. Circumstances will inevitably arise that will put the internist in charge of treating a pediatric patient, so healthcare organizations should avoid settling for any specialty other than the one they are specifically seeking.

**Specifying the Requisite Skill and Expected Case Load Before Hiring**

It is important for healthcare organizations to be realistic about the skills and the time commitment required for the position they are temporarily trying to fill and convey this information to the potential locum physician. For example, if the healthcare organization sees an unusually high number of patients with autoimmune diseases, it might be wise for the healthcare organization to disclose this information to a potential locum candidate to ensure the locum physician is equipped with the expertise to handle a high number of these patients.

Healthcare organizations might also find it beneficial to inquire about the locum physician's past case load management to make sure they are comfortable with the time commitment required to fill the position. While working a 24-hour call shift may not seem unusual for many physicians, others may not feel comfortable working these hours. By discussing these issues during the hiring process, healthcare organizations can reduce exposure to liability by understanding any limitations of a locum physician before they begin seeing patients.

**Verifying All Physician Documentation and Licensing**

Healthcare organizations should ensure all documentation and licensing requirements of the locum physician are up-to-date and authentic. This may require verification of criminal background checks, education, training, past and future privileges, and board certification. Additionally, physician practices affiliated with larger organizations may need to look into whether their organization has any specific requirements for locum physicians, as that organization may have its own particular requirements for privileging or credentialing. Likewise, the physician practice should notify their malpractice carrier of the locum arrangement to ensure malpractice

coverage applies for physician services provided by the locum provider. Most malpractice carriers will provide malpractice coverage for a locum arrangement for sixty (60) days per malpractice policy period.

**Providing a Thorough Orientation for the Locum Tenens Physician**

Healthcare organizations should schedule time before the locum physician's start date to provide a proper orientation for them to become acquainted with the healthcare organization's facility, staff, and equipment.

At a minimum, this orientation should cover:

- a facility tour (including the locations of equipment, supplies, and medications);
- a point of contact (for the entire duration of the locum physician's services);
- the code of conduct or specific rules at the facility, if applicable;
- the medical records system at the facility;
- the process for ordering diagnostic tests;
- the availability of specialists, equipment, and support staff;
- the process for referrals; and
- the healthcare organization's philosophy on prescription drugs.

Conveying the availability of specialists and support staff to the locum provider is especially important in rural areas. Locum physicians need to know whether the nearest cardiologist is located in the facility itself or in a town thirty miles away. Additionally, if a locum physician usually heavily relies upon support staff during procedures, the locum physician may feel uncomfortable in a setting where they have to handle procedures without that support. A thorough discussion between the healthcare organization and the locum physician about the practice environment reduces the chances of surprising the locum physician with unexpected circumstances that can affect the quality of care.

**Becoming Familiar with Locum Tenens Billing Requirements**

Billing requirements for locum physicians vary by payer. Even though both public and private payers tend to follow Centers for Medicare and Medicaid Services (CMS) guidelines for locum reimbursement, healthcare organizations should first validate reimbursement with the individual payers as to whether the payers have adopted these CMS guidelines, and if not, inquire as to which specific rules govern their reimbursement procedures for locum providers.[2]

If the payer follows the CMS guidelines, CMS allows payment for services provided by locum physicians, subject to the following conditions:

- If a healthcare organization needs locum physician services for *less than sixty days*, the healthcare organization should bill under the name and billing number of the absent physician while the healthcare organization pays them "on a per diem or similar fee-for-time basis."[3] The locum physician must have a National Provider Identifier (NPI), and the healthcare organization must document each service provided by the locum with the locum physician's NPI.[4] Claims for services provided by locums should be submitted with a Q6 modifier appended to each procedure code.[5]
- If a healthcare organization needs locum physician services for *more than sixty days*, the healthcare organization should enroll the physician in the healthcare organization's contracted payer mix prior to their start date.[6] The sixty-day period begins on the first day that the locum physician sees a patient.[7] Note that it is impermissible to bill for any locum tenens physician services for more than sixty days—even if the healthcare organization rotates among different locum physicians. For example, a healthcare organization cannot avoid enrolling the locum in their contracted

payer mix by switching locum tenens providers on day fifty of the services.

**Ensuring Compliance with U.S. Drug Enforcement Administration Requirements**

As locum physicians sometimes practice in different states, healthcare organizations should ensure that the locum physician has a separate U.S. Drug Enforcement Administration (DEA) registration in the state in which the healthcare organization is located.[8] In certain situations, the DEA allows locums who will be working solely in a hospital or clinic setting to use the hospital's DEA registration instead of registering independently with the DEA.[9]

In addition, healthcare organizations should be clear with the locum on their prescribing pattern and comfort level with dispensing drugs and controlled substances. As a representative of the healthcare organization, the locum provider should mirror the healthcare organization's attitude towards prescribing drugs. Freely dispensing large amounts of drugs and controlled substances can open the healthcare organization up to liability.[10]

**Understanding Physician Supervision Requirements**

If a locum tenens arrangement involves supervisory duties of mid-levels, a healthcare organization should be clear with the locum physician regarding what these responsibilities entail. When applicable, the healthcare organization should make sure the locum realizes they will still be considered a supervising physician in the new setting.

**Encouraging the Locum Tenens Physician to Maintain Solid Documentation**

While maintaining solid documentation is important in any healthcare organization, it is *especially* important when employing a locum physician due to the short-term nature of the arrangement. If a new patient sees the locum physician and needs to be monitored closely to avoid progression of a condition, this should be thoroughly documented and carefully coordinated with other physicians and support staff to avoid any gaps in coverage for the patient once the locum leaves. Failing to follow up with a patient can expose a practice to significant liability.[11]

Following these legal and regulatory risk management best practices will ensure that a healthcare organization is able to enjoy the benefits of filling short-term physician vacancies with locum physicians while still managing the risks and exposure to liability that these arrangements can bring.

*Raj Shah is the Senior Regulatory Attorney and Policy Advisor at MagMutual. He provides consultation to MagMutal policyholders regarding federal and state healthcare regulatory matters and prepares risk management educational materials on best practices regarding healthcare compliance. He is certified in Healthcare Compliance (CHC) and Certified as an Information Privacy Professional (CIPP-US). He is a former practice group Vice-Chair of the American Health Law Association (AHLA) and serves as a mentor through the State Bar of Georgia Health Law Section's Mentoring Program.*

*A risk intern at MagMutual, Baylee Culverhouse is a second-year J.D./M.S.H.A. student at Georgia State University College of Law. She currently serves as Lead Articles Editor for the Georgia State University Law Review and was recently elected to serve as 3L President of the Student Health Law Association. In the past, she has interned at Grady Health System's Office of Legal Affairs and the Centers for Disease Control and Prevention (CDC) Office of the General Counsel. She graduated from the University of Georgia with degrees in English and political science and a minor in music (violin performance).*

**Endnotes**


1. Ken Terry, *Locum Tenens Surge Due to Doc Shortage, Turnover: Report*, MEDSCAPE (Feb. 26, 2020), https://www.medscape.com/viewarticle/925729.
2. CompHealth, *How to Bill for Locum Tenens Services*, COMPHEALTH BLOG (Jan. 7, 2015), https://comphealth.com/resources/bill-locum-tenens-services/.
3. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS PROCESSING MANUAL (2008), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf.
4. *Id*.
5. *Id*.
6. A narrow exception to the sixty-day limit on locum tenens physician services exists for absent physicians who have been called to active duty in the Armed Forces. *See id*.
7. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 3.
8. 21 C.F.R. § 1301 (2016).
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# Past Health Law Section Chairs

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# WE ARE HIRING

## Soliciting Applications for Executive Director

The State Bar of Georgia is soliciting applications for the position of Executive Director. Based in Atlanta, the Executive Director is responsible for managing and executing the operations of the State Bar of Georgia and its offices, and implementing the policies, programs and objectives set by the Board of Governors. The position encompasses the management of a large staff as well as supervision of large budgets and responsibility for financial matters.

**The complete job description is available at www.gabar.org/jobpositions.**

Indications of interest, inquiries, applications and nominations should be directed by email to:

**Barbara Mendel Mayden**
**Young Mayden, LLC**
**bmayden@youngmayden.com**

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State Bar of Georgia

# The Doctor Is In … Your Living Room: COVID-19 Ushers In A New Era For Telemedicine

**by Lynn Adam[1], Lee Earnest[2] and Amy Fouts[3]**

A surge in demand for telemedicine services has accompanied the surge of the Coronavirus, the highly contagious virus that causes COVID-19. This article surveys the government's efforts to promote telemedicine in response to COVID-19 with rapidly evolving regulations and guidance that change almost daily.

Before the Coronavirus pandemic, our healthcare delivery infrastructure, laws, and reimbursement were inching toward more extensive use of telemedicine, with a primary focus on rural healthcare. But most physicians still had no experience providing telemedicine services, and most had no incentive to consider it as an alternative to face-to-face medical care.

The Coronavirus pandemic, however, has significantly accelerated the adoption of telemedicine, and many physicians and hospitals have embraced this method of healthcare delivery. Surprisingly, telemedicine is now viewed as the *safer* alternative to in-person care for routine medical services during the Coronavirus pandemic, particularly for elderly and immunocompromised patients.

The U.S. Department of Health and Human Services (HHS) declared a public health emergency on January 31, 2020, and subsequently issued dozens of "waivers" to remove regulatory barriers in response to the pandemic.[4] The waivers reflect a temporary stand-down on enforcement during the public health emergency. While temporary, the waivers aimed at telemedicine may prove transformative in the delivery of healthcare going forward.

### *1. What Is Telemedicine?*

"Telemedicine," sometimes used interchangeably with "telehealth," means the delivery of healthcare services remotely through information or telecommunications technology.[5] Such technology includes telephone, remote patient monitoring devices, email, texting, video-conferencing, and online patient portals.[6]

Historically, telemedicine has primarily been used to facilitate communication between physicians, *e.g.*, between a radiologist and a treating physician, but recently it has increasingly been employed to allow providers to communicate directly with patients.[7] While these may be the two most obvious applications for telemedicine, they are not the only contexts in which they can be useful. For example, some hospitals have deployed programs to utilize telemedicine to electronically monitor ICU patients remotely.[8] Others have used telemedicine to provide virtual physician support to first responders providing emergency medical treatment. In response to COVID-19, hospitals have started to use telemedicine in a variety of ways to meet the challenges arising from both the threat of infection posed by direct patient contact and from diminished ranks of health workers who must be isolated if and when that threat is realized.[9]

Before COVID-19, telemedicine was typically divided into two distinct categories: (i) "synchronous," which consists of real-time, two-way communication such as phone calls and video conferences; and (ii) "asynchronous," also known as "store-and-forward," which consists of sending recorded information, such as written descriptions, images, and test results to the provider; occasionally, remote continuous monitoring was classified as a third category.[10] Synchronous telemedicine may involve only audio interaction or may combine both audio and visual interaction. When used for the purpose of remotely evaluating a patient or for managing treatment, the interaction typically occurred while the patient was physically at a medical facility. An onsite provider generally examined the patient and communicated information such as blood

pressure to a remote physician. Continuous remote patient monitoring involved anything from regular audio check-ins (phone calls), to a constant video feed, to transmission of readings from wearable biometric devices.

These distinctions are important because different forms of telemedicine are more costly and/or feasible, depending on the equipment required to make use of them; and different types of care require higher or lower degrees of interaction depending upon the nature of the care. Thus, different forms of telemedicine may be employed for different types of care, allowing healthcare providers to tailor the means of delivering the care to the patient's needs.

***2. Telemedicine Offers Unique Advantages During A Pandemic.***

"First, do no harm." During an outbreak of an extremely contagious and potentially deadly virus for which we have no vaccine, physicians recognize that the traditional model of face-to-face medicine poses health risks for patients. And for routine care, the benefits of an in-person encounter generally do not outweigh significant risks of individual exposure and community spread.

Current CDC guidelines advise the American public to stay home if possible, wear a mask in public, maintain a distance of at least six feet from others, and avoid groups of 10 or more people. A typical office visit with a physician would not comply with these guidelines.

These days, public health is better protected when a physician treats a patient via telemedicine. The medical staff have less exposure to the virus. As for the patient, telemedicine means no more crowded waiting rooms, no germy pin pads or elevator buttons, and no incidental interactions with other sick patients. The flexibility offered by virtual doctor's visits also means physicians can schedule appointments at more convenient times, they may be able to serve more patients because telemedicine visits are generally shorter, and they can arrange timely consultations with faraway specialists.

Well before COVID-19, providers recognized the important privacy benefits of telemedicine, especially for those seeking treatment for mental health conditions and substance use disorders. Now, deep into a pandemic that magnifies these issues for many people, the anxiety and potential stigma of in-person visits are alleviated when a fragile patient can access care from the comfort of their living room – via telemedicine.

***3. Pre-COVID-19 Barriers Prevented Widespread Use Of Telemedicine Services.***

The crucial barrier to broader adoption before the pandemic was limited reimbursement. Despite the many benefits of telemedicine, Centers for Medicare and Medicaid Services (CMS) was approving only incremental expansions in coverage when prodded by Congress.

Both Georgia Medicaid and Medicare Part B generally pay physicians and hospitals for services furnished via telemedicine only to reach rural patients willing to go to a nearby medical facility to receive telehealth services, only for live video, and only when the treating provider already had an established relationship with the patient.[11] In other words, under current regulations, patients typically must *leave home* for an office visit via telemedicine to qualify as a covered service under Medicaid and Medicare Part B.

Starting last year, Congress directed CMS to make a few important but limited expansions of coverage for telemedicine.[12] Geographic restrictions were removed for home dialysis patients, stroke treatment, and treatment for a substance use disorder or a co-occurring mental health disorder.[13] Before the pandemic, CMS also had begun covering remote patient monitoring, virtual check-ins[14] ( brief consultations with providers using a phone, text, audio/video system, or video image), and e-visits[15] (communication through online patient portal).

So, while coverage expansion for telemedicine was palpable in some contexts, it remained piecemeal. Before the pandemic, most Medicare and Georgia Medicaid patients were not covered for telemedicine services delivered in their homes.

Another significant barrier was that telemedicine technology and services also had to comply with Health Insurance Portability and Accountability

Act of 1996 (HIPAA), which meant many common applications that were readily available and familiar to patients, such as FaceTime, Google Hangouts, Zoom, or Skype, could not be used. Given the restricted opportunities for reimbursement, many providers had little incentive to invest in the necessary HIPAA-compliant technology platforms to deliver care through telemedicine.

***4. Telemedicine Explodes In The Age Of COVID-19***

That all changed in March when the threat of a global pandemic posed by COVID-19 became a reality, and government agencies and healthcare stakeholders turned to the untapped potential of telemedicine. Many payors, including CMS, waived restrictions on reimbursement to encourage the use of telemedicine. The HHS Office of Civil Rights (OCR) announced flexibility in HIPAA enforcement, and Congress made funds available for investment in telemedicine devices and services.

CMS. On March 17, 2020, CMS issued a blanket waiver confirming coverage for practitioners nationwide to conduct certain health care visits through virtual means.[16] Due to the pandemic, Medicare now pays for office, hospital, and other visits furnished via telehealth across the country, wherever the patient is located -- including a beneficiary's home -- and irrespective of whether the provider already had an established relationship with the patient. This waiver was not limited to patients with COVID-19. During the waiver period, all Medicare patients can be seen using a telephone with "audio and video capabilities that are used for two-way, real-time interactive communication," such as smartphones.[17]

OCR. Also in March, OCR announced that it would exercise "enforcement discretion" under HIPAA when it comes to the good faith use of telemedicine during the pandemic.[18] As a result, popular applications such as Apple FaceTime, Google Hangouts, Zoom, and Skype are now permissible tools for healthcare delivery.[19] OCR announced that "[c]overed health care providers will not be subject to penalties for violations of the HIPAA Privacy, Security, and Breach Notification Rules that occur in the good faith provision of telehealth during the COVID-19 nationwide public health emergency."[20] OCR published important FAQ's that detail the scope of their enforcement discretion.[21]

FCC. In addition to the new opportunity to deploy these widely available technologies, healthcare providers now may apply for federal funding to assist in the provision of telemedicine services. As part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Congress appropriated $200 million to establish a COVID-19 Telehealth Program under the jurisdiction of the Federal Communications Commission (FCC). The agency will distribute funds to eligible non-profit healthcare provider applicants, thereby facilitating investment in more sophisticated means of remote interaction for the purpose of telemedicine.[22] Though created in response to COVID-19, the infrastructure built with this funding is likely to have long-term benefits in terms of reducing the cost barrier to providing telemedicine services.

New Flexibilities. On March 30, 2020, CMS issued an interim rule that outlined additional flexibilities for providers to address the ongoing global COVID-19 pandemic.[23] Considered "sweeping regulatory changes," CMS believed that these modifications would enable providers to focus on expected surges in patient care needs.[24] Among the changes, CMS will now allow hospitals to provide certain routine services to inpatients through arrangements outside of the hospital walls.

CMS continued to build upon the existing telehealth evaluation and management (E/M) codes to enable greater flexibilities for providers to render services. CMS addressed telemedicine criteria for inpatient rehabilitation facilities, home health agencies, hospices and expanded access for hospitals and healthcare practitioners. CMS stated that it "expect[s] physicians and other practitioners to use the E/M code that best describes the nature of the care they are providing, regardless of the physical location or status of the patient." CMS added emergency department visit codes CPT 99281-99285 and codes for observation CPT 99217-99220 and CPT 99224-99226 and several hospital care codes to those services that may be rendered via telehealth.[25]

On April 30, 2020 CMS issued a second round of extensive changes to assist providers in providing services to beneficiaries.[26] For the duration of the

COVID-19 emergency, CMS waived restrictions on Medicare coverage based on the types of clinical practitioner furnishing Medicare telehealth services. Prior to April 30, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. CMS expanded this list to cover physical therapists, occupational therapists, and speech language pathologists. Further, CMS broadened the list of services that Medicare would pay for when conducted by audio-only telephone to include many behavioral health and patient education services. CMS also increased payments for these telephone visits to match payments for similar office and outpatient visits.[27]

To address licensure and enrollment issues, CMS established a hotline for providers and suppliers to enroll and receive temporary Medicare billing privileges. Many States have also relaxed licensure requirements in light of the pandemic to allow providers in good-standing to provide services to patients in other states, particularly through telemedicine.

CMS continues to reassess and refine its policies through guidance documents, stakeholder calls and interactive calls with Medicare Administrative Contractors. For the most current official guidance, providers should keep abreast of frequent updates by CMS and the Medicare Administrative Contractors.

Other Payors. In addition to Medicare, State Medicaid programs, Medicare Advantage programs and commercial payors are following suit and expanding the ability of practitioners to provide covered services through telemedicine. Under the emergency declaration and waivers, the Georgia Medicaid Program waived originating site limitations to allow all members to receive services in their homes by telephone, webcam, audio and video technology communication to reduce exposure to themselves and others.[28] Qualified healthcare providers must continue to comply with applicable state telehealth laws and regulations and the services must meet established medical necessity criteria.[29]

The changes to telemedicine services have led to an influx of challenges for providers and telemedicine vendors alike. Hospitals and physicians are scrambling to implement user-friendly telemedicine technology solutions, while navigating the new (and temporary) billing, documentation and regulatory environment. Telemedicine technology companies also face an unexpected onslaught of new users and the almost overnight demand for access to their telehealth platforms by both patients and providers. Some telehealth providers have had to turn away providers wanting to use their technology.

***5. The Expanded Use of Telemedicine Presents New Fraud and Abuse Considerations***

The government has rapidly mobilized in response to the pandemic and implemented many regulatory and coverage waivers in quick succession. There is little doubt that scrutiny will follow the relaxing of these rules. The HHS Office of the Inspector General has stated that it does not intend to seek administrative sanctions against providers who forego patient cost sharing responsibilities for any virtual services, including check-ins, e-visits and telehealth visits. In the aftermath of COVID-19, however, CMS will surely look at the increase in services provided by these methods and confirm that providers correctly documented and billed government programs.

In conclusion, now that many of the barriers to telemedicine have been waived for the duration of the national public health emergency, these temporary changes will likely lead to a permanent transformation of the healthcare industry. Indeed, CMS issued a proposed rule on August 3, 2020 that, if adopted, would permanently allow physicians to deliver via telehealth some of the 135 services that CMS added temporarily to the telehealth list during the pandemic.[30] Telemedicine of course will never replace in-person care for many essential medical services; but increased demand[31] and changing reimbursement have prompted hospitals, physicians and other providers to invest tremendous effort and resources into being able to treat and "see" patients in their homes and facilities via telemedicine. The added safety and increased convenience for both providers and patients will be hard to forego once the pandemic subsides, particularly if we experience comparable health outcomes with telemedicine. Given the efficiencies realized at this point, the future looks bright for telemedicine.

**Endnotes**

1. Lynn M. Adam is a former federal prosecutor with over 20 years of experience in healthcare law. Adam Law LLC represents whistleblowers in qui tam litigation under the False Claims Act and advises healthcare organizations on internal audits, investigations, and other compliance matters. She is the Director of the Mentorship Program and a past Chairperson of the Health Law Section for the State Bar of Georgia.
2. Lee Earnest is an associate with Southern Health Lawyers and a member of the Health Law Section Mentorship Program's current mentee class.
3. Amy E. Fouts is the current Chair of the HLS and a partner with Baker Hostetler in the Healthcare group.
4. Section 1135(b)(8) of the Social Security Act authorizes the Secretary of HHS to issue "1135 waivers" during a national emergency. See 42 U.S.C. § 1320b–5.
5. World Health Organization [WHO], *Telemedicine: opportunities and developments in Member States: report on the second global survey on eHealth* (2010) at 8-10.
6. See O.C.G.A. § 33-24-56.4(b)(6)-(7); Medicare Telemedicine Health Care Provider Fact Sheet, Mar. 17, 2020, available at: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.
7. OJ Mechanic & AB Kimball, *Telehealth Systems*, STATPEARLS (Jan 2020),https://www.ncbi.nlm.nih.gov/books/NBK459384/.
8. Judd E. Hollander & Brendan G. Carr, *Virtually Perfect? Telemedicine for Covid-19*, 382 NEW ENGL. J. MED 1679, 80 (2020).
9. *Id*.
10. Supra note 2.
11. *See* 42 C.F.R. § 410.78; Telehealth Guidance, Georgia Department of Community Health, Division of Medicaid (Jan. 1, 2020).
12. *See* 42 U.S.C. § 1395m(m); 42 C.F.R. § 410.78.
13. *See id*. § 1395m(m)(5)-(7).
14. https://www.medicare.gov/coverage/virtual-check-ins
15. https://www.medicare.gov/coverage/e-visits
16. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
17. *Id*.
18. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
19. *Id*.
20. https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf
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23. https://www.cms.gov/files/document/covid-final-ifc.pdf
24. https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19
25. *Id*.
26. https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid
27. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
28. https://medicaid.georgia.gov/covid-19
29. *Id*.
30. https://www.cms.gov/newsroom/press-releases/trump-administration-proposes-expand-telehealth-benefits-permanently-medicare-beneficiaries-beyond
31. "Before the public health emergency (PHE), only 14,000 beneficiaries received a Medicare telehealth service in a week while over 10.1 million beneficiaries have received a Medicare telehealth service during the public health emergency from mid-March through early-July." https://www.cms.gov/newsroom/press-releases/trump-administration-proposes-expand-telehealth-benefits-permanently-medicare-beneficiaries-beyond

# Mentorship Program News - Welcome to The Class of 2020

**by Lynn M. Adam[1]**

The Health Law Section is pleased to welcome the Mentorship Class of 2020! The purpose of the Mentorship Program is to enhance our sense of community, collegiality, and professionalism among health law attorneys in Georgia. And we have a great time doing it.

We selected 10 Mentees and 10 Mentors to participate in this year's program. Mentees in the Class have the benefit of one-on-one interactions with an assigned Mentor as well as group networking with all of our Mentors and Advisory Board. Mentees also perform a service project during the year. So far, we have enjoyed an Orientation in October, a Social Networking Event in January, and a Mid-Year Meeting (with a terrific professionalism CLE presented by Karlise Grier, Esq.) in February.

***Intermission***. We are experiencing an "intermission in our regularly scheduled programming" because of COVID-19. But we will come roaring back when it is safe to resume networking events. The Executive Committee and Advisory Board have approved extending the mentorship program for the Class of 2020 as long as needed to give everyone in the Class an opportunity for a full year of participation.

***Sponsorship***. The Mentorship Program is looking for sponsors! We have many sponsorship levels ranging from $100 (individual) to $3,000 (Diamond Sponsor). Donations help to fund the cost of a graduation ceremony and celebration dinner for the Mentorship Class of 2020. Sponsors will receive tickets to our fabulous dinner and visibility with the Health Law Section membership through a variety of channels depending on sponsorship level. Full details are available in our sponsorship brochure. If interested, please email Brittany N. Jones (bnjones@benevis.com) or me (ladam@lynnadamlaw.com) to request a brochure.

***Recognition***. This is a perfect time to recognize and extend our gratitude to the many members of the Health Law Section who make this Program possible. Our Mentees, Mentors, and Advisory Board are listed here. Please give them a word of thanks and encouragement for their outstanding contributions. This is how we create community!

**Mentees**
**Mentorship Class of 2020**

| | |
|---|---|
| Lee Earnest | Southern Health Lawyers |
| Hannah Hale | Georgia School of Orthodontics |
| Brittany N. Jones | Benevis |
| Dana King | Cruser & Mitchell |
| Caitlin Pardue | Athenahealth |
| Greg Tanner | Baker Hostetler |
| Angela Tompkins | Hall Booth Smith |
| Zeke Van Keuren | Southern Health Lawyers |
| Tonya S. Watson | Zelis Healthcare |
| Sarah Catherine Whalen | Consulate Health Care |

**Mentors**
**Mentorship Class of 2020**

| | |
|---|---|
| Charlotte Combre | BakerHostetler |
| Aaron Danzig | Arnall Golden Gregory |
| Mark Kashdan | CDC |
| Beth Kitchens | Parker Hudson |
| Summer Martin | Dentons |
| Keith Mauriello | WellStar |
| John Ray | Ray & Gregory |
| Jonathan Rue | Parker Hudson |
| Raj Shah | MagMutual Insurance Company |
| Philip Sprinkle | Akerman |

**Advisory Board**
**Mentorship Class of 2020**

| | |
|---|---|
| Lynn M. Adam | Adam Law LLC |
| Scott C. Crowley | Shumaker |
| Aaron M. Danzig | Arnall Golden Gregory |
| Amy E. Fouts<br>Chair, Health Law Section | BakerHostetler |
| Lauren Slive Gennett | King & Spalding |
| Brittany N. Jones | Benevis Corporation |
| Charlene McGinty | BakerHostetler |
| Rebecca J. Merrill<br>Vice Chair, Health Law Section | Dentons US |
| Wade Pearson Miller | Alston & Bird |
| Jay D. Mitchell | Jackson Healthcare |
| Ifuero Obaseki | Department of Community Health |
| Lynnette R. Rhodes | Department of Community Health |
| Barbara J. Rogers | Arnall Golden Gregory |
| Charity Scott | Georgia State University College of Law |
| Sean T. Sullivan | Alston & Bird |

**Endnotes**

1. Lynn M. Adam is a former federal prosecutor with over 20 years of experience in healthcare law. Adam Law LLC represents whistleblowers in qui tam litigation under the False Claims Act and advises healthcare organizations on internal audits, investigations, and other compliance matters. She is the Director of the Mentorship Program and a past Chairperson of the Health Law Section for the State Bar of Georgia.

## LAWYER ASSISTANCE PROGRAM

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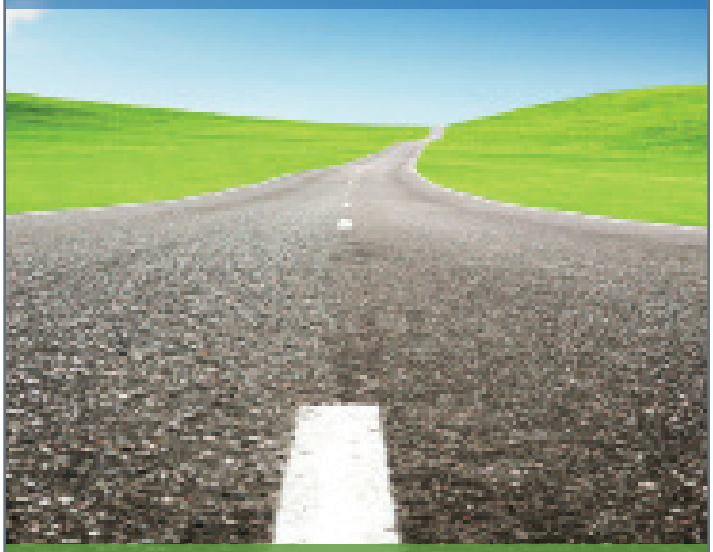

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# 2020 Executive Committee

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*Lynnette Rhodes, Immediate Past Chair*
*Amy Fouts, Chair*
*Rebecca Merrill, Vice Chair*
*Kerri Conley, Secretary*
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*Rob Rozier*
*Beth Stephens*

**Advisors**

*Stacie Kershner (Georgia State University College of Law)*

*Elizabeth Weeks (University of Georgia School of Law)*

***Health Law Developments* is looking for authors of new content for publication.**

**If you would like to contribute an article or have an idea for content, please email Keri F. Conley at kconley@gha.org.**

# Be Aware/Beware of Collateral Consequences – A Parallax

**By: Anthony L. Cochran[1] and Amy E. Buice[2]**

The concept of "parallel proceedings"[3] came into vogue several decades ago as prosecution and regulatory oversight began expanding[4] into matters traditionally handled in civil litigation. In today's intertwined healthcare environment, a more apt description may be a parallax instead of parallel proceedings. A parallax is the effect when the position or direction of an object appears to differ when viewed from different positions. Healthcare providers who find themselves in one legal proceeding, audit or investigation, need to be aware of a myriad of potential civil, criminal, regulatory, and administrative collateral consequences. A provider's position in one proceeding, audit, or investigation will likely appear different when viewed from a different perspective. Consequently, anticipation and vigilance are essential skills for any healthcare attorney.

This article is about the multiple risks to physicians, hospitals, and other healthcare entities when confronted by state, federal or private investigators, auditors, regulatory agencies, litigators, prosecutors, and reporters. This article also illustrates the need to include diverse legal specialties in responding to such investigations, e.g. contract law, corporate law, labor and employment, administrative and regulatory law, criminal law, and ethics. Lest anyone doubt that separate proceedings can become interwoven or tangled, they need only read the various federal agencies' policies on coordination.[5] Finally, this article will provide a reference guide as a starting point when confronted with a potentially multifaceted situation.

There are many different ways a heath care attorney might encounter these issues. A ZPIC or RAC may initiate an audit.[6] A provider may receive a Civil Investigative Demand ("CID")[7] that could be the prelude for a lawsuit under the False Claim Act.[8] Investigators from Health and Human Services, the FBI, the DEA, the FDA, the State Medicaid Fraud Control Unit, or the Department of Community Health could unexpectedly arrive on an employee's doorstep early in the morning as she is leaving for work and try to interview her. An attorney might receive a frantic phone call from a client as agents are executing a search warrant. In the role as in-house counsel or as a compliance officer, an attorney could receive an anonymous tip on the hospital's compliance "hotline." A physician could receive a letter or subpoena from the State Medical Board seeking information and an interview. A physician could receive notice of a peer review investigation by the Medical Executive Committee of a hospital where she holds clinical privileges. Or, a physician employed by a hospital or by a group could receive notice that she is in material breach of her employment contract. This is only a small sample of how a healthcare attorney can become engaged, and each scenario presents unique problems and concerns.

## I. Who is Your Client?

As a starting point, a healthcare attorney needs to understand who she or he represents. Knowing your clients' goals, concerns, and priorities is key.[9] Each client's objectives will likely differ depending on whether you represent a physician, a physician group, a hospital, an administrator/officer, an employee, or the medical staff.[10] An attorney must know who the client is to understand the various ethical and legal obligations triggered by the representation.

### A. Avoiding Conflicts of Interest

At a fundamental level, a client is entitled to representation free from conflicts of interest. Under Rule 1.7 of the Georgia Rules of Professional Conduct: "A lawyer shall not represent or continue to represent a client if there is a significant risk that the lawyer's . . . duties to another client . . . will materially and adversely affect the representation of the client . . . ." Thus, when undertaking representation, healthcare attorneys know they should carefully consider any divergent interests when deciding whether to represent multiple individuals or form a joint defense or

common interest group.[11]

What is in the best legal or financial interest of a hospital may not be in the best interest of an individual physician on the medical staff at the hospital, even if she or he is a hospital employee or officer. This simple example becomes more complicated when the interests of a physician group that has contracts with both the hospital and the physician are added to the mix.[12]

As one example, the intersection of corporate bylaws and ethics often surfaces when employees, officers or directors are entitled to indemnification. Counsel for individual employees are paid more often than not by the corporate employer.[13] Corporate (and insurance) counsel often want to limit the number of attorneys hired. Thus, it is not uncommon for one attorney to represent multiple employees who are considered to be witnesses, not subjects or targets by prosecutors.[14] Although this approach is appropriate, it warrants constant evaluation of potential conflicts.

**B. Preserving Client Confidentiality**

In addition to potential conflicts arising in the increasingly complex healthcare legal landscape, a lawyer needs to know who the client is in order to strictly adhere to Rule 1.6 of the Georgia Rules of Professional Conduct. Rule 1.6 requires a lawyer to "maintain in confidence all information gained in the professional relationship with the client" unless the client gives informed consent or the disclosure is impliedly authorized to carry out representation. A physician and hospital, or a physician and her group, or an administrator and a hospital, for example, might appear to have similar interests, but that shared or common interest often requires discretion and caution to preserve confidentiality and privilege to adequately protect the client's interests.

**C. Clarifying Who You Represent**

In addition to the duty to avoid conflicts and preserve client confidentiality, a healthcare attorney also sometimes has a duty to third parties to ensure that they understand who the attorney represents. Corporations often retain outside counsel to conduct an internal investigation to determine the facts, the entity's potential liability, and any misconduct by employees, officers or directors.[15] This may be one of the first intersections where the position of a participant appears to differ when viewed from different positions. Corporate counsel may take one view, prosecutors often differ, and the individual's counsel may have yet a third perspective.

Rule 1.13 of the Georgia Rules of Professional Conduct requires an attorney to have a clear understanding of who she or he represents because when representing an organization, the attorney has an assortment of ethical obligations. There is a whole body of law on *Upjohn* warnings for employees and officers when counsel for the corporate entity wants to interview them to ascertain the facts.[16] A lawyer is required when dealing with an organization's employees to explain, consistent with *Upjohn*, the identity of the client when the lawyer knows or reasonably should know that the organization's interests are adverse to those of the employee. However, if the attorney does not clarify the identity of his client, employees may share confidential information based on a faulty assumption that they are engaged in a privileged attorney-client communication with the corporate entity's attorney.

**II. <u>Specific Scenarios</u>**

An initial interview of an employed physician by an employer hospital's counsel ultimately could land in the hands of outside counsel conducting an internal investigation, an *ad hoc* peer review committee, Human Resources officers, a hearing officer, the Medical Executive Committee of the hospital's Medical Staff, the Georgia Composite Medical Board, the Georgia Department of Community Health, the State Medicaid Fraud Control Unit, Health and Human Services, the Department of Justice, the DEA, the EEOC, the professional certifying board for the physician's medical specialty, plaintiff's counsel in a *qui tam* whistleblower action, and the divorce lawyer for the physician's spouse. The extent of this not-exaggerated scenario will ultimately depend on whether or not a waiver occurred of the attorney work product privilege of hospital counsel and the hospital's attorney-client privilege. This, in turn, will depend on whether the physician is seen as a rogue or someone with a common interest. That is a parallax. As noted above, what is in the best interest of a hospital legally or financially may not be in the best interest

of an individual physician on the Medical Staff at the hospital.

The following review of potential scenarios a healthcare professional might encounter illustrates the diversity of additional legal concepts intersecting contract law, labor and employment, administrative and regulatory law, and of course, the potential of criminal law which must be considered.

**A. Termination: Contracts, Process and Consequences**

An attorney representing a physician whose employment has been terminated by a hospital or group practice must know whether the physician's employment contract (1) provides for termination with or without cause, (2) provides a right to cure, (3) has notice requirements, and (4) includes the automatic termination of clinical privileges at any healthcare facility, and if so, provides any due process procedures (e.g., peer review or the right to a hearing).[17] If due process procedures are included in the employment contract and applicable to the circumstances, then the attorney must be familiar with the procedural requirements in the applicable Medical Staff Bylaws.

Termination without cause under an employment contract is usually a two-way street providing that either the employer or the physician can terminate the contract at any time for any reason, or for no reason. Typically, without cause termination requires a notice period of 30-90 days. A without cause termination can sometimes avoid adverse collateral consequences since there will be no formal determination of "cause" for the termination.

Often, however, an employment contract provides for termination with cause and specifies terminable offenses. Labor and employment counsel and Human Resources more often than not become involved with a termination for cause. Loss, suspension, or restriction of a physician's medical license, loss of hospital privileges, loss of participation with third-party payors, board certification revocation, and material breach of the physician's duties under the contract are common "causes" justifying termination. Counsel should immediately determine if the contract includes a cure provision with which the physician can comply, since taking immediate steps to do so can be critically important in preserving the physician's employment as well as avoiding the related adverse consequences.

A termination for cause clause is sometimes accompanied by provisions to ensure a physician is afforded due process before termination. When the cause involves patient safety or other matters that might lead to disciplinary action by the hospital's Medical Staff, the contract sometimes requires that a physician receive due process under the Medical Staff Bylaws before termination. Due process can include, among other protections: a written decision and rationale to terminate; adequate notice of the right to a hearing and a reasonable opportunity to prepare for the hearing; discovery of the evidence and witnesses; a fair, objective, and independent hearing; a statement of findings; and written notice of the right of appellate review after a hearing.

Additionally, certain causes for termination (e.g., loss of license, suspension, loss of board certification, etc.) cannot occur without due process.[18] A physician cannot have her medical license revoked without due process. Although the specific procedural protections depend on a flexible balancing test that weighs the government's interest and that of the individual, generally a physician is entitled to a hearing before any adverse action is taken.[19] The exception, however, is when a physician's license or clinical privileges are summarily suspended and due process is afforded after-the-fact.[20] This can occur under certain circumstances specified in the applicable regulations or Medical Staff Bylaws (such as when a physician has been charged with certain crimes) and when pre-deprivation process is impractical (such as when patient safety is at risk).[21]

Physicians working at all hospitals receiving federal funds, including private hospitals, receive minimal due process protections from the Healthcare Quality Improvement Act of 1986 (HCQIA). HCQIA requires at least 30 days' notice prior to a revocation hearing, a mutually acceptable hearing officer, a right to representation at the hearing, a record of the hearing, the right to call and examine witnesses, the right to present evidence, the right to submit a written statement at the end of the hearing, the right to receive a written communication of the decision including the basis for the decision, and the right of

appeal.[22] Also, the Joint Commission,[23] American Medical Association,[24] and American College of Emergency Physicians[25] all encourage some due process before suspension or revocation of licenses or privileges. However, the cases are few in which a court finds a failure to provide due process.[26] Many courts afford hospitals great deference by viewing peer review as specialized alternative dispute resolution for physicians.[27]

After assessing the process due to the client from an employer, it is important for the attorney to understand the possible consequences of such process. For example, hospitals have a statutory obligation to refer peer review disciplinary matters to the Georgia Composite Medical Board.[28] Another very significant risk for a physician finding himself in a peer review proceeding is the HCQIA's requirement that a hospital imposing discipline on a physician must make a report to the National Practitioner Data Bank (NPDB).[29] The consequences for a hospital that does not provide a timely report are so severe that no prudent hospital counsel would entertain such a risk. Attorneys must be aware of the Medical Board and NPDB requirements, as the negotiation of the wording of the report is often career-determining for an individual physician.

Another issue to consider is that many contracts also contain non-compete covenants that can prevent a physician from practicing within a certain geographic location for a specified amount of time.[30] Some contracts also contain "tail" insurance coverage requirements – provisions specifying who (physician, hospital, or medical group) must pay for the insurance covering defense costs and liability for any suits arising from alleged tort liability for the physician's actions that occurred before termination. Depending on the length of employment, there might also be provisions requiring the terminated physician to reimburse the employer for its recruitment costs. The attorney must be sure to identify these provisions and explain them to the client.

These are only the civil consequences of termination. Other, larger, risks loom.

**B. False Claims Act**

The False Claims Act ("FCA") is a huge risk in and of itself.[31] There are entire treatises devoted to the FCA. The financial risks under the FCA are considerable, and Corporate Integrity Agreements are commonly imposed when settling claims under the FCA. The potential for the client to be excluded from participation in Medicare and Medicaid is a common risk when defending claims under the FCA. Both the federal and state governments actively seek, and tout, large financial recoveries under the FCA.[32] Counsel for "relators" (private litigants) have become much more aggressive in recent years when the government declines to intervene under the FCA.[33]

One significant consideration when a potential criminal prosecution is on the horizon, or staring a client in the face, is when and whether to invoke the Fifth Amendment privilege against self-incrimination. This decision vividly illustrates a parallax. Invoking the privilege in the midst of a criminal investigation is commonplace,[34] but invocation when a physician faces a civil matter, like an action under the FCA, could result in a negative inference to be used against the provider in the FCA case. Similarly, in an administrative proceeding before the Georgia Composite Medical Board or the Depart of Community Health, invoking the Fifth Amendment could easily lead to license suspension (if not revocation) and the accompanying loss of the physician's livelihood.[35] As with a parallax, one's position appears to differ when viewed from a different position. Viewed from another position, corporations and other collective entities cannot invoke the Fifth Amendment privilege.[36]

Negotiation of a resolution can be incredibly complicated. More often than not, a global resolution is impossible. Settlement agreements with the Department of Justice of *qui tam* whistleblower actions typically contain carve-out provisions that explicitly exclude other proceedings (e.g., the risk of criminal prosecution).[37] Regardless of whether a *nolo contendere*, First Offender, or an *Alford* plea is entered in a criminal prosecution, regulatory agencies treat the plea as a guilty plea,[38] and exclusion under Medicare and Medicaid becomes inevitable.[39] This can also result in other severe consequences, including insurance carriers removing a physician from eligibility as an approved provider, loss of DEA registration, or loss of a medical license.

### C. Public Relations and Response to Adverse Action

Competition among hospitals has become fierce, and public relations has become an essential part of hospital marketing. A robust media response with the participation of counsel may be necessary in the midst of an investigation, audit or litigation. On the other hand, some healthcare professionals prefer to avoid publicity to protect their reputations and careers, and do not want counsel making public statements. In these circumstances, often "discretion is the better part of valor."[40] Once again, there are ethical rules to consider.[41] A fair response may be appropriate, depending on the setting, "to protect a client from the substantial undue prejudicial effect of recent publicity not initiated by the lawyer or the lawyer's client."[42]

## CONCLUSION

While this article could go on, it should be clear that today's healthcare environment presents a complex interrelationship of oversight, regulation and risks. Your view depends on where you stand in the parallax.

### Endnotes

1. Anthony L. Cochran is a former AUSA and a former partner of Chilivis, Cochran, Larkins & Bever LLP. Tony is a partner in the Litigation Practice of Smith, Gambrell & Russell, LLP.
2. Amy E. Buice is an associate in the Litigation Practice of Smith, Gambrell & Russell, LLP.
3. Anthony L. Cochran, "Government Investigations of Physicians: The Perils of Parallel Proceedings," Georgia Health Law Developments 12-15 (Spring 2014), available at https://www.gabar.org/committeesprogramssections/sections/healthlaw/upload/Spring_2014_Healthlaw.pdf.; Stacey Mitchell and Amanda Kane, "Parallel Proceeding or Piling On?", American Bar Association (July 2, 2018), available at https://www.americanbar.org/groups/environment_energy_resources/publications/trends/2017-2018/july-august-2018/parallel_proceedings/. Unless otherwise noted, all references to internet locations of documents set forth herein are based on the authors' access to such documents during 2020.
4. *See, e.g., United States v. Kordel*, 397 U.S. 1 (1970).
5. "Coordination of Parallel Criminal, Civil, Regulatory, and Administrative Proceedings," The Department of Justice (January 30, 2012), available at https://www.justice.gov/jm/organization-and-functions-manual-27-parallel-proceedings; "Coordination of Parallel Criminal, Civil, Regulatory, and Administrative Proceedings," The Department of Justice (May | 2018), available at https://www.justice.gov/jm/jm-1-12000-coordination-parallel-criminal-civil-regulatory-and-administrative-proceedings; "Policy Statement of the Department of Justice on its Relationship and Coordination with the Statutory Inspectors General of the Various Departments and Agencies in the United States," The Department of Justice (Updated January 21, 2020), available at https://www.justice.gov/archives/jm/criminal-resource-manual-934-policy-statement-department-justice-its-relationship-and; Memorandum of Rod J. Rosenstein regarding Policy of Coordination of Corporate Resolution Penalties, The Department of Justice (May 9, 2018), available at https://www.justice.gov/opa/speech/file/1061186/download; "Heath Care Fraud and Abuse Control Program," U.S. Department of Health and Human Services Office of Inspector General, available at https://oig.hhs.gov/reports-and-publications/hcfac/index.asp (stating that the "national Healthcare Fraud and Abuse Control Program … is designed to coordinate Federal, State and local law enforcement activities with respect to healthcare fraud and abuse.").
6. David Stewart, "Spotlight on Healthcare Audit Defense: Medicare ZPIC Audits," Crowder Stewart LLP (March 23, 2018), available at http://www.crowderstewart.com/2018/03/23/spotlight-on-healthcare-audit-defense-medicare-zpic-audits/; "What is MAC," Centers for Medicare and Medicaid Services (last modified December, 13, 2019), available at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC
7. "What To Do When the Government Asks for Everything: Strategies for Healthcare Companies to Negotiate the Scope of Civil Investigative Demands in False Claims Act Investigations," American Bar Association (January 1, 2014),

available at https://www.americanbar.org/groups/health_law/publications/aba_health_esource/2013-14/january/what_to_do/.

8. "The False Claims Act: A Primer," The Department of Justice (April 22, 2011), available at https://www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf.
9. *See* Georgia Code of Professional Responsibility, Rule 1.4(a); *see also*, Cochran, "Government Investigations of Physicians: The Perils of Parallel Proceedings," *supra* note 1.
10. The same concerns arise when representing other healthcare entities, e.g., a medical equipment company, a pharmacy or pharmacist, a billing and coding company, etc.
11. Practical Law Glossary: Common Interest Doctrine, available at https://content.next.westlaw.com/0-510-1094?transitionType=Default&contextData=(sc.Default)&__lrTS=20200214020657004&firstPage=true&bhcp=1;
Same Joint Defense/Common Interest Agreement, Beveridge & Diamond PC, available at https://www.acc.com/sites/default/files/resources/vl/membersonly/SampleFormPolicy/1421855_1.pdf; Mark L. Tuft and Brandon Lawrence, "What's Uncommon About the "Common Interest" Doctrine," 38th ABA National Conference on Professional Responsibility (May 31, 2012), available at https://www.americanbar.org/content/dam/aba/administrative/professional_responsibility/38th_conf_session8_whats_uncommon_about_the_common_interest_doctrine.authcheckdam.pdf.
12. As healthcare lawyers readily appreciate, this simple example becomes even more complex if other entities, e.g., billing, coding, pharmaceutical, or equipment companies, are involved.
13. Memorandum from Paul J. McNulty regarding Principles of Federal Prosecution of Business Organizations, Deputy Att'y Gen., to all U.S.D.O.J. Component Heads and U.S. Att'ys (July 5, 2007), available at https://www.justice.gov/sites/default/files/dag/legacy/2007/07/05/mcnulty_memo.pdf)
14. See Peter W. Tague, "Multiple Representation of Targets and Witnesses During a Grand Jury Investigation," Georgetown University Law 17 Am. Crim. Law Rev. 301-339 (1980), available at https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1703&context=facpub (detailing circumstances when counsel is or is not disqualified for representing multiple clients in grand jury investigations).
15. *See* "Effective Corporate Investigations," American Bar Association (April 25, 2019), https://www.americanbar.org/groups/tort_trial_insurance_practice/publications/the_brief/2016_17/winter/effective_corporate_investigations/ ("In 2014, more than two thirds of companies in the insurance, energy, financial services, and healthcare industries reported retaining outside counsel to assist with regulatory and government investigative activity" and that number "continues to increase.").
16. *See Upjohn Company v. United States*, 449 U.S. 383 (1981). Note, Ethics Rule 4.3 (Dealing with Unrepresented Person) might also come into play here.
17. A "without cause" termination clause typically looks like this: "Except as otherwise provided herein, either Party may terminate this Agreement by giving not less than 90 days advance written notice to the other Party. Both parties shall have the right to terminate the Agreement for cause during any without cause notice period." "Terminating an Employment Contract," American Medical Association 8 (2016), available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/aps/a18-levenstein-contract.pdf.
18. *See*, generally, O.C.G.A. § 50-13-13.
19. *See Mathews v. Eldridge*, 424 U.S. 319 (1976); *see also, Darlak v. Bobear*, 814 F.2d 1055 (5th Cir. 1987) (holding that an informal hearing satisfied due process rights of a temporarily suspended physician but that a formal hearing was required before final suspension).
20. *See* O.C.G.A. § 43-34-8(a.1) and § 50-13-18(c).
21. *See* O.C.G.A. § 50-13-18(c)(1); *Patel v. Midland Memorial Hosp. and Med. Ctr.*, 298 F.3d 333 (5th Cir. 2002); June M. McKoy, "Suspending a Physician without a Hearing," Journal of Ethics AMA (March 2004), available at https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-07/hlaw1-0403.pdf (no hearing is required before suspending a physician's hospital privileges if the medical facility had *reasonable grounds* for suspending).
22. *See* 42 USC § 11112.
23. The Joint Commission requires a hearing and appellate review of any adverse decision by the medical staff regarding physician's privileges.

24. AMA also suggests adhering to principles of a fair and objective hearing by including: "(1) A listing of specific charges; (2) adequate notice of the right of a hearing; (3) the opportunity to be present and to rebut the evidence; (4) the opportunity to present a defense." AMA Code of Medical Ethics Opinion 9.4.1, available at https://www.ama-assn.org/delivering-care/ethics/peer-review-due-process.
25. American College of Emergency Physicians Policy Statement on Emergency Physician Rights and Responsibilities (September 2000), available at https://www.acep.org/patient-care/policy-statements/emergency-physician-rights-and-responsibilities/.
26. *See Patton v. St. Francis Hosp*., 260 Ga. App. 202 (2003) and 246 Ga. App. 4 (2000); *Northeast Georgia Medical Ctr., Inc. v. Davenport*, 272 Ga. 173 (2000); *Wood v. Archbold Medical Center, Inc*., 738 F.Supp.2d 1298, 1358 (M.D. Ga. 2010); *Kolb v. Northside Hosp*., 342 Ga. App. 192 (2017); *Cancel v. The Medical Center of Central Ga., Inc*., 345 Ga. App. 215 (2018); DeKalb Medical Center, Inc. v. Obekpa, 315 Ga. App. 739 (2012); *Burrowes v. Northside Hosp*., 294 Ga. App. 472 (2008).
27. *See Sosa v. Board of Managers of Val Verde Memorial Hospital*, 437 F.2d 173 (5th Cir. 1971); *Bonner v. City of Pritchard*, 661 F. 2d 1206 (11th Cir. 1981); ICLE Fundamentals of Healthcare Law 146 (February 27, 2009), available at https://www.gabar.org/membership/cle/upload/10169_Fundamentals_of_health_care_law.pdf.
28. O.C.G.A. § 31-7-8 ("medical staff privileges denied, restricted, or revoked for any reason involving the medical care given his patient").
29. "What you Must Report to NPDB," National Practitioner Data Bank, available at https://www.npdb.hrsa.gov/hcorg/"whatYouMustReportToTheDataBank.jsp (listing reporting requirements).
30. *See* O.C.G.A. §§ 13-8-50 – 59; "Physician contracting: Restrictive covenants, termination clauses," American Medical Association (November 7, 2019), available at https://www.ama-assn.org/residents-students/transition-"practice/physician-contracting-restrictive-covenants-termination; Vanessa Maire Griffith, "Non-Compete Agreements with Employers," Practical Law Labor & Employment (Westlaw), available at https://www.westlaw.com/7-501-3409?transitionType=Default&contextData=(sc.Default)&VR=3.0&RS=cblt1.0.
31. *See* "The False Claims Act: A Primer," *supra* note 6; Jetson Leder-Luis, "Whistleblowers, The False Claims Act, and the Behavior of Healthcare Providers," Massachusetts Institute of Technology (December 9, 2019), available at https://economics.mit.edu/files/18187.
32. *See e.g.*, The United States Department of Justice Press Release: Justice Department Recovers over $2.8 Billion from False Claims Act Cases in Fiscal Year 2018 (December 18, 2018), available at https://www.justice.gov/opa/pr/justice-department-recovers-over-28-billion-false-claims-act-cases-fiscal-year-2018; The United States Department of Justice Press Release: Justice Department Recovers over $3 Billion from False Claims Act Cases in Fiscal Year 2019, available at https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019; The United States Department of Justice Press Release: Georgia Hospital Pays U.S. $13.9 Million to Resolve Medicaid False Claims Act Allegations, available at https://www.justice.gov/opa/pr/georgia-hospital-pays-us-139-million-resolve-medicaid-false-claims-act-allegations.
33. *See* Michael A. Sullivan, *The Federal False Claims Act and Georgia's Two False Claims Acts*, Georgia Bar Journal 69 (May 10, 2019) ("More than 80% of federal FCA recoveries now are in cases of fraud brought by private citizen "relators.").
34. Don Samuel and Scott Grubman, *Parallel Proceedings*, Georgia State Bar Journal, Feb., 2020 ed., at 22, n. 22 (criminal defense counsel often see the invocation as "essentially cost-free"; however, a medical professional with a reputation and career to protect will often be quite reluctant to invoke the privilege against self-incrimination, and not see the invocation as "cost-free").
35. *See, e.g., In the matter of Narendra Nagareddy*, Interim Consent Order, Docket Number 200160038, Feb. 5, 2016; *In the matter of Seth Alex Pope*, Interim Consent Order, Docket Number 2010002, Nov. 5, 2009.
36. *See, Bellis v. United States*, 417 U. S. 85 (1974), and *Braswell v. United States*, 487 U.S. 99 (1988).
37. Jonathan Cone, Robert Rhoad, and Robert Sneckenberg, "Negotiating False Claims Settlements," Briefing Papers, Thomson Reuters

(February 2014), available at https://www.crowell.com/files/Negotiating-False-Claims-Act-Settlements.pdf.

38. O.C.G.A. Section 43-34-8(a)(3); Nick Oberheiden, "What Charges Can Result in the Loss of a Medical License," Oberheiden P.C. (July 17, 2018), available at https://criminaldefense.com/what-charges-can-result-in-loss-of-medical-license/.
39. *See* Steven L. Simas, "Collateral Consequences of Healthcare License Discipline – Medicare Exclusion," Simas & Associates (October 3, 2017), available at https://simasgovlaw.com/collateral-consequence-healthcare-license-discipline-medicare-exclusion/
40. William Shakespeare, *King Henry the Fourth*, Part One.
41. *See e.g.*, Rule 3.6, Georgia Rules of Professional Conduct.
42. *Id*.

**The opinions expressed within *Health Law Developments* are those of the authors and do not necessarily reflect the opinions of the State Bar of Georgia, the Health Law Section or the Section's Executive Committee.**